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, August 10, 2017
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

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. Updates on TDSHS Budget and Programs — Shelley Lucas, Texas Dept. of State Health Services (TDSHS)

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: Update on Speakers Bureau
      Recommended Action: FYI: The Speaker's Bureau Workgroup met on June 6th to revise the procedure for securing and scheduling speaking engagements. Please see the attached procedure. On August 15th, the Speaker's Bureau Workgroup will determine speaking engagement goals and measures, with particular focus on recruiting applicants for Project LEAP and Planning Council from among local business communities. Please see Diane if you would like to be added to the Speaker's Bureau Workgroup.

Item: Needs Assessment - Youth and Aging Profile
Recommended Action: FYI: See the attached Youth and Aging Profile.

Item: FY 2018 EIIHA Plan
Recommended Action: Motion: In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2018 EIIHA Plan, provided that:

- The FY 2018 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and
- The recommended FY 2018 EIIHA Plan is distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.

Item: FY 2018 EIIHA Plan
Recommended Action: FYI: The EIIHA Workgroup will tentatively meet at 1:00 p.m. on Thursday August 17, 2017 to begin work on the FY18 EIIHA Plan, pending receipt of the FY18 Plan Guidance. Please see Diane if you would like to be added to the EIIHA Workgroup.

B. Quality Improvement Committee — Robert Noble and Gloria Sierra, Co-Chairs
Item: Assessment of the Administrative Mechanism – Part A/MAI*
Recommendation: **Motion:** Pending committee approval.

Item: Proposed Part B Standards of Care Review
Recommendation: **Motion:** Pending committee approval of input into proposed Part B standards of care for LPAP, Emergency Financial Assistance, Health Education and Risk Reduction, Home and Community Health Services and Linguistic Services.

Item: Reports from the Administrative Agency – Part A/MAI*
Recommendation: See the attached FY 2016 Performance Measures Highlights

C. Affected Community Committee — Rodney Mills and Tana Pradia, Co-Chairs
Item: Standards of Care Training
Recommended Action: FYI: Standards of care training will take place for all who wish to participate at the Affected Community Committee meeting at 12 noon on Monday, August 21, 2017. On September 25, 2017, there will be a consumer-only workgroup to provide input into standards of care for FY 2018 Ryan White Part A/MAI*, Part B and State Services funded services.

* *Minority AIDS Initiative funding (MAI)*
*** State Services funding (SS)*

Item: Camino hacia tu Salud
Recommended Action: FYI: *Camino hacia tu Salud*, the Spanish version of *Road 2 Success,* will take place on Monday evening, August 28, 2017. The Affected Community Committee is partnering with Positive713 to co-host the event.

Item: 2017 Community Events
Recommended Action: FYI: See the attached list for 2017 community events where the Council will have a presence.

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

D. Operations Committee — Curtis Bellard and Nancy Miertschin, Co-Chairs
Item: Cross Committee Trainings
Recommended Action: FYI: Verbal update.

Item: 2017 Council Training Topics
Recommended Action: FYI: See the attached schedule.

Item: Council Bylaws, Policies and Procedures
Recommended Action: FYI: The Operations Committee continues to review and make suggested revisions to all Council policies and procedures, as well as the bylaws.

Item: Council Bylaws, Policies and Procedures
Recommended Action: **Motion:** Office of Support staff is to remove and replace all stigmatizing language found in the Council bylaws, policies and procedures.

Item: 2017 Attendance
Recommended Action: FYI: The Operations Committee reviewed attendance records and sent reminder letters to Council and external Committee members who have missed four meetings or more in 2017.

E. Priority and Allocations Committee — Ella Collins-Nelson and Paul Grunenwald, Co-Chairs
Item: Pilot Project: Mobile App for Engagement in Care
Recommended Action: Motion: Pending approval by the Quality Improvement Committee, approve $347,746 in MAI* funds for a pilot project to test a mobile app designed to improve engagement and retention in care for African American and Hispanic Ryan White consumers.

* *Minority AIDS Initiative funding (MAI)*

Item: Reallocation of FY 2016 Carryover Funds – Part A and MAI*
Recommended Action: **Motion:** Approve the attached chart, which reallocates $444,642 in Ryan White Part A and $631,496 in Minority AIDS Initiative funding.

Item: FY 2017 Emergency Financial Assistance
Recommended Action: **Motion:** If Ryan White Grant Administration is unable to allocate $50,000 in Ryan White Part A and/or $50,000 in MAI* funding to Emergency Financial Assistance in FY 2017, then the Part A funds will be allocated to LPAP and the MAI* funds will be allocated to the Mobile App pilot project in FY 2017.

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

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

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

VII. 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

* *Minority AIDS Initiative funding (MAI)*

J. Texas HIV Syndicate — Amber Harbolt

K. Legislative Updates — Denis Kelly

L. Texans Living with HIV Network — Venita Ray

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, July 13, 2017
Meeting Location: Ryan White Offices, 2223 W. Loop South, Room 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Cecilia Ross, Chair	Tana Pradia	Alex Moses
Carol Suazo, Secretary	Venita Ray	Veria Steptoe
Ted Artiaga	Viviana Santibanez	Shola Oshugbade
Connie Barnes	Gloria Sierra	Undrea Goodwin, Detroit, MI
Curtis Bellard	Steven Vargas	Quintin Stroud, Detroit, MI
Skeet Boyle	Larry Woods	
Bianca Burley		
Ella Collins-Nelson		**STAFF PRESENT**
Amber David		*Ryan White Grant Administration*
Johnny Deal		Carin Martin
Evelio Salinas Escamilla	**MEMBERS ABSENT**	Heather Keizman
Herman Finley	David Benson, excused	Tasha Traylor
Tracy Gorden	Arlene Johnson	
Paul Grunenwald	Peta-gay Ledbetter, excused	*The Resource Group*
Angela F. Hawkins	Nancy Miertschin, excused	Sha'Terra Johnson-Fairley
J. Hoxi Jones	Rodney Mills, excused	
Denis Kelly	Robert Noble, excused	*Office of Support*
Tom Lindstrom	Shital Patel, excused	Tori Williams
Osaro Mgbere	Teresa Pruitt, excused	Amber Harbolt
Allen Murray	Krystal Shultz, excused	
John Poole	Isis Torrente, excused	

Call to Order: Cecilia Ross, Chair, called the meeting to order at 12:10 p.m.

During the opening remarks, Ross welcomed Tracy Gorden, the new Vice Chair. She also welcomed Quintin Stroud, Chair, and Undrea Goodwin, Health Planning Coordinator, Southeastern Michigan HIV/AIDS Council. Mr. Stroud and Ms. Goodwin explained that they were visiting the Houston Council in order to learn about Project LEAP so that they could start a similar project in the Detroit area. Ross continued by thanking the Priority and Allocations Committee for their hard work preparing recommendations; the Committee held several special meetings, their regularly scheduled

meeting and a public hearing all in the month of June. She also thanked the co-chairs of the Affected Community for chairing the public hearing. Everyone arrived at the hearing prepared and ready to be televised! Amber gave an excellent review of the 2016 Needs Assessment at the public hearing. She has an amazing ability to make complex data easy to understand and her cartoons and jokes make all of her presentations fun and interesting. She also thanked Diane for her hard work on the public hearing. She spent a lot of time in June preparing scripts, handouts, signs and more, which made all of us look good when the cameras started rolling. This month, members of the Affected Community Committee hosted *Road 2 Success* at the public clinic. The conference room was packed which shows that consumers are hungry for information about case management. Congratulations to the Affected Community Committee for a job well done. And, Ross extended thanks to the Affected Community Committee for organizing the Ryan White booth at the Pride Festival. Then, Ross called for a Moment of Reflection,

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Bellard, Barnes) to approve the June 8, 2017 minutes.* **Motion carried.** Abstentions: Boyle, David, Mgbere and Pradia.

Training: Priority Setting and Allocations Processes: Collins-Nelson walked the Council through the attached power point presentation which described the priority setting process. She also reviewed the philosophy which was used, along with the FY 2018 Principles and Criteria, to determine the allocations for FY 2018. Grunenwald pointed out that a description of and justification for allocation changes made to an individual service category were documented in the far right hand column of the FY 2018 Level Funding Scenario.

Public Comment and Announcements: See three attached written comments. Vargas distributed a flyer about a community meeting for the Hispanic community and invited members to read a recently released *National Health Assessment of Latinos Growing Older with HIV*. Hard copies were on the information table and electronic copies will be distributed to members later in the day.

Reports from Committees:
Comprehensive HIV Planning Committee: Vargas, Co-Chair, reported on the following:
In May and June, Amber Harbolt shared the results of the 2016 Houston Area HIV Needs Assessment and Continuum of Care at the 2017 Ryan White televised public hearings.

Quality Improvement Committee: No report.

Affected Community Committee: Tana Pradia, Co-Chair, reported on the following:
June 26, 2017 Public Hearing: In June, the Affected Community Committee hosted the second televised 2017 Public Hearing where the proposed Ryan White FY 2018 service priorities & allocations were presented.

2017 Road 2 Success: On Thursday, June 29, 2017 the Affected Community Committee partnered with Thomas Street Health Center to co-host Road 2 Success. Presentations focused on eligibility and case management services. Amber Harbolt also met with consumers to solicit ideas for strengthening Ryan White funded services.

Camino hacia tu Salud: Camino hacia tu Salud, the Spanish version of Road 2 Success, will take place on Monday evening, August 28, 2017. The Affected Community Committee is partnering with Positive713 to co-host the event.

2017 Community Events: The Affected Community Committee hosted a booth at the Houston Pride Festival. See the attached list for additional community events where the Council will have a presence.

2017 Greeters: See the attached list of Greeters at the 2017 Council meetings.

Operations Committee: No report.

Priority and Allocations Committee: Paul Grunenwald, Co-Chair, reported on the following:
Reports from the Administrative Agent – Part A/MAI: See the attached reports:

- FY 2016 RW Part A/MAI Procurement, dated 06/12//17
- FY 2016 RW Part A/MAI Service Utilization, dated 06/12/17

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

- FY16/17 RW Part B Procurement, dated 06/12//17
- FY16/17 RW Part B Service Utilization, dated 06/12/17
- FY15/16 State Services Procurement, dated 06/12//17
- FY15/16 State Services Service Utilization, dated 06/12/17
- FY16/17 Health Insurance Assistance Report, dated 06/02/17

FY 2018 Ryan White Service Priorities*:* **Motion #3:** Approve the attached FY 2018 Service Priorities for Ryan White Parts A and B, MAI and State Services. **Motion carried. Abstentions:** Artiaga, David, Escamilla, Finley, Kelly, Lindstrom, Mgbere and Ray.

Philosophy Used for FY 2018 Allocations: See the attached philosophy.

FY 2018 Allocations: Level Funding Scenario – All Funding Streams: **Motion #4**: Approve the attached FY 2018 Level Funding Scenario for Ryan White Parts A and B, MAI and State Services funds. See motion 1 on the attached chart for details. **Motion carried. Abstentions:** Artiaga, David, Escamilla, Finley, Kelly, Lindstrom, Mgbere and Ray.

FY 2018 Allocations: Increase/Decrease Funding Scenarios – MAI: **Motion #5**: Approve the attached FY 2018 Increase & Decrease Funding Scenarios for Ryan White MAI funds (motion 2). **Motion carried. Abstentions:** Artiaga, David, Escamilla, Finley, Kelly, Lindstrom, Mgbere and Ray.

FY 2018 Allocations: Increase/Decrease Funding Scenarios – Part A: **Motion #6**: Approve the attached FY 2018 Increase & Decrease Funding Scenarios for Ryan White Part A funds (motion 3). **Motion carried. Abstentions:** Artiaga, David, Escamilla, Finley, Kelly, Lindstrom, Mgbere and Ray.

FY 2018 Allocations: Increase/Decrease Funding Scenarios - Part B & SS: **Motion #7**: Approve the attached FY 2018 Increase & Decrease Funding Scenarios for Ryan White Part B and State Services funds (motion 4). **Motion carried unanimously.**
Report from Office of Support: Tori Williams, Director, summarized the attached report.

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

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

New Business
Updates from Task Forces
African American: Sha'Terra Johnson-Fairley said African American State of Emergency would meet on Friday July 14th at the Fifth Ward Multi-Service Center (4014 Market Street) at noon, and reported that the TBWI would meet Thursday July 20th at The Resource Group.

Latino: Sierra reiterated that there would be an Immigration Community Meeting on Tuesday July 25th at AAMA's Garza Building (6001 Gulf Freeway) from 2:00 p.m. to 6:00 p.m.

MSM: Artiaga said MPact did not meet in June. The next meeting will take place Monday July 24th.

Transgender: No update.

Hepatitis C: Vargas submitted the attached report, and noted that the Task Force will be encouraging agencies to provide hepatitis testing during the last week of July in observance of National African American Hepatitis C Action Day (Tuesday July 25th) and World Hepatitis Day (Friday July 28th). Those who wish to participate in hepatitis testing observance in July can contact Steven Vargas or the Hepatitis C Task Force.

Youth: Sierra said the Youth Task Force is currently working with the Houston Independent School District to adjust the sexual education provided in schools.

HIV and Aging: Finley said there will be an HIV and Aging Conference in Austin, and asked those interested to contact the Office of Support for the information provided in the Texas Department of State Health Services Insider newsletter.

Positive Women's Network (PWN): Pradia said PWN has expanded to encompass the state of Texas. The next PWN meeting will take place on Monday, August 7th at 6:00 p.m. Pradia also announced there will be a Community Advisory Board (CAB) meeting for women's care at Legacy Community Health (LCH) on Thursday, July 27th at 6:00 p.m.

END HIV Houston: Ray said the next END HIV Houston meeting will take place on Tuesday, July 18th at 6:00 p.m. at LCH. Topics will including implementation development and next steps.

Texas HIV Syndicate: No update

Texans Living with HIV Network: Ray said that the Texas Living with HIV Network is forming to provide support and advocacy for people living with HIV statewide. The Texas Living with HIV Network Steering Committee is still in its planning phase for the network and taking names of individuals interested in participating. Please contact Steven Vargas or Venita Ray for more information.

Legislative Updates: Kelly said that the Texas Special Session will start Tuesday, July 18th. Kelly noted that two bills in particular will affect LGBTQ individuals, with 20 topics overall.
.

Announcements: David reported that 400 individuals were tested June 27th-29th at the National Testing Day event, with many individuals re-linked to care and 180 individuals received recommended immunizations. David also mentioned that Catholic Charities will be holding a forum on HIV and veterans in October or November. Sierra asked members to keep the campers and counselors at the upcoming Camp Hope in their thoughts. Finley said that there had been another murder of a transgender individual in the U.S., and noted that there would be a screening of the film *Major!* on the life of transgender rights advocate Major Griffin-Gracy. Gorden provided a brief update on Friends Together projects in Africa. Ray announced the Positive Strike Force would soon be available to provide brief presentations on eliminating stigmatizing language from organizations, and asked anyone interested in receiving this presentation to contact Venita Ray.

Adjournment: The meeting was adjourned at 1:05 p.m.

Respectfully submitted,

_____ _____

Victoria Williams, Director Date

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for July 13, 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** FY18 Service Priorities **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** FY18 Service Priorities **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	Tana Pradia		X						X		X		
Carol Suazo, Secretary		X				X				X			Venita Ray		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			Steven Vargas		X				X				X		
Skeet Boyle		X						X		X			Larry Woods		X				X				X		
Bianca Burley		X				X				X															
Ella Collins-Nelson		X				X				X															
Amber David		X						X				X	**MEMBERS ABSENT**												
Johnny Deal		X				X				X			David Benson												
Evelio Salinas Escamilla		X				X						X	Arlene Johnson												
Herman Finley		X				X						X	Peta-gay Ledbetter												
Tracy Gorden		X				X				X			Nancy Miertschin												
Paul Grunenwald		X				X				X			Rodney Mills												
Angela F. Hawkins		X				X				X			Robert Noble												
J. Hoxi Jones		X				X				X			Shital Patel												
Denis Kelly		X				X						X	Teresa Pruitt												
Tom Lindstrom		X				X						X	Krystal Shultz												
Osaro Mgbere		X						X				X	Isis Torrente												
Allen Murray		X				X				X															
John Poole		X				X				X															

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #4** FY18 Level Funding **Carried**				**Motion #5** FY18 MAI Increase/Decrease **Carried**				**Motion #6** FY18 Part A Increase/Decrease **Carried**					**Motion #4** FY18 Level Funding **Carried**				**Motion #5** FY18 MAI Increase/Decrease **Carried**				**Motion #6** FY18 Part A Increase/Decrease **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	Tana Pradia		X				X				X		
Carol Suazo, Secretary		X				X				X			Venita Ray				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			Steven Vargas		X				X				X		
Skeet Boyle		X				X				X			Larry Woods		X				X				X		
Bianca Burley		X				X				X															
Ella Collins-Nelson		X				X				X															
Amber David				X				X				X	**MEMBERS ABSENT**												
Johnny Deal		X				X				X			David Benson												
Evelio Salinas Escamilla				X				X				X	Arlene Johnson												
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Tracy Gorden		X				X				X			Nancy Miertschin												
Paul Grunenwald		X				X				X			Rodney Mills												
Angela F. Hawkins		X				X				X			Robert Noble												
J. Hoxi Jones		X				X				X			Shital Patel												
Denis Kelly				X				X				X	Teresa Pruitt												
Tom Lindstrom				X				X				X	Krystal Shultz												
Osaro Mgbere				X				X				X	Isis Torrente												
Allen Murray		X				X				X															
John Poole		X				X				X															

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #7** FY18 Part B/SS Increase/Decrease **Carried**													**Motion #7** FY18 Part B/SS Increase/Decrease **Carried**									
MEMBERS	ABSENT	YES	NO	ABSTAIN									MEMBERS	ABSENT	YES	NO	ABSTAIN							
Cecilia Ross, Chair				C									Tana Pradia		X									
Carol Suazo, Secretary		X											Venita Ray				X							
Ted Artiaga				X									Viviana Santibanez		X									
Connie Barnes		X											Gloria Sierra		X									
Curtis Bellard		X											Steven Vargas		X									
Skeet Boyle		X											Larry Woods		X									
Bianca Burley		X																						
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Amber David				X									**MEMBERS ABSENT**											
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Tracy Gorden		X											Nancy Miertschin											
Paul Grunenwald		X											Rodney Mills											
Angela F. Hawkins		X											Robert Noble											
J. Hoxi Jones		X											Shital Patel											
Denis Kelly				X									Teresa Pruitt											
Tom Lindstrom				X									Krystal Shultz											
Osaro Mgbere				X									Isis Torrente											
Allen Murray		X																						
John Poole		X																						

Public Comment

In an effort to save paper, please see attached two sided copies.

Public comment – 06-19-17

Last year one CCM contractor served 558 consumers and spent the total contract amount of $244,325.00 and had 173 units ($4,325.00) left in No Pay for a total that should have been billed of $248,650.

This year if that contractor does the same amount of units (9,946) with a higher unit rate ($30), at least $298,380.00 will be needed to keep the amount of services level . Since there are 2 providers, we request that the category be $596,760 to keep level services. Please keep in mind that even clients who have insurance for primary care need CCM which is not reimbursable by insurance. Thank you.

Comprehensive HIV Planning Committee Report

SPEAKERS BUREAU
PROCEDURE FOR SECURING A SPEAKING ENGAGEMENT

(Updated: 06-06-17)

Establishing Contact & Scheduling the Event

1. Contact the Chamber of Commerce representatives to see if they are interested in securing one of our speakers with mailing (Office of Support) and follow-up calls (Workgroup Contact Appointee). If yes:
2. A Workgroup Contact Appointee works with the Chamber representative and speakers to select at least two appropriate speakers (one alternate) and a date for the presentation. The Workgroup Contact Appointee then sends this information to the Office of Support via email.

Anyone who has a contact with a local Chamber of Commerce/Business Group should obtain contact information for the Chamber/Group member responsible for coordinating speaker, sends this information to the Office of Support via email, and the Office of Support will confirm that the Chamber is within the Houston HSDA, and share the contact information with a Workgroup Contact Appointee.

If a Chamber of Commerce contacts the Office of Support, staff will email an information packet (speakers, topics, etc.) to the contact for review prior to follow-up from a Workgroup Contact Appointee.

Before the Event

3. The Office of Support contacts all Workgroup members to see if 1 – 2 event volunteers can assist at the event.
4. Event volunteers will contact the Office of Support to arrange a date when they can come to pick up:
    a. Evaluation forms
    b. Case(s) of Blue Books (when available) and Blue Book Flyers
    c. Project LEAP and Planning Council Applications
5. The Office of Support sends follow up reminders to the Chamber representative, speaker and event volunteers assigned to the event.

The Day of the Event

6. Event volunteers will meet up with the speaker and:
    a. Offer to help the speaker hand out any materials
    b. Manage distribution of Blue Books (when available)
    c. Distribute and collect evaluation forms near the end of the presentation

After the Event

7. Event volunteers will return to the Office of Support to drop off completed evaluations and any remaining Blue Books.
8. The Office of Support will create and send thank you notes to the Chamber representative and speaker, which the Workgroup co-chairs and the Council chair will sign
9. Staff will compile the evaluations for review at the next Workgroup meeting. Attendees who indicated they would like to be contacted regarding Ryan White news and events will be added to the email distribution list.

DRAFT

FY 2018 EIIHA Plan

For the past few years, the Council approved the following motion regarding the EIIHA Strategy. Staff suggests that the Comprehensive HIV Planning Committee recommend an updated version of this same motion in 2017 for the FY 2018 EIIHA Plan.

Item: FY 2018 EIIHA* Plan
Recommended Action: Motion: In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2018 EIIHA Plan, provided that:

- The FY 2018 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and

- The recommended FY 2018 EIIHA Plan is distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.

**EIIHA = Early Identification of Individuals with HIV/AIDS*

2016 Houston HIV Care Services Needs Assessment: Profile of Youth and Aging with HIV

PROFILE OF YOUTH AND AGING WITH HIV

While HIV may affect people of all ages, the impact of HIV varies across age groups. The Centers for Disease Control and Prevention (**CDC**) report that youth aged 13 to 24 accounted for more than 1 in 5 new HIV diagnoses in 2015, with 81% of youth new diagnoses occurring among young men who have sex with men (**MSM**).[1] Locally, the HIV diagnosis rate for youth aged 13 to 24 in the Houston Eligible Metropolitan Area (**EMA**) was 32.2 new diagnoses per 100,000 population, 42% higher than the population as a whole.[2] People Living with HIV (**PLWH**) ages 45 to 54 had the highest prevalence rate of any age group within the Houston EMA in 2015 at 967.9 diagnosed cases per 100,000 population. Data about the needs and experiences of youth and those aging with HIV in the greater Houston area of particular importance to local HIV planning as this information equips communities to tailor HIV prevention and care services to meet the markedly different yet equally critical needs of these age groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2016 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This Profile highlights results *only* for participants who were youth or aging at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: "Youth" and "aging" are defined in this analysis as PLWH who indicated at survey that they were between 18 and 24 years of age for youth, and age 50 or over for aging. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

[1] https://www.cdc.gov/hiv/group/age/youth/index.html

[2] Texas Department of State Health Services

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 17 participants in the 2016 Houston HIV Care Services Needs Assessment were between the ages of 18 and 24 at the time of survey, while 270 were ages 50 and over. Youth comprised just over 3% of the total sample, while aging participants comprised 54%. This reflects the increasing number of aging PLWH in the Houston area.

Eighty-eight percent (88%) of youth participants and 94% of aging participants were residing in Houston/Harris County at the time of data collection. As all needs assessment participants, the majority of youth and aging participants were male (82% and 71%), and African American/Black (77% and 67%). Three aging participants and no youth participants reported being out of care. However, several differences were observed between these populations and the total sample. A greater proportion of youth participants were gay/lesbian (41% v. 34%) or bisexual (24% v. 8%), multiracial (6% v. 0.6%), and were born in the United States (100% v. 85%). There was also a greater proportion of transgender participants among the youth age group than the total sample (6% v. 4%). Compared to the total sample, higher proportions of aging participants were heterosexual (60% v. 54%)

Several socio-economic characteristics of youth and aging participants were also different from all participants. No youth participants reported having private health insurance, and a smaller proportion reported public health insurance in the form of Medicaid and/or Medicare compared to the total sample (16% v. 50%). The average annual income among those reporting income for the total sample was $9,380, compared to $12,017 among youth participants and $9,581 among aging participants. A greater proportion of aging participants (31%) reported experiencing current housing instability compared to the total sample (28%) and youth participants (18%) (*not shown).*

Characteristics of youth participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Gay/lesbian
- With higher occurrences of no health insurance coverage, higher average annual income, and a lower proportion unstably housed.

Characteristics of aging participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Heterosexual
- With lower occurrences of no health insurance coverage, slightly higher average annual income, and a greater proportion unstably housed.

TABLE 1-Select Participant Characteristics among Youth (18-24) and Aging (50+) participants, Houston Area HIV Needs Assessment, 2016

	Youth %	Aging %	Total %
County of residence			
Harris	88%	94%	93%
Fort Bend	6%	5%	4%
Liberty	6%	-	0.2%
Montgomery	-	0.8%	1%
Other	-	0.8%	1%
Sexual orientation			
Heterosexual	29%	60%	54%
Gay/Lesbian	41%	31%	34%
Bisexual	24%	6%	8%
Other	6%	3%	5%
MSM	77%	37%	43%
Yearly income (average: $9,380) Yearly income – Youth (average: $12,017) Yearly income – Aging (average: $9,581)			
Below 100%	71%	78%	79%
100%	-	13%	13%
150%	14%	3%	4%
200%	-	3%	3%
250%	14%	0.5%	0.6%
≥300%	-	1%	1%

	Youth %	Aging %	Total %
Sex at birth			
Male	82%	71%	67%
Female	3%	29%	38%
Intersex	-	-	-
Transgender	6%	3%	4%
Currently pregnant	-	-	0.2%
Health insurance (multiple response)			
Private insurance	-	7%	7%
Medicaid/Medicare	16%	59%	50%
Harris Health System	26%	21%	24%
Ryan White Only	53%	12%	17%
None	5%	0.3%	1%

	Youth %	Aging %	Total %
Primary race/ethnicity			
White	-	14%	12%
African American / Black	77%	67%	63%
Hispanic/Latino	18%	17%	24%
Asian American	-	1%	1%
Other/Multiracial	6%	0.4%	0.6%
Immigration status			
Born in the U.S.	100 %	87%	85%
Citizen > 5 years	-	9%	7%
Citizen < 5 years	-	0.4%	0.8%
Undocumented	-	2%	2%
Prefer not to answer	-	0.7%	4%
Other			2%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2014) in order to produce proportional results (See: *Methodology*, full document).

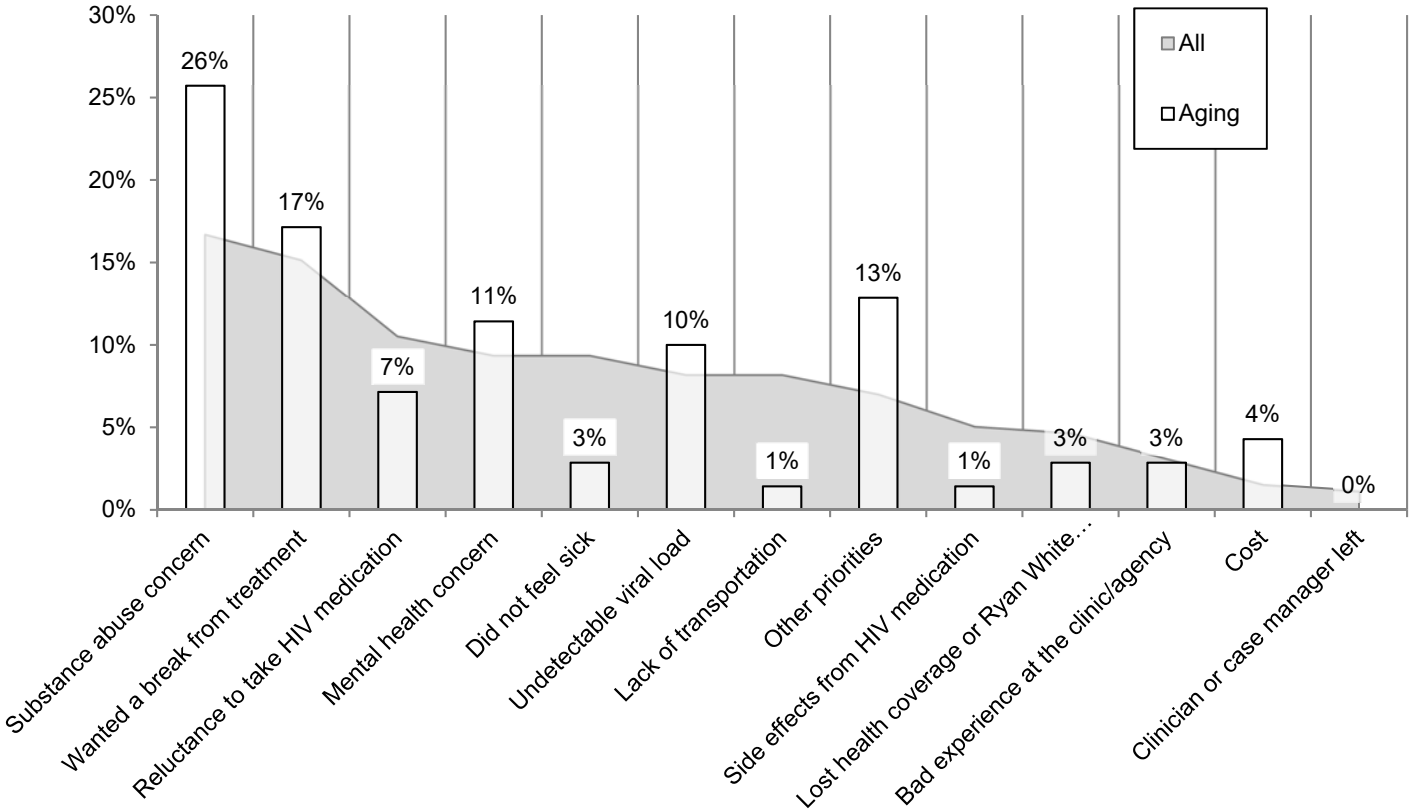
While 71% of needs assessment participants reported no interruption in their HIV care for 12 months or more since their diagnosis, 75% of both youth and aging participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons.

(**Graph 1**) The sample of youth participants with a history of interruption in care was too small to compare to aging participants and the total sample. Among aging participants, experiencing substance abuse concerns (26%), wanting a break from treatment (17%), having other priorities at the time (13%), experiencing mental health concerns (11%), and having an undetectable viral load (12%) were the most cited reasons for a break in HIV medical care.

Compared to the total sample, greater proportions of aging participants reported falling out of care due to substance abuse concerns, having other priorities at the time, cost, wanting a break from treatment, mental health concerns, and having an undetectable viral load. The only write-in reason for aging participants falling out of care was experiencing moving often.

GRAPH 1-Reasons for Falling Out of HIV Care among Aging PLWH in the Houston Area, 2016

Definition: Percent of times each item was reported by aging needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

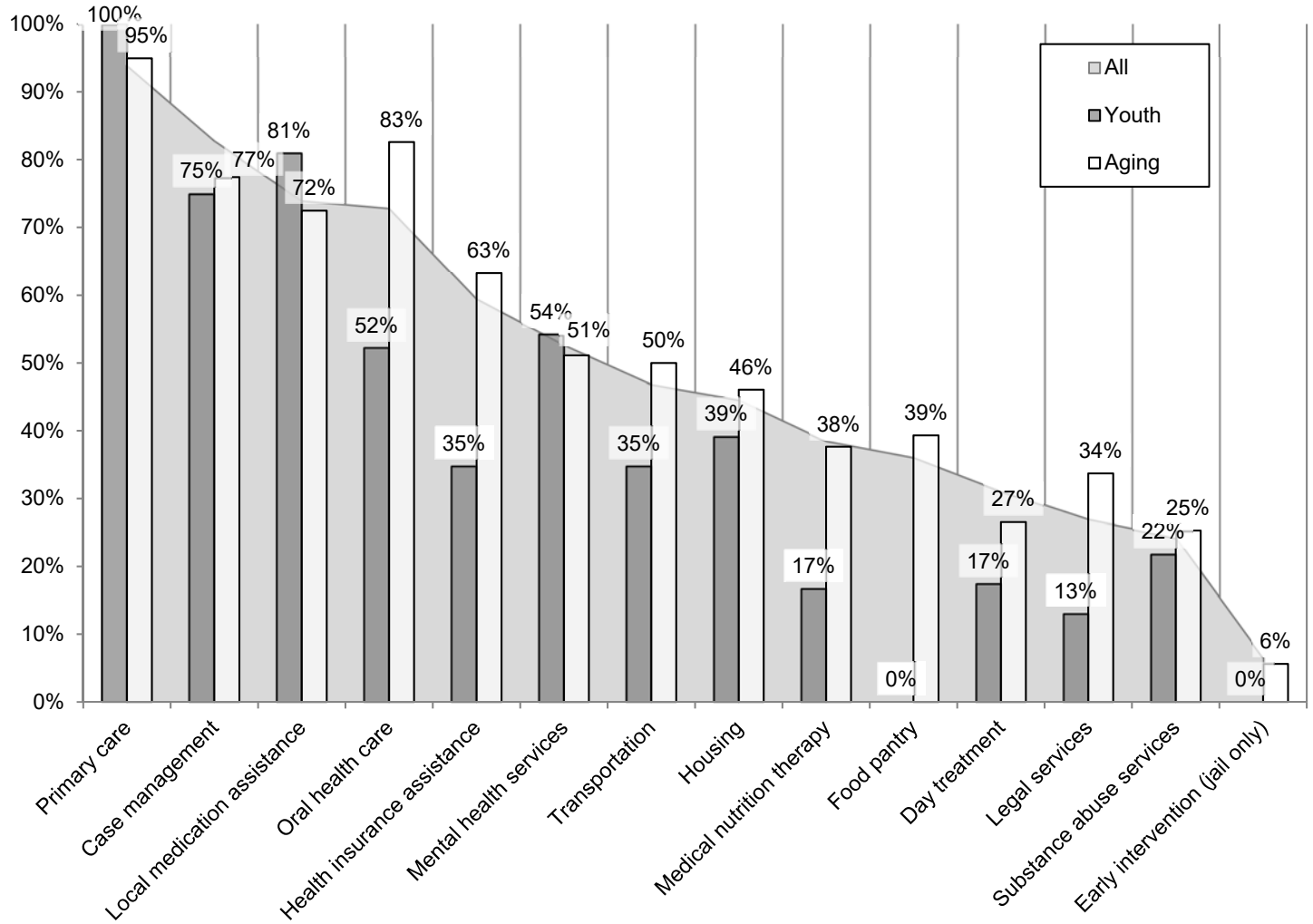
In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed. Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Overall, youth expressed lower need for funded services compared to both the total sample and aging participants. As see in the total sample, youth and aging participants identified primary care as the most needed funded service (100% and 95%). For youth, local medication assistance (81%), case management (75%), mental health services (54%), and oral health care (52%) followed in ranking of need. For aging participants, oral health care (83%), case management (77%), local medication assistance (72%), and health insurance assistance (72%) followed in ranking of need.

Compared to the total sample, higher proportions of youth participants indicated needing local medication assistance, primary care, and mental health services, while higher proportions of aging participants indicated needing oral health care, legal services, health insurance assistance, transportation, food pantry, housing, primary care, and substance abuse services.

GRAPH 2-Ranking of HIV Services among Youth and Aging PLWH in the Houston Area, By Need, 2016

Definition: Percent of youth and aging needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services.

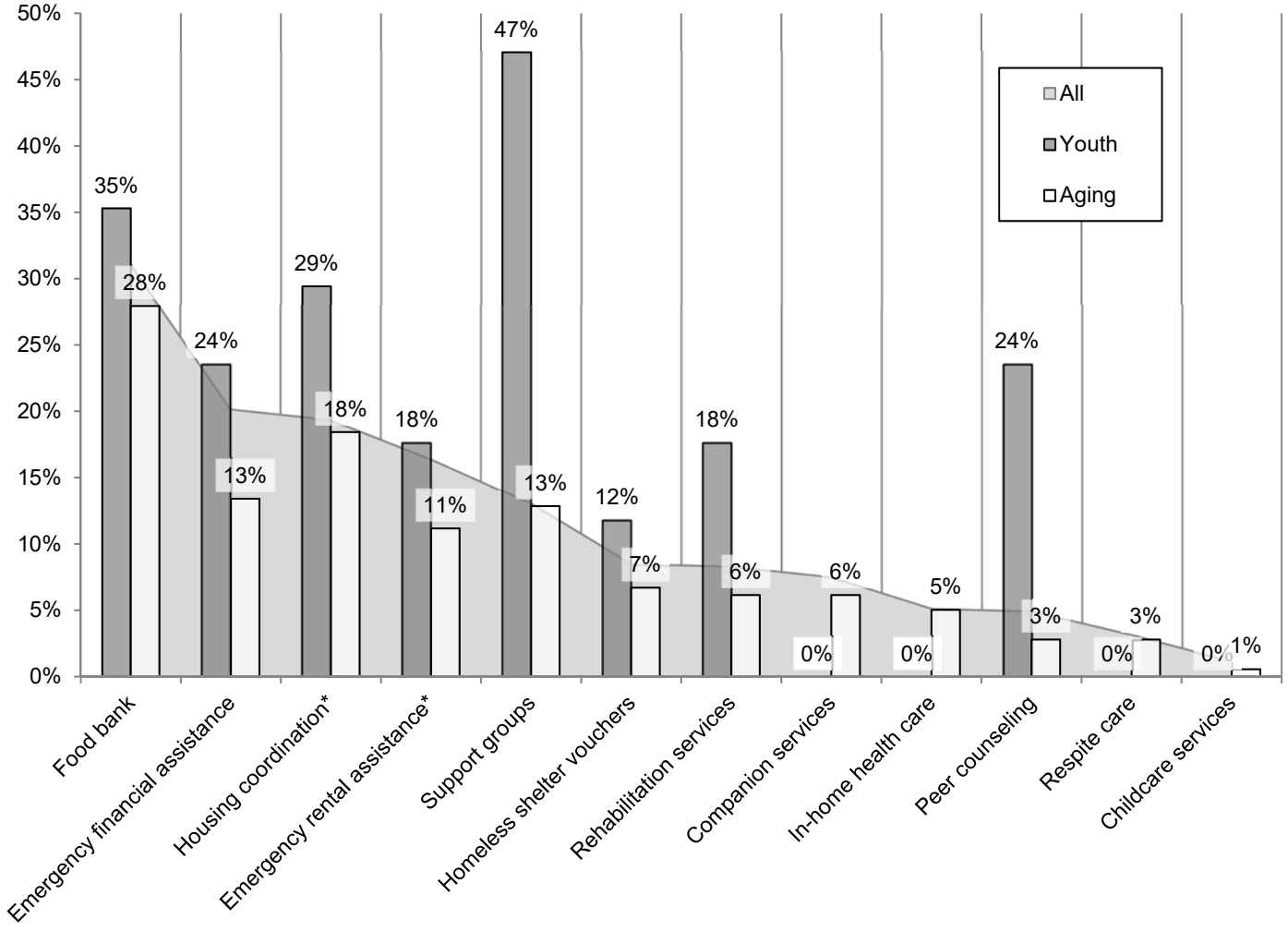
(**Graph 3**) From the 12 services options provided, the greatest proportion of youth participants reported needing support groups (47%), followed by food bank (35%), housing coordination (29%), emergency financial assistance (24%), and peer counseling (24%). This may indicate a need for peer-to-peer support and counseling among young PLWH in the Houston Area. Aging participants indicated needing food bank (28%), followed by housing coordination (18%), emergency financial assistance (13%), support groups (13%), and emergency rental assistance (11%).

While aging participants reported comparable or lower need for other services compared to the total sample, youth expressed a higher need for other/non-Ryan White funded HIV-related services. Greater proportions of youth participants reported needing support groups (47% v. 13%), peer counseling (24% v. 5%), housing coordination (29% v. 19%), rehabilitation services (18% v. 8%), food bank (35% v. 31%), emergency financial assistance (24% v. 20%), homeless shelter vouchers (12% v. 8%), and emergency rental assistance (18% v. 16%).

GRAPH 3-Other Needs for HIV Services among Youth and Aging PLWH in the Houston Area, 2016

Definition: Percent of youth and aging needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 4**) Youth participants reported encountering 11 barriers to the services, while aging participants reported encountering 278 barriers. This difference is likely an artifact of the sample size for each age range, but may also be reflective of the lower need for funded services reported among youth participants. (See: *Demographics and Socio-economic Characteristics* and *Overall Ranking of Funded Services, By Need*, above).

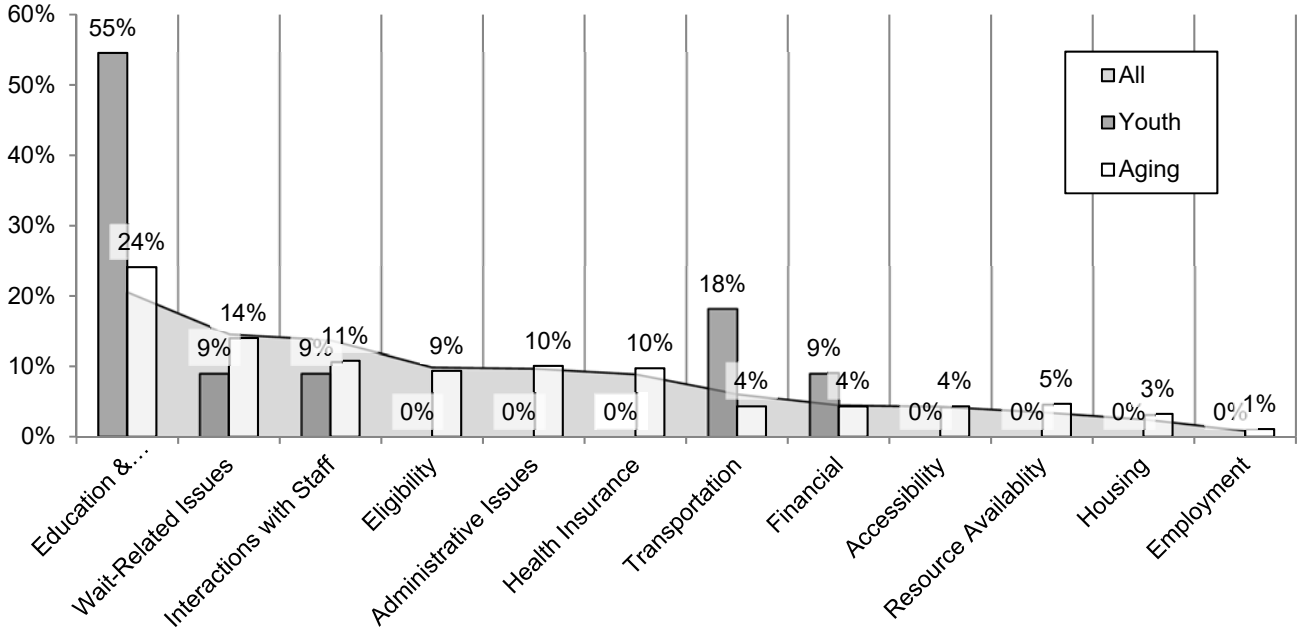
Overall, the barrier types reported most often among youth participants related to service education and awareness issues (55% of reported barriers, n=6 reports), and transportation issues (18%, n=2). Education and awareness barriers reported were most often not knowing where particular services are located.

The barrier types reported most often among aging participants related to education and awareness issues (24% or reported barriers, n=67), wait-related issues (14%, n=39), interactions with staff (11%, n=30), administrative issues (10%, n=28), and health insurance issues (10%, n=27). Education and awareness barriers among aging participants most often pertained to being unaware that a particular service was available. Aging participants reporting wait-related issues most often referred to being placed on a waiting list. Most often barriers relating to interactions with staff were reported as poor communication or follow-up from staff. Administrative barriers for aging participants related most often to long complex processes encountered to access services. The most common barrier related to eligibility among aging participants was being ineligible for the service.

While the number of barrier reports among youth participants is too low for comparison to the total sample, a greater portion of aging participants compared to the total sample reported education and awareness related barriers (24% vs. 21%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among Youth and Aging PLWH in the Houston Area, 2016

Definition: Percent of times each barrier type was reported by youth and aging needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



For more information or a copy of the full 2016 Houston HIV Care Services Needs Assessment contact:

Houston Area Ryan White Planning Council
2223 West Loop South #240
Houston, TX 77027
Tel: (713) 572-3724
Fax: (713) 572-3740
Web: www.rwpchouston.org

Quality Improvement Committee Report

DRAFT

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

Part A and Minority AIDS Initiative (MAI)
Fiscal Year 2016

Prepared by
Houston Area Ryan White Planning Council
Office of Support
Approved: Pending

Houston Area
Ryan White HIV/AIDS Program
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Part A and Minority AIDS Initiative (MAI)
Fiscal Year 2016

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Background

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

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

Methodology

In July 2017, the approved assessment tool was applied to the administrative mechanism for Part A and MAI funds. The approved assessment tool will be applied to the administrative mechanism for Part B and State Services funds in fall 2017. The contract periods designated in the tool are:

- Part A and MAI: March 1, 2016 – February 28, 2017 (FY16)
- Part B: April 1, 2016 –March 31, 2017 (FY 1617)
- State Services: Most recent completed FY

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

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

Part A and Minority AIDS Initiative (MAI)
Contract Period: March 1, 2016 – February 28, 2017 (FY16)

Summary of Findings

I. Procurement/Request for Proposals Process

a) Traditionally, the Administrative Agent (**AA**) for Part A and MAI processes extensions of Part A and MAI contracts and positions with Harris County Commissioners Court prior to receipt of the Notice of Grant Award (**NGA**) from HRSA. As a result of this practice, zero days elapsed between receipt of the initial NGA by the AA and contract execution with any funded service providers, and 28 days elapsed for contract execution with all service providers. This practice continued for the FY16 contract period, and as a result there were no lapses in services to consumers.

b) Due to the extensions of Part A and MAI contracts and positions described in (a) above, 100% of the FY16 Part A and MAI grant award was procured to funded service providers by the first day of the contract period (3/1/16), or within the 1st quarter of the contract period. As such, the AA's timely procurement process resulted in no gaps in procured funds to service providers.

c) The AA procured funds in FY16 only to Planning Council-approved Service Categories. Moreover, the amounts of funds procured per Service Category at the beginning of the contract period matched Planning Council-approved final allocations for level funding for FY16. During the contract period, the AA applied Planning Council-approved policies for the shifting of funds within Service Categories, including application of the increased funding scenarios for Part A and MAI, billing reconciliations, and receipt of carry-over funds in approved categories.

d) Beginning in FY12, Part A and MAI services could be contracted for up to four years, with Service Categories rotated for bidding every three years. According to this schedule, Clinical Case Management, bundled Primary Medical Care, Medical Case Management, and Service Linkage Services – Pediatric, Vision Care, Oral Health – Rural, Medical Nutrition Therapy, and Other Professional Services - Income Tax Preparation Services under Part A was slated for the Request for Proposal (RFP) process during FY16 for FY17 contracts. This Service Category was competitively bid via a RFP process during the FY16 contract period for service contracts beginning in FY17.The RFP issued by the AA for these services contains information about the grant application process, which takes place via the Harris County Purchasing Agent. A pre-proposal conference for the RFP was also held. These steps indicate that the AA maintains a grant award process that provides potential bidders with information on applying for grants through the Purchasing Agent as well as the opportunity to address questions prior to submission.

e) As described in (d) above, the AA issued an RFP during the FY16 contract period for 6 Part A Service Categories (including bundled Primary Care, Medical Case Management, and Service Linkage Services – Pediatric). The RFP issued for this service includes the FY17 Planning Council-adopted Service Category definition. This indicates that the AA maintains a grant award process that adheres potential bidders to Planning Council-approved definitions for contracted Service Categories.

f) **Pending receipt of Final FY16 Part A and MAI Procurement Report**

g) **Pending receipt of Final FY16 Part A and MAI Procurement Report**

h) In FY16, the AA continued to communicate to the Planning Council the results of the procurement process, including agendizing procurement reports at Committee and Full Council meetings throughout the contract period.

II. Reimbursement Process

i) The average number of days elapsed between receipt of an accurate Contractor Reimbursement Report (CER) from contracted agencies and the issuance of payment by the AA for FY16 was 20 days. All contracted Part A and/or MAI agencies were paid within an average of 24 days following receipt of an accurate invoice.

III. Monitoring Process

j) The AA continued to use the Standards of Care as part of the FY16 contract selection and monitoring process and clearly indicates this in various quality management policies, procedures, and plans, including the AA's Policy and Procedure for Performing Site Visits and the AA's current Quality Management Plan. Moreover, the RFP issued during the FY16 contract period states that the AA will monitor for compliance with Standards of Care during site monitoring visits of contracted agencies.

Administrative Assessment Checklist -- Part A and MAI		Contract Period: 3/1/16 - 2/28/17 (FY16)	
Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	• The Administrative Agent (AA) for Part A and MAI typically processes extensions of Part A and MAI contracts and positions with Commissioners Court prior to receipt of the Notice of Grant Award (NGA) in order to prevent lapses in services to consumers. • For the FY16 contract period, extensions of positions and contract renewals for Part A and MAI service providers were approved at Commissioners Court meetings on 1/26/16. The Part A and MAI NGA was received on 1/26/16 and 5/11/16, and agreements were executed at the Court meetings on 12/15/15, 2/9/16 and 2/23/16, and amended to reflect the final NGA on 7/16/16. *Conclusion*: Because contract and position extensions were processed by the AA in anticipation of the grant award, 0 days elapsed between receipt of the initial NGA by the AA and contract execution with any funded service providers, and 28 days elapsed for contract execution with all service providers.	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	FY16 Part A and MAI NGA (issued 1/26/16 and 5/11/16) Commissioner's Court Agendas (12/15/15, 1/26/16, 2/9/16, 2/23/16, 7/19/16)
b) What percentage of the grant award was procured by the: ☒ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	• FY16 procurement reports from the AA indicate that 100% of total allocated funds in each Service Category were procured by 3/1/16, the first day of the contract period. This is due to the contract and position extensions processed by the AA prior to receipt of the NGA, as described in (a) above. *Conclusion*: Because of contract and position extensions processed by the AA in anticipation of the grant award, 100% of the Part A and MAI grant award was procured by the 1st quarter of the contract period.	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	FY16 Part A and MAI Procurement Report provided by the AA to the PC (Printed 6/12/17)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
c) Did the awarding of funds in specific categories match the allocations established by the Planning Council?	• The Planning Council makes allocations per Service Category for each upcoming contract period based on the assumption of level funding. It then designs scenarios to be applied in the event of an increase or decrease in funding per the actual NGA. The Planning Council further permits the AA to re-allocate funds within Service Categories (up to 10%) without pre-approval throughout the contract period for standard business practice reasons, such as billing reconciliations, and to apply carry-over funds as directed. In addition, the Planning Council allows the AA to shift funds in the final quarter of the contract period in order to prevent the grantee from leaving more than 5% of its formula funds unspent. • The most recent FY16 procurement report from the AA (dated 6/12/17) shows that the Service Categories to be funded and the amounts of funds per Service Category procured at the beginning of the contract period matched the final Planning Council-approved allocations for level funding for FY16. Upon receipt of the final NGA, the Increased Funding Scenario was applied for the $276,200 (1.35%) increase in Part A Formula and Supplemental and $46,743 (2.32%) increase in MAI, as was the allowable shifting of funds described above. As a result, total allocations for FY16 did not match the original level-funding allocations approved by the Planning Council, but did match the Final FY16 Allocations Worksheet after application of the Increased Funding Scenario. *Conclusion*: The AA procured funds in FY16 only to Planning Council-approved Service Categories, and the amounts of funds per Service Category procured at the beginning of the contract period were a match to final allocations approved by the Planning Council for level funding. The AA applied Planning Council-approved policies for the shifting of funds within Service Categories during the contract period, including increased funding scenarios, billing reconciliations, and receipt of carry-over funds.	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	FY16 Part A and MAI Procurement Report provided by the AA to the PC (Printed 6/12/17) PC FY16 Allocations Level Funding Scenario Worksheet (6/25/15) PC Final FY16 Allocations Increase Scenario (6/7/16)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
d) Does the AA have a grant award process which: ☒ Provides bidders with information on applying for grants? ☒ Offers a bidder's conference?	• Beginning in FY12, Part A and MAI services could be contracted for up to four years, with Service Categories rotated for bidding every three years. According to this schedule, Clinical Case Management, bundled Primary Medical Care, Medical Case Management, and Service Linkage Services – Pediatric, Vision Care, Oral Health – Rural, Medical Nutrition Therapy, and Other Professional Services - Income Tax Preparation Services under Part A was slated for the Request for Proposal (RFP) process during FY16 for FY17 contracts. • The RFP issued on 09/30/16 for the above Service Categories (Job No. 16/0270) contains information about the process for applying for grants through the Harris County Purchasing Agent (see, for example, "Vendor Instructions," page 9, and "Suggestions for Completing Proposals," page 24). • Moreover, a pre-proposal conference for the RFP was held by the AA on 10/12/16 with the stated purpose to "discuss and clarify the RFP requirements and answer vendor questions regarding the proposal review and award process." *Conclusion*: A review of the RFP issued in FY16 indicates that the AA has maintained a grant award process that provides potential bidders with information on how to apply for grants via the Harris County Purchasing Agent as well as the opportunity to address questions about the grant award process.	Confirmation of communication by the AAs to potential bidders specific to the grant award process	Part A and MAI RFP issued in FY16 for FY17 contracts - Job No. 16/0270 (09/30/16) Courtesy Notice for Pre-Proposal Conference in FY 16 for FY17 contracts (10/12/16)
e) Does the REQUEST FOR PROPOSALS incorporate service category definitions that are consistent with those defined by the Planning Council?	• The RFP issued in FY16 (on 09/30/16) (Job No. 16/0270) for services to be contracted for FY17 includes the FY17 Planning Council-adopted Service Category definitions for this service category (see "Service Category Specifications," pages 33-68). *Conclusion*: The RFP issued in FY16 includes Service Category definitions that are consistent with those defined by the Planning Council.	Confirmation of communication by the AAs to potential bidders specific to PC products	Part A and MAI RFP issued in FY16 for FY17 contracts - Job No. 16/0270 (09/30/16)
f) At the end of the award process, were there still unobligated funds?	****Pending receipt of Final FY16 Part A and MAI Procurement Report****	Comparison of final amounts procured and total amounts allocated in each service category	Final FY16 Part A and MAI Procurement Report provided by the AA to the PC (Pending)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
g) At the end of the year, were there unspent funds? If so, in which service categories?	****Pending receipt of Final FY16 Part A and MAI Procurement Report****	Review of final spending amounts for each service category	Final FY16 Part A and MAI Procurement Report provided by the AA to the PC (Pending)
h) Does the ADMINISTRATIVE AGENT have a method of communicating back to the Planning Council the results of the procurement process?	• The Memorandum of Understanding (MOU) (signed 3/1/12) between the CEO, Planning Council, AA, and Office of Support requires the AA to "inform the Council no later than the next scheduled [.] Steering Committee meeting of any allocation changes" (page 4). • In addition, FY16 Part A and MAI procurement reports from the AA were agendized for Planning Council meetings occurring on 9/8/16, 11/10/16, 3/9/17, 6/8/17, and 7/13/17. Results of the procurement process were also provided during the AA report. *Conclusion*: The AA is required to and maintains a method of communicating back to the Planning Council the results of the procurement process, including agendized procurement reports to Committees and Full Council.	Confirmation of communication by the AAs to the PC specific to procurement results	Houston EMA MOU (signed 3/1/12) PC Agendas (9/8/16, 11/10/16, 3/9/17, 6/8/17, 7/13/17)

Section II: Reimbursement Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
i) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA? What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: ☐ Within 20 days? ☒ Within 35 days? ☐ Within 50 days?	• The Annual Contractor Reimbursement Report (CER) Tracking Summary for FY16 produced by the AA on 7/18/17 showed an average of 20 days elapsing between receipt of an accurate CER from contracted agencies and the issuance of payment by the AA, compared to 23 days on average in FY15. • 100% of contracted agencies were paid within an average of 24 days following the receipt of an accurate CER. In comparison, 100% of contracted agencies were paid within an average of 25 days in FY15. *Conclusion*: The average number of days elapsing between receipt of an accurate contractor reimbursement request for Part A and/or MAI funds and the issuance of payment by the AA was 20 days. All contracted Part A and/or MAI agencies were paid within an average of 24 days following receipt of an accurate invoice.	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	FY16 Part A and MAI Contractor Reimbursement Report (CER) Tracking Summary (7/18/17)

Section III: Contract Monitoring Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
j) Does the ADMINISTRATIVE AGENT use the Standards of Care as part of the contract monitoring process?	• As described in (d) above, the AA issued an RFP during the FY16 contract period for Clinical Case Management, bundled Primary Medical Care, Medical Case Management, and Service Linkage Services – Pediatric, Vision Care, Oral Health – Rural, Medical Nutrition Therapy, and Other Professional Services - Income Tax Preparation Services. Page 58 of the RFP states that the AA will monitor for compliance with the Standards of Care during site monitoring visits of contracted agencies. Directions to current Standards of Care document is also provided. • In addition, the AA's Site Visit Guidelines used during the FY16 contract period includes the process for reviewing compliance with Standards of Care. • The AA's Quality Management Plan (dated 1/17) states that the RWGA Clinical Quality Improvement Project Coordinator and Quality Management Development Project Coordinator both "[conduct] onsite QM program monitoring of funded services to ensure compliance with RWGA Standards of Care and QM plan" (Page 6). The Plan also states that "Annual site visits are conducted by RWGA at all agencies to ensure compliance with the standards of care" (Page 9). *Conclusion*: The AA uses the Standards of Care as part of the contract monitoring process and clearly indicates this in its quality management policies, procedures, and plans.	Confirmation of use of adopted SOC in contract monitoring activities	Part A and MAI RFP issued in FY16 for FY17 contracts - Job No. 16/0270 (09/30/16) HCPH/RWGA Site Visit Guidelines (Revised 9/1/16) HCPH/RWGA Quality Management Plan (1/17)

Umair A. Shah, M.D., M.P.H.
Executive Director
2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

Harris County Public Health
Building a Healthy Community

Brian C. Reed, M.D
Director,
Disease Control & Clinical Prevention Division
2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6199

FY 2016 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

Follow HCPH on Twitter @hcphtx and like us on Facebook

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Highlights from FY 2016 Performance Measures

Clinical Case Management

- During FY 2016, from 3/1/2016 through 2/28/2017, 1,406 clients utilized Part A clinical case management. According to CPCDMS, 684 (49%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 360 (26%) accessed mental health services at least once during this time period after utilizing clinical case management.

Local Pharmacy Assistance

- Among LPAP clients with viral load tests, 2,839 (73%) clients were virally suppressed during this time period.

Medical Case Management

- During FY 2016, 5,073 clients utilized Part A medical case management. According to CPCDMS, 2,553 (50%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these medical case management clients, 616 (12%) accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 1,909 (38%) clients had third-party payer coverage after accessing medical case management.

Primary Medical Care

- During FY 2016, 7,393 clients utilized Part A primary medical care. According to CPCDMS, 4,205 (75%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 266 (18%) had an AIDS diagnosis (CD4 < 200) within the first 90 days of initial enrollment in primary medical care.
- Among clients, 3,584 (80%) had a viral load test performed at least every six months during this time period.
- Among clients with viral load tests, 7,189 (71%) clients were virally suppressed during this time period.
- During FY 2016, the average wait time for an initial appointment availability to enroll in primary medical care was 7 days, while the average wait time for an appointment availability to receive primary medical care was 11 days.

Non-Medical Case Management / Service Linkage

- During FY 2016, 6,824 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,072 (45%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, 508 (53%) clients utilized primary medical care for the first time after accessing service linkage for the first time.

- Among these clients, the average number of days between the first service linkage visit and the first primary medical care visit was 36 days during this time period.

Substance Abuse Treatment

- During FY 2016, 18 (62%) clients utilized primary medical care after accessing Part A substance abuse treatment services.
- Among clients with viral load tests, 17 (74%) clients were virally suppressed during this time period.

Transportation

- Van-Based Transportation:
  - During FY 2016, 493 (69%) clients accessed primary care after utilizing van transportation services.
  - Among van-based transportation clients, 386 (54%) clients accessed LPAP services at least once during this time period after utilizing van transportation services.

- Bus Pass Transportation:
  - During FY 2016, 914 (37%) clients accessed primary care after utilizing bus pass services.
  - Among bus pass clients, 535 (22%) clients accessed LPAP services at least once during this time period after utilizing bus pass services.
  - Among bus pass clients, 1,955 (80%) clients accessed any RW or State service after accessing bus pass services.

Vision Care

- During FY 2016, 950 clients were diagnosed with HIV/AIDS related and general ocular disorders. Among 426 clients with follow-up appointments, 420 (99%) clients had disorders that were either resolved, improved or had remained the same.

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Clinical Case Management
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 1,406 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	402 (39.5%)	685 (48.7%)	**9.2%**
Percentage of clinical case management clients who utilized mental health services	247 (24.3%)	360 (25.6%)	**1.3%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	382 (73.0%)	501 (69.0%)	**-4.0%**
Percentage of clients who were homeless or unstably housed	267 (26.2%)	322 (22.9%)	**-3.3%**

According to CPCDMS, 33 (2.4%) clients utilized primary care for the first time and 118 (8.4%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2015
Percentage of HIV-infected clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year	80%
Percentage of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment*	0%

*Data was not collected in FY 2015

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Legal Services

HIV Performance Measures	FY 2015	FY 2016	Change
Change in the number of permanency planning cases completed over time	51	0	**N/A**
65% of completed SSI disability, insurance, public benefits and income-related cases will result in access to or continued access to benefits	44 (47.3%)	2 (66.7%)	**19.4%**

Type of Case	Number of Completed Cases FY 2016	Number and Percent of Completed Cases that Resulted in Access (or Continued Access) to Benefits	
SSI Disability	0	0	0%
Insurance	0	0	0%
Public Benefits	0	0	0%
Income-Related	1	1	100%
Other	2	1	50%
Total	**3**	**2**	**67%**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2015	FY 2016	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,549 (73.9%)	2,839 (72.6%)	**-1.3%**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Medical Case Management
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 5,073 clients utilized Part A medical case management.

HIV Performance Measures	**FY 2015**	**FY 2016**	**Change**
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,484 (49.2%)	2,553 (50.3%)	**1.1%**
Percentage of medical case management clients who utilized mental health services	599 (11.9%)	616 (12.1%)	**0.2%**
Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	2,117 (41.9%)	1,909 (37.6%)	**-4.3%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,110 (70.9%)	2,032 (67.7%)	**-3.2%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	836 (44.8%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	545 (23.3%)	591 (23.9%)	**0.6%**
Percentage of clients who were homeless or unstably housed	1,420 (28.1%)	1,190 (23.5%)	**-4.6%**

According to CPCDMS, 147 (2.9%) clients utilized primary care for the first time and 243 (4.8%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	**FY 2015**
60% of HIV-infected medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	12%

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Medical Nutritional Supplements

HIV Performance Measures	FY 2015	FY 2016	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	396 (79.7%)	378 (77.8%)	**-1.9%**
90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year	7 (58.3%)	9 (75.0%)	**16.7%**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Oral Health Care
All Providers

HIV Performance Measures	**FY 2016**
75% of diagnosed HIV/AIDS-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up	See Oral Pathology Table

Clinical Chart Review Measures*	**FY 2014**	**FY 2015**
75% of HIV-infected oral health patients will have a dental health history (initial or updated) at least once in the measurement year	97%	93%
75% of HIV-infected oral health patients will have a medical health history (initial or updated) at least once in the measurement year	81%	83%
90% of HIV-infected oral health patients will have a dental treatment plan developed and/or updated at least once in the measurement year	89%	81%
85% of HIV-infected oral health patients will receive oral health education at least once in the measurement year	87%	80%
90% of HIV-infected oral health patients will have a periodontal screen or examination at least once in the measurement year	91%	92%
60% of HIV-infected oral health patients will have a Phase 1 treatment plan that is completed within 12 months	79%	86%

* To view the full FY 2015 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

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

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Primary Medical Care
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 7,393 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2015	FY 2016	Change
90% of clients with HIV infection will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,019 (76.3%)	4,205 (75.3%)	**-1.0%**
Less than 20% of clients who have a CD-4 < 200 within the first 90 days of initial enrollment in primary medical care	299 (20.6%)	266 (17.9%)	**-2.7%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD-4 cell counts or percentages performed during the measurement year at least three months apart	3,683 (69.9%)	3,782 (67.7%)	**-2.2%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,081 (72.9%)	5,486 (74.2%)	**1.3%**
Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year	1,729 (24.8%)	1,837 (24.8%)	**0.0%**
85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year	5,791 (83.2%)	5,960 (80.7%)	**-2.5%**
95% of clients with HIV infection will be screened for Hepatitis B virus infection status (ever)	5,211 (74.8%)	5,846 (79.1%)	**4.3%**
90% of clients with a diagnosis of HIV/AIDS will have a viral load test performed at least every six months during the measurement year	3,405 (78.0%)	3,584 (79.7%)	**1.7%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	6,962 (73.7%)	7,189 (71.3%)	**-2.4%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,162 (23.0%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	1,394 (26.5%)	1,542 (27.6%)	**1.1%**
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	**Data below**		
Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network who had a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	**Data below**		

From 3/1/2016 through 2/28/2017, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 7 Days

Agency 1: 7
Agency 2: 5
Agency 3: 12
Agency 4: 4
Agency 5: 6

From 3/1/2016 through 2/28/2017, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 11 Days

Agency 1: 5
Agency 2: 2
Agency 3: 10
Agency 4: 4
Agency 5: 5

Clinical Chart Review Measures*	FY 2014	FY 2015
100% of clients with a diagnosis of HIV/AIDS will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	100%	93.0%
100% of pregnant women with HIV infection will be prescribed antiretroviral therapy	100%	100%
Percentage of female clients with a diagnosis of HIV who have a pap screening in the measurement year	63.5%	68.2%
55% of clients with HIV infection will complete the vaccination series for Hepatitis B	55.6%	59.9%
85% of clients with HIV infection will receive HIV risk counseling within the measurement year	77.0%	71.3%
95% of clients with a diagnosis of HIV will be screened for substance abuse (alcohol and drugs) in the measurement year	98.3%	98.7%
90% of clients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	93.1%	88.4%
65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	67.2%	69.6%
75% of clients with a diagnosis of HIV/AIDS, for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	71.1%	67.1%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	66.6%	56.3%
95% of clients will be screened for clinical depression using a standardized tool with follow up plan documented	89.3%	92.3%
90% of clients with HIV infection will have ever received pneumococcal vaccine	89.2%	87.8%
100% of clients will be screened for tobacco use at least one during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user	99.4%	100%
95% of clients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	95.3%	96.5%
85% of clients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	85.0%	70.0%

* To view the full FY 2015 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Non-Medical Case Management / Service Linkage
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 6,824 clients utilized Part A non-medical case management.

HIV Performance Measures	**FY 2015**	**FY 2016**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	2,870 (45.9%)	3,072 (45.0%)	**-0.4%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage for the first time	423 (54.4%)	508 (52.5%)	**-1.9%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	29	36	**24.1%**
Median	14	21	**50.0%**
Mode	7	14	**100.0%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	105 (49.3%)	132 (46.3%)	**-3.0%**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Substance Abuse Treatment

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	12 (50.0%)	18 (62.1%)	**12.1%**
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	11 (57.9%)	17 (73.9%)	**16.0%**
Change in the rate of program completion over time	See data below		

***Overall, the number of clients who received primary care in FY 2016 was 24 (82.8%), with 18 receiving the services through Ryan White and 6 receiving the services through other insurance such as Medicare.**

Number of clients completing substance abuse treatment program from March 2015 to February 2016: **21**

Number of clients engaged in substance abuse treatment program from March 2016 to February 2017: **24**

Number of clients completing substance abuse treatment from March 2016 to February 2017 who entered treatment in FY 2015: **4**

Number of clients who received treatment in FY 2015 who are still in treatment from March 2016 to February 2017: **12**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Transportation

Van-Based Transportation	FY 2015	FY 2016	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Van Transportation services	464 (68.8%)	493 (69.1%)	**0.3%**
35% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	345 (51.2%)	386 (54.1%)	**2.9%**

Bus Pass Transportation	FY 2015	FY 2016	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Bus Pass services	898 (34.3%)	914 (37.3%)	**3.0%**
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	440 (16.8%)	535 (21.8%)	**5.0%**
A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services	1,993 (76.2%)	1,955 (79.7%)	**3.5%**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Vision Care
All Providers

HIV Performance Measures	**FY 2016**
75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve or stay the same over time	See ocular disorder table

Clinical Chart Review Measures*	**FY 2014**	**FY 2015**
100% of HIV-infected vision patients will have a medical health history (initial or updated) at least once in the measurement year	100%	100%
100% of HIV-infected vision patients will have a vision history (initial or updated) at least once in the measurement year	100%	100%
100% of HIV-infected vision patients will have a comprehensive eye examination at least once in the measurement year	99%	100%

* To view the full FY 2015 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Accommodation Spasm										
Acute Retinal Necrosis	1	0								
Anisocoria	13	3					3	100%		
Bacterial Retinitis										
Cataract	152	76			2	2.6%	72	94.7%	2	2.6%
Chalazion										
Chorioretinal Scar	5	2					2	100%		
Chorioretinitis	1	1					1	100%		
CMV Retinitis - Active										
CMV Retinitis - Inactive										
Conjunctivitis	14	4					4	100%		
Covergence Excess										
Convergence Insufficiency										
Corneal Edema										
Corneal Erosion										
Corneal Foreign Body										
Corneal Opacity	25	10					10	100%		
Corneal Ulcer	1	1			1	100%				
Cotton Wool Spots										
Diabetic Retinopathy	6	4					4	100%		
Dry Eye Syndrome	431	229			2	0.9%	227	99.1%		
Ecchymosis										
Esotropia	2	0								
Exotropia	6	5					5	100%		
Glaucoma	5	2					2	100%		
Glaucoma Suspect	83	20					18	90%	2	10%
Iritis	1	0								
Kaposi Sarcoma										
Keratitis	5	1					1	100%		
Keratoconjuctivitis	1	1					1	100%		
Keratoconus	2	0								
Lagophthalmos	1	0								
Macular Hole	2	2					2	100%		
Meibomianitis										
Molluscum Contagiosum										
Optic Atrophy	10	4					4	100%		
Papilledema										

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Paresis of Accommodation										
Pseudophakia	7	2					2	100%		
Refractive Change/Transient	1	0								
Retinal Detachment	1	0								
Retinal Hemorrhage										
Retinopathy HTN	5	1							1	100%
Retinal Hole/Tear										
Suspicious Optic Nervehead(s)	1	0								
Toxoplasma Retinochoriochitis										
Thyroid Eye Disease										
Visual Field Defect	7	2					2	100%		
Vitreous Degeneration	7	3					3	100%		
Other	154	53					52	98.1%	1	1.9%
Total	**950**	**426**			**5**	**1.2%**	**415**	**97.4%**	**6**	**1.4%**

Standards of Care Report from Tasha Traylor

August 3, 2017

Packet Includes

Local Pharmacy Assistance Program

Outreach

Not Included in this Packet

EFA

Linguistic Services

Home/Community Health Services

HERR

Rehabilitation Services

Hospice

Respite Care

Local Pharmacy Assistance Program (LPAP)

HRSA

Definition: LPAP is operated by a RWHAP Part B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list, and/or restricted financial eligibility criteria.

Limitations: State AIDS Drug Assistance Program (ADAP) funds may not be used for LPAP support. LPAP funds are not emergency financial assistance for medications.

- Local pharmacy assistance programs are not funded with ADAP earmark funding.
- LPAPs are not to take the place of the ADAP program.
- Clients cannot be enrolled in another medication assistance program for the same medication, excluding co-payment discounts.
- Funds may not be used to make direct payments of cash/vouchers to a client.
- No charges may be imposed on clients with incomes below 100% of the Federal Poverty Level (FPL).
- Local AIDS Pharmacy Assistance Programs (LPAP) do not dispense medications as:
    - A result or component of a primary medical visit;
    - A single occurrence of short duration (an emergency);
    - Vouchers to clients on an emergency basis.

  (Emergency Financial Assistance service category funds should be used for the above situations)

Services: RWHAP recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area;
- A recordkeeping system for distributed medications;
- An LPAP advisory board;
- A drug formulary approved by the local advisory committee/board;
- A drug distribution system;
- A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at a minimum of every six months;
- Coordination with the State's RWHAP Part B ADAP (a statement of need should specify restrictions of the state ADAP and the need for the LPAP); and
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program.

Program Guidance: An LPAP is a program to ensure that clients receive medications when other means to procure medications are unavailable or insufficient. As such, LPAPSs are meant to serve as an ongoing means of providing medications for a period of time. Only RWHAP Part B Base award or Part A grant funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

Statement of Need: The Texas ADAP (TX ADAP) has a limited formulary and currently limits income eligibility to 200%[1] of the Federal Poverty Limit (FPL), with a spend-down adjustment to account for the cost of HIV medications. Providers must first use patient and/or pharmaceutical assistance programs (PAP) prior to the use of LPAP. However, these programs may not fully meet the needs of clients with HIV-related medication needs because the full spectrum of HIV and HIV-related medications that may be prescribed to improve health outcomes may not be affordable or available via a PAP. The LPAP is needed to assist clients that have incomes above 200% of FPL, after spend down adjustment. LPAP is further needed to assist clients requiring long-term HIV and HIV-related medications that cannot be obtained through the TX ADAP program or PAPs.

The TX ADAP must be accessed by eligible clients prior to using the LPAP.

- The LPAP may not duplicate services available through the TX ADAP program.
- Clients needing long-term assistance with prescription medications shall be assisted with completing a TX ADAP application and, when applicable, PAP applications.
- If the medication is not on the TX ADAP formulary and is not available through assistance programs, the client may be served with LPAP funds if the medication is on the LPAP formulary.
- If short-term medication assistance is required and a client is eligible, this need may be met with Emergency Financial Assistance funds.
- Clients with insurance and other third-party payer sources are not eligible for LPAP assistance unless there is documentation on file that the medication is not covered by their prescription benefits.

Purchase of pharmaceuticals must be directly linked to the management of HIV disease that is:

- Consistent with the most current HIV/AIDS Treatment Guidelines;
- Coordinated with the State's Part B Texas HIV Medication Program (THMP) of which the TX ADAP is part of; and/or
- Implemented in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program[2].

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[1] In the event that TX ADAP income eligibility changes, this policy will comply with the revised TX ADAP income eligibility/percentage of FPL.

[2] For a list of 340B eligible entity types see: https://www.hrsa.gov/opa/eligibilityandregistration/index.html. Ryan White HIV/AIDS Program Recipients and

LPAP can fund prescribed medications deemed medically necessary by a provider for medication not on the TX ADAP formulary for TX THMP enrolled patients. Patients denied enrollment into THMP may also access funding through LPAP if other payer sources have been exhausted.

LPAP medications must be purchased at the lowest possible cost, such as 340B Program pricing. Clients must obtain their medications through a 340B covered entity or pharmacy OR a comparable medication discount program. Contracts/Memorandums of Understanding (MOU) must be set up to purchase medications at wholesale or another below retail price.

All LPAP programs will use the statement of need and available standards of care to inform their services and will operate in accordance with legal and ethical standards. The importance of maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards.

Prescribed Over-the-Counter (OTC) medications may be purchased with LPAP funds if the medication is listed on the LPAP formulary and the provider has deemed that the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of health. All OTC medications purchased with LPAP funds must be FDA approved.

Medications not included in the LPAP formulary cannot be purchased. All medications purchased with LPAP funds must be FDA-approved. The provider wishing to prescribe a medication not on the formulary shall make a request to the LPAP Board for approval.

Subrecipients are eligible entities.

PART B	PART A

~~Personnel and Facility Standards~~

Standard	Performance Measure	RWGA Part A Standards	Measured/ Monitored	Differences
~~Facility Standards~~	**~~Expected Practice~~**	**Non-LPAP Standard**		
~~Agencies dispensing medications shall adhere to all local, state and federal regulations and maintain current facility licenses required to operate as a pharmacy in the State of Texas.~~	~~Active pharmacy license is on site and is renewed every two years. Pharmacies and pharmacy staff will adhere to the Texas State Board of Pharmacy rules and regulations.~~	Please see RWGA SOC General Standards 2.4 for an overview of expectations of sub-recipient sites.	Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply Staff interviews indicate compliance	Not a part of LPAP for Part A but listed in General Standards 2.4.
~~If the owner of the pharmacy is not a Texas licensed pharmacist, the owner is consulting with a pharmacist in charge (PIC) or with another licensed pharmacist.~~	~~Documentation on file that a licensed pharmacist is consulting with the owner.~~	**N/A**	**N/A**	This does not apply to Part A.
~~Confidentiality statement signed by pharmacy employees.~~	~~Signed confidentiality statements of staff on file (HIPPA compliance)~~	**General Standards 3.2** Confidentiality Agency has Policy and Procedure regarding client confidentiality in accordance with RWGA /TRG site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes	Review of Agency's Policies and Procedures Manual indicates compliance Clients interview indicates compliance Agency's structural layout and	Listed under General Standards and not specifically under LPAP section. Thus, confidentiality applies to all aspects of client contact.

		throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	information management indicates compliance Signed confidentiality statement in each employee's personnel file	
~~Storage of Medications~~	~~Pharmacy shall maintain appropriate, locked storage of medications and supplies (including refrigeration) according to the State Board of Pharmacy regulations.~~	**N/A**	**N/A**	Part A does not govern the activities of pharmacies.
~~Client Grievance Policy~~	~~Pharmacy or medication site providing medications will have a policy and procedure in place for clients to voice complaints or grievances with services~~	Grievance Procedure Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • time lines and steps taken by the agency to resolve the grievance	Signed receipt of agency Grievance Procedure, filed in client chart Review of Agency's Policies and Procedures Manual indicates compliance Review of Agency's Grievance file indicates compliance, Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section	

		• documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form • resolution of each grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources	A: Access to Care #2	
~~Staff Qualification~~	**~~Expected Practice~~**	**RWGA Part A Standards**	**Measured/ Monitored**	**Differences**
~~Only authorized personnel may dispense/provide prescription medication.~~	~~Licensed pharmacists authorized by the Texas State Board of Pharmacy to dispense medications.~~ ~~Pharmacy technicians and other personnel authorized to dispense medications are under the supervision of a licensed pharmacist.~~	<u>Ongoing Training</u> Eight (8) hours annually of continuing education in HIV/AIDS related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	Documentation of work experience in personnel file Review of personnel files indicates compliance	While many changes are being made to DSHS' standards, Part A standards will remain in place unless they become

	~~A licensed nurse or practitioner designated by the pharmacist-in-charge (PIC) as supportive personnel may provide unit of use packaged medications.~~	Pharmacy Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	Review of agency's Policies & Procedures Manual indicates compliance Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present	burdensome to clients and/or the sub-recipients.

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.

Part A Local Pharmacy Assistance Program

The Local Pharmacy Assistance Programs (LPAP) are co-located in ambulatory medical care centers and provide HIV/AIDS and HIV-related pharmaceutical services to clients who are not eligible for medications through private insurance, Medicaid/Medicare, State ADAP, State SPAP or other sources. HRSA requirements for LPAP include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

Standard	Performance Measure	RWGA Part A Standards	Measured/Monitored	Differences
~~Implement a Local AIDS Pharmaceutical Assistance Program (LPAP) for the provision of HIV/AIDS medication using a drug distribution system that is consistent with the most current HIV/AIDS Treatment Guidelines~~	~~Elements of the Program must include:~~ ~~-A client enrollment and eligibility determination process for Ryan White/state services funding that includes screening/applying for ADAP~~ ~~Additional LPAP eligibility (i.e. financial criteria) if applicable~~ ~~-A LPAP advisory board~~ ~~-Uniform benefits for all enrolled clients throughout the region~~ ~~-Compliance with Ryan White requirement of payer of last resort~~ ~~-A recordkeeping system for distributed medications~~ ~~-A drug distribution system that includes a drug formulary approved by the LPAP Board or a subcommittee of a Planning Council/ADAP -Advisory Board~~ ~~-All medications have to be FDA approved~~ ~~-A system for drug therapy management~~	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 300% of the Federal poverty level for HIV-related medications	Documentation of income in the client record.	Please see Part A LPAP definition above.

~~LPAP Advisory Board~~	~~The AA shall establish a formal LPAP Advisory Board. There may not be more than one (1) advisory board in a single HSDA to ensure uniform LPAP benefits within the HSDA.~~ ~~A single advisory board may serve multiple HSDAs.~~ ~~An advisory board may not be comprised solely of employees of the agency/agencies funded to provide LPAP services.~~ ~~The AA shall support the advisory board to ensure actions taken by the board are documented and are in compliance with applicable standards of care and State and Ryan White HIV/AIDS Program requirements.~~ ~~A written agreement may be established between two administrative agencies to formalize and established LPAP advisory board serving more than one jurisdiction.~~	Part A has a CQI Committee which accords itself in a similar function. The committee reviews all drugs on the formulary and discusses the removal of medication from the formulary and the potential impact it may have to clients.	The board is comprised of clinical and quality management staff members from the sub-recipient sites, as well as QM members from the RWGA staff along with the RWGA Program Manager.	Part A CQI Committee acts in a similar function as does DSHS' Advisory Board.

~~LPAP Formulary~~	~~The AA must maintain a published formulary listing the medications approved by the LPAP Advisory Board~~ ~~The formulary must at minimum meet the requirements listed in the Standards of Care.~~ ~~The formulary must be readily accessible to providers, clients and other stakeholders~~ ~~There must be a formalized policy and procedure for medications to be added to, or removed from, the LPAP formulary by the advisory board.~~	RWGA Part A Formulary is listed within the Appendix.		See Appendix.
~~Payer of Last Resort~~	~~Clients must have successfully completed the TX ADAP application and requisite re-certifications to be eligible for LPAP. Eligibility for LPAP will be determined by eligibility staff and documentation will be kept on file in the primary client record system. Ryan White Part B funds can be used to supplement approved~~	N/A	N/A	After all other resources have been exhausted for other services as well as pharmaceuticals, RWGA is the payor of last result.

	~~state-operated pharmaceutical payment programs, only if adhering to the state ADAP co-payment sliding scale guidelines.~~ ~~Before assistance is provided there should be written documentation in the client's file that Ryan White funding is being used as the payer of last resort.~~ ~~Programs providing LPAP medications must develop procedures to pursue all feasible alternative revenues systems (e.g., pharmaceutical company patient assistance programs) before requesting reimbursement through LPAP.~~			
LPAP Prescriptions: Providers may use funding to assist eligible clients with purchasing medications that are over the Medicaid monthly allotment or that the THMP program does	Percentage of client charts that have the documented prescriptions funded through LPAP assistance with: name of client; date of birth; medication; dose; and signature of prescribing	<u>LPAP Medication Formulary</u> RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-	Review of agency's Policies & Procedures Manual indicates compliance Review of billing history indicates compliance Documentation in	While these two areas do not specifically align, there is a direct correlation in the amount and type of knowledge pharmacy staff must have and maintain for administering medication to PLWH.

not cover. A copy of the client's prescription from the prescribing provider is on file with the agency. The prescription must include: • Name of the client • Date of Birth • Medication • Dose • Signature of prescribing medical provider	medical provider.	prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	client's record	
Timeliness of Service: Agencies must have a system for clients to access prescriptions. Prescriptions should be available and approved for LPAP assistance within two (2) business days. Clients should have access to long-term medications through LPAP program that are not on the State ADAP formulary as medically	Percentage of clients accessing services under LPAP have access to their prescribed medication(s) that are not on the State Formulary within two (2) business days of approved LPAP-funding. ~~Percentage of clients accessing LPAP for HIV medication assistance for more~~	<u>Timeliness of Service Provision</u> Agency will process prescription for approval within two (2) business days Pharmacy will fill prescription within one (1) business day of approval	Documentation in the client record and review of pharmacy summary sheets Review of agency's Policies & Procedures Manual indicates compliance	None

indicated by their HIV provider and/or primary care provider. ~~In the event of State ADAP complete and accurate applications being longer term for approval, clients have access to their HIV medications (over 60 days for applications to be approved).~~	~~than 60 days have documentation of awaiting approval for State ADAP documented in their client files~~.			
Prescribed Over the Counter (OTC) medications: LPAP can assist clients with their OTC medications if the provider has prescribed the medication and has deemed the medication is needed for prevention and treatment of opportunistic infections (OI) or to prevent the serious deterioration of the client's health AND the medication is on the LPAP formulary.	Percentage of client files with prescribed OTC medications paid through LPAP funding have documented evidence from prescribing provider of medical necessity.	N/A	N/A	N/A

Medication Adherence Counseling: Clients are offered counseling on medication adherence when assistance is requested.	Percentage of clients who have documented evidence of adherence counseling offered at the time of assistance request.	Orientation Initial orientation includes twelve (12) hours of HIV/AIDS basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date. Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	Review of training curriculum indicates compliance Documentation of all training in personnel file Specific training requirements are specified in the staff guidelines Materials for staff training and continuing education are on file Staff interviews indicate compliance	Anyone who receives medication is offered a consultation with a pharmacist as a minimal standard.
Viral Suppression: Clients who access HIV medications for long-term assistance (more than 60 days) have documentation in their files of viral suppression.	Percentage of clients accessing HIV medication assistance for long-term (more than 60 days) have documented evidence of viral suppression within the measurement year.	Medical Evaluation/Assessment 1.6 Viral Suppression is addressed within the Primary Care section of Part A's Standards of Care.	Completed assessment in client's record	Viral Suppression is addressed within the Primary Care section of Part A's Standards of Care.
~~Cost efficient form of medication~~	~~Prescriptions filled are the most cost efficient medications provided by the dispensing pharmacy as evidenced by receipts.~~	RWGA Part A LPAP Standards of Care focus more on the effectiveness of the medication for the patient and not cost efficiency.	Please see RWGA Part A LPAP SOC for the complete guidelines which the AA follows.	RWGA remains payor of last resort after all other resources have been exhausted; e.g., private insurance, Medicaid/Medicare, State ADAP, State SPAP and adheres to

				HRSA's guidelines above all.
~~Record Keeping~~	~~Agency shall provide and maintain accurate program record keeping, including medication inventory control. Agency shall provide and maintain accurate program record keeping, including medication inventory control.~~	Primary Care Standard 1.7 Medical Records Medical Records should clearly document the following components, separate from progress notes: A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) A vaccination record, including dates administered The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies)	Documentation in client's record	This reference to medication is listed under the Primary Care section for Part A standards.
~~Documentation~~	~~Eligibility determination will be kept on file in the primary client record system.~~ ~~Copies of receipt(s) for payment will be kept on file.~~	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 300% of the Federal	Documentation of income in the client record.	RWGA specifies that income is used to determine clients' eligibility for services; specifically where the client falls via the Federal Poverty scale/level.

		poverty level for HIV-related medications		

References

HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2013, page 6-7.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 6-7.

HRSA HAB Local Pharmaceutical Assistance Programs (LPAPs): Update and clarifications. December 2013.

HRSA HAB Local Pharmaceutical Assistance Program (LPAP) FAQs · LPAP Policy Clarification Memo (8/29/13)

Texas Administrative Code: TAC 22, Chapter 15, 291.6

Texas Department of State Health Services HIV/STD Program Policies. Payer of Last Resort (Policy 590.001). Located at http://www.dshs.texas.gov/hivstd/policy/policies.shtm

Texas Department of State Health Services HIV/STD Program Policies Purchasing Prescription or Over-The-Counter Medications and Vitamins not Covered by a Third-Party Payer. (Policy 220.101). Located at http://www.dshs.texas.gov/hivstd/policy/policies.shtm

Texas Department of State Health Services HIV/STD Program Policies HIV/STD Medication Program Pharmacy Eligibility Criteria. (Policy 700.003) Located at http://www.dshs.texas.gov.tx.us/hivstd/policy/policies.shtm

Attachment 1
Letter of Agreement
Local Pharmacy Assistance Program (LPAP)

The ["Requesting Administrative Agency"] and the ["Administrative Agency with an LPAP"] agree to the following with regard to the implementation of a Local Pharmacy Assistance Program for the [Name of HIV Service Delivery Area(s) (HSDAs]:

Purpose of Agreement:
The purpose of a Local AIDS Pharmaceutical Assistance Program (LPAP) is to provide therapeutics to treat HIV/AIDS or to prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for prevention and treatment of opportunistic infections. An LPAP is a program to ensure that clients receive medications when other means to procure medications are unavailable or insufficient. As such, LPAPs are meant to serve as an ongoing means of providing medications for a period of time. Texas Department of State Health Services (DSHS) LPAP Standards of Care require an Administrative Agency (AA) allocating funds to the local pharmacy assistance service category in an HSDA under their jurisdiction to, among other requirements, establish a formal LPAP Advisory Board and publish an approved Formulary of medications allowable to be provided though the LPAP.

This agreement stipulates that the ["Requesting Administrative Agency"] shall rely on the already established LPAP Advisory Board and published LPAP formulary of the ["Administrative Agency with an LPAP"] which is supported to function as the LPAP advisory board for the [Name of HSDA(s)].

["Requesting Administrative Agency"] and the ["Administrative Agency with an LPAP"] agree to the following conditions and stipulations regarding the agreement:

- This agreement is expressly limited to the reliance by ["Requesting Administrative Agency"] on the already established LPAP advisory board and formulary in order for ["Requesting Administrative Agency"] to meet Health Resources Services Administration (HRSA) Ryan White HIV/AIDS Program LPAP requirements;
- ["Administrative Agency with an LPAP"] shall not incur cost or liability with respect to ["Requesting Administrative Agency"] meeting its contractual obligations to DSHS;
- ["Requesting Administrative Agency"] shall not provide funding towards the support of the already established LPAP advisory board;
- ["Administrative Agency with an LPAP"] agrees to share the most current list of medications approved by the LPAP Advisory Board with the ["Requesting Administrative Agency"];
- ["Administrative Agency with an LPAP"] will include ["Requesting Administrative Agency"] to the extent feasible when convening LPAP advisory board meetings. ["Administrative Agency with an LPAP"] will promptly notify ["Requesting Administrative Agency"] of changes made to the formulary by the LPAP advisory board;
- ["Requesting Administrative Agency"] may participate in the ["Administrative Agency with an LPAP"] LPAP advisory board to the extent feasible;
- ["Requesting Administrative Agency"] shall follow the same procedure as other stakeholders with respect to requesting the LPAP advisory board to add medications to the formulary. The decisions of the LPAP advisory board with respect to adding or removing medications from the formulary shall be binding upon ["Requesting Administrative Agency"] except as noted below;

- ["Requesting Administrative Agency"] may, when clinically indicated, supplement the published LPAP formulary by adding otherwise allowable medications to the LPAP formulary for the HSDA(s) administered by ["Requesting Administrative Agency"]. Such additions shall not be binding on the ["Administrative Agency with an LPAP"] LPAP formulary;
- ["Name of Requesting Administrative Agency"] may, when appropriate, further restrict medications on the approved LPAP formulary for the HSDA(s) administered by ["Name of Requesting Administrative Agency"]. Such restrictions shall not be binding on ["Administrative Agency with an LPAP"] LPAP formulary;
- This agreement shall be reviewed annually by all parties and updated as needed;
- Any party to this agreement may terminate the agreement by giving thirty (30) day written notice to the other parties.

Agreed to this date by:

["Requesting Administrative Agency"]

_____ _____

Name & Title Date

["Administrative Agency with an LPAP"]

_____ _____

Name & Title Date

Appendix

HOUSTON EMA RYAN WHITE PART A LOCAL PHARMACY ASSISTANCE PROGRAM FORMULARY

Introduction:

The Houston EMA Local Pharmacy Assistance Program (LPAP) is co-located in Ryan White Part A funded ambulatory medical care centers. LPAPs provide HIV/AIDS and HIV-related pharmaceutical services to clients who are not eligible for medications through private insurance, Medicaid/Medicare, State ADAP, State SPAP or other sources. As with other RW funded programs, the LPAP program is the payor of last resort. Clients who are eligible for the LPAP services must have income within 500% or less of the Federal Poverty Level (FPL) for HIV medications and 300% for HIV-related medications. In accordance with the Health Resources and Services Administration (HRSA) recommendations for a local advisory body for LPAP programs, the RWGA Clinical Quality Improvement Committee will be the local advisory board for the development and implementation of the formulary for the Houston EMA LPAP.

HRSA guidelines require that the LPAP formulary be consistent with the most current US Public Health Services (US PHS) guidelines for the treatment of HIV/AIDS and co-morbidities. Several resources were utilized in the development of the formulary. These include formularies from Ryan White Part A funded LPAP programs, US PHS guidelines for antiretroviral therapy and guidelines for the prevention and treatment of opportunistic infections (see reference section). Other resources include a consumer medication survey, and recommendations from the Ryan White Grant Administration Clinical Quality Improvement committee and the Ryan White Planning Council Quality Improvement Committee. The drug d- codes were derived from the Multum Lexicon Database (Multum Lexicon Database Inc, 2007).

Statement of Need:

The LPAP is a mainstay of Houston's overall primary care strategy. Compliant with the HRSA/BPHC/OPA 340B program, this program assists clients in enrolling in the State ADAP and maximizes utilization of other 3rd party payors, such as pharmaceutical assistance programs, ensuring that RW funds are available to fill gaps and cover those persons without other resources to pay for necessary drugs. Examples of clients who may be eligible for LPAP include: clients who have private health insurance coverage, but have limited prescription coverage on their policy; those whose Medicare Rx were denied through the SPAP program or had a prescription need that was not covered by their Medicare drug plan; and finally those with Medicaid who had exhausted their monthly limit or had a prescription need that was not covered by Medicaid. In addition to providing all medications on the State ADAP formulary, the Houston EMA LPAP also provides HIV-related medications necessary to the health and well-being of Persons Living with HIV/AIDS (PLWHA) that would otherwise be unavailable so that they may achieve maximum benefit from their primary care services. The EMA's LPAP also serves as a tool of reducing or eliminating disparities in care. Historically underserved populations are well represented in the LPAP, with African American, Hispanic and female PLWHA all reflecting stable utilization. The high rate of virally suppressed LPAP clients is a testament to the effectiveness of the LPAP in slowing and preventing disease progression.

Waiver Process for Medications Not Listed on the Formulary

All drug codes for various drug formulations and strengths for each listed medication are allowable. Other FDA-approved prescription medications necessary for the treatment of HIV-related conditions that are not listed on the formulary may be requested on a case by case basis with prior approval from Ryan White Grant Administration.

The following are not allowable:

- Medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the services provided during that visit
- Medications that are available over the counter (OTC)
- Syringes, Test Kits or other similar items
- Medications that are available without cost from other sources (e.g. TB Treatment provided by Health Department)
- Erectile Dysfunction (ED) Medications

HOUSTON EMA RYAN WHITE PART A LOCAL DRUG ASSISTANCE PROGRAM FORMULARY

Antiretroviral Agents: Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Abacavir Sulphate (ABC)	Ziagen	d04376	Emtricitabine/Tenofovir alafenamide (FTC/TAF)	Descovy	99999
Abacavir Sulphate/ Lamivudine (ABC/3TC)	Epzicom EPZ	d05354	Lamivudine (3TC)	Epivir	d03858
Abacavir Sulphate/Lamivudine/ Zidovudine, (ABC/3TC/AZT)	Trizivir TRZ	d04727	Lamivudine/Zidovudine (3TC/AZT)	Combivir (CBV)	d04219
Didanosine, ddl EC	Videx EC	d00078	Stavudine (d4T)	Zerit	d03773
Emtricitabine (FTC)	Emtriva	d04884	Tenofovir (TDF)	Viread	d04774
Emtricitabine/Tenofovir (FTC/TDF)	Truvada (TVD)	d05352	Zidovudine (AZT or ZDV)	Retrovir	d00034

Antiretroviral Agents: Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Delavirdine mesylate (DLV)	Rescriptor	d04119	Nevirapine (NVP)	Viramune	d04029
Efavirenz (EFV)	Sustiva	d04355	Rilpivirine (RPV)	Edurant	d07776
Etravirine (ETV)	Intelence	d07076			

Antiretroviral Agents: Combined Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Dolutegravir/abacavir sulfate/lamivudine	Triumeq	d08284	Emtricitabine/Tenofovir Alafenamide/ Elvitegravir/Cobicistat	Genvoya	d07899
Efavirenz/Emtricitabine/Tenofovir (EFV/FTC/TDF)	Atripla ATR	d05847	Emtricitabine/Rilpivirine/Tenofovir (FTC/RPV/TDF)	Complera	d07796
Emtricitabine/Tenofovir/Elvitegravir/Cobicistat	Stribild	d07899	Emtricitabine/Rilpivirine/Tenofovir alafenamide (FTC/RPV/TAF)	Odefsey	999999

Antiretrovirals: Integrase Strand Transfer Inhibitors

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Dolutegravir (DRV)	Tivicay	d8117	Raltegravir (RAL)	Isentress	d07048
Elvitegravir (EVG)	Vitekta	d07898			

Antiretrovirals: Protease Inhibitors (PIs)

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Atazanavir Sulphate (ATV)	Reyataz	d04882	Lopinavir/Ritonavir (LPV/RTV or LPV/r)	Kaletra	d04717
Atazanavir/Cobicistat	Evotaz	99999	Nelfinavir mesylate (NFV)	Viracept	d04118
Darunavir (DRV)	Prezista PRZ	d05825	Ritonavir (RTV)	Norvir	d03984
Darunavir/Cobicistat	Prezcobix	99999	Saquinavir mesylate (SQV-HGC)	Invirase	d03860
Fosamprenavir (FPV)	Lexiva	d04901	Tipranavir (TPV)	Aptivus	d05538
Indinavir (IDV)	Crixivan	d03985			

Antiretroviral: Fusion Inhibitors

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Enfuvirtide, T-20 - injectable (with prior RWGA approval)	Fuzeon	d04853			

Antiretrovirals: CCR5 Antagonist

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Maraviroc (MVC)	Selzentry	d06852			

Antiretrovirals: CYP3A Inhibitors

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Cobicistat	Tybost	d07897			

Anti-Viral Agents: Herpes/CMV Disease

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Acyclovir	Zovirax	d00001	Trifluridine 1% ophthalmic Solution	Viroptic	d01215
Cidofovir	Vistide	d04028	Valacyclovir	Valtrex	d03838
Famicilovir	Famvir	d03775	Valganciclovir	Valcyte	d04755

Anti-Viral Agents: Hepatitis B/C Treatments

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Adefovir	Hepsera	d04814	PEG-Interferon alfa-2a	Pegasys	d04821
Entecavir	Baraclude	d05525	PEG-Interferon alfa-2b	PEG-Intron/PI-Redipen	d04746
Interferon-alfa 2a	Roferon-A	d01368	Ribavirin	Rebetol/Copegus	d00085
Interferon-alfa 2b	Intron-A	d01369	Telbivudine	Tyzeka	d05912

Other Antimicrobial Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Albendazole	Albenza	d03806	Itraconazole	Sporanox (capsules)	d00102a
Amantadine HCL	Symmetrel	d00086	Kanamycin	Kantrex	d00271
Amoxicillin/Clavulanate pot.	Augumentin	d00089	Ketoconazole	Nizoral	d00103
Amoxicillin trhydrate	Amoxil	d00088	Leucovorin	Wellcovorin	d00275
Amphotericin B	Fungizone B	d00077	Levofloxacin	Levaquin	d04109
Amikacin Sulphate	Amikin	d00087	Linezolid	Zyvox	d04534
Ampicillin	Principen	d00003	Mefloquine	Larium	d00286
Ampicillin Sulbactam	Unasyn	d00090	Meropenem	Merrem	d04027
Anidulafungin	Eraxis	d05767	Metronidazole	Flagyl	d00108
Atovaquone	Mepron	d01120	Micafungin	mycamine	d05487
Atovaquine/proguanil	Malarone	d04547	Miconazole	Oravig	d00155
Aztreonam	Azactam	d00067	Minocycline HCL	Dynacin	d00110
Azithromycin	Zithromax	d00091	Moxifloxacin	Avelox	d04500
Capreomycin	Capastat	d01103	Nafcillin Sodium	Nafcil, Nallpen,	d00029
Caspofungin	Cancidas	d04748	Natamycin	Natacyn	d01213
Chloroquine	Aralen	d00035	Nitazoxanide	Alinia	d04826
Cefazolin Sodium	Ancef, Kefzol	d00007	Nitrofurantoin Monohydrate	Macrobid	d00112
Cefditoren Pivoxil	Spectracef	d04767	Nystatin	Bio-Statin	d01233
Cefepime	Maxipime	d03882	Ofloxacin	Floxin	d00114
Cefixime	Suprax	d00072	Oseltamivir Phosphate	Tamiflu	d04462
Cefoxitin	Mefoxin	d00094	Oxacillin	Bactocill	d00115
Cefotaxime	Claforan	d00008	Paromomycin	Humatin	d01104
Cefotetan	Cefotan	d00055	Penicillin G Benzathine	Bicillin	d00116
Ceftizoxime	Cefizox	d00010	Penicillin V Potassium	Veetids	d00116
Ceftriaxone	Rocephin	d00052	Pentamidine	Pentam 300, NebuPent	d00030
Cefuroxime	Zinacef,Ceftin	d00056	Piperacillin/tazobactum	Zosyn	d03165
Cephalexin	Keflex	d00096	Posaconazole	Noxafil	d05853
Ciprofloxacin	Cipro	d00011	Primaquine Phosphate	Premaquine	d00351
Clarithromycin	Biaxin	d00097	Procaine penicillin G	Wycillin	d07390
Clindamycin	Cleocin	d00043	Pyrazinamide	Pyrazinamide	d00117
Clofazimine	Lamprene	d01121	Pyrimethamine	Daraprim	d00364
Colistimethate Sodium	Coly-Mycin M	d01113	Quinidine glucuronate	Quinaglute	d00020
Cycloserine	Seromycin	d01101	Quinine Sulphate	Quinam	d00366
Dapsone	Avlosulfon	d00098	Rifabutin	Mycobutin	d01097
Daptomycin	Cubicin	d04894	Streptomycin Sulphate	Streptomycin sulphate	d00159
Dicloxacillin	Dynapen	d00153	Sulfadiazine	Lantrisul	d00118
Doxycycline calcium	Vibramycin	d00037	Sulfisoxazole	Truxazole	d00120

Erythromycin	E-mycin	d00046	Terbinafine	Lamisil	d04012
Ethambutol	Myambutol	d00068	Terconazole	Terazol	d01238
Ethionamide	Trecator-SC	d01100	Tetracycline Hydrochloride	Sumycin	d00041
Fluconazole	Diflucan	d00071	Trimethoprim	Proloprim	d00123
Flucytosine	Ancobon	d00038	Trimethoprim-sulfamethoxazole, TMP-SMX	Bactrim, Septra	d00124
Gatifloxacin	Tequin	d04504	Trimetrexate	Neutrexin	d03169
Gentamicin	Garamycin	d00014	Voriconazole	Vfend	d04803
Isoniazid INH	Isoniazid	d00101	Zanamivir	Relenza	d04443
Itraconazole	Sporanox Injection	d00102			

Analgesic Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Acetaminophen with butalbital	Phrenilin	d03456	Morphine Sulphate	Roxanol, Avinza	d00308
Acetaminophen with codeine	Tylenol with codeine no. 3	d03423	Oxycodone HCL – CR	Oxycontin	d00329
APAP/isometheptene/dichloralphenazone	Midrin	d03459	Oxycodone / APAP 5/325	Percocet	d03431
Anhydrous Morphine (Opium)	Paregoric	d00824	Oxycodone/ APAP SLN	Roxicet	d03431
Buprenorphine	Buprenex	d00840	Oxymorphone	Numorphan	d00833
Codeine Sulphate	Codeine	d00012	Pregabalin	Lyrica	d05508
Fentanyl Transdermal System	Duragesic	d00233	Propoxyphene HCL	Darvon	d00360
Hydrocodone	Hydrocodol	d03075	Propoxyphene, napsylate and acetaminophen	Darvocet N	d03434
Hydrocodone/acetaminophen	Vicodin	d03428	Sumatriptan	Imitrex	d03160
Hydromorphone	Dilaudid	d00255	Sumatriptan/naproxen sodium	Treximet	d07130
Morphine Sulphate SR	MS Contin, Kadian	d00308	Tramadol HCL	Ultram	d03826
Methadone	Dolophine	d00050	Tramadol/APAP	Ultracet	d04766
Metaxalone	Skelaxin	d00964			

Decongestant & Expectorant Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Chlorpheniramine-hydrocodone	Tussionex Pennkinetic	d03356	Guaifenesin/Codeine PH	Tussi-organidin S-NR	d03393
Chlorpheniramine/hydrocodone/phenylephrine	Poly- Tussion	d03361	Guaifenesin/DM HBr	Tussi-Organidin DM-S-NR	d03400
Codeine/guaifenesin/PSE	Cheratussin DAC	d03398			

Anti-Inflammatory Agents (NSAID)

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Celecoxib	Celebrex	d04380	Ketoprofen	Orudis	d00028
Diflunisal	Dolobid	d00208	Meloxicam	Mobic	d04532
Fenoprofen Calcium	Nalfon	d00026	Naproxen (Prescription Strength)	Naprosyn (Rx Strength)	d00019
Ibuprofen (Prescription Strength)	Motrin (Rx Strength)	d00015	Sulindac	Clinoril	d00033
Indomethacin	Indocin	d00039			

Anti-Hyperlipidemic Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Atorvastatin	Lipitor	d04105	Fenofibrate	Tricor, Antara	d04286
Cholestyramine	Questran	d00193	Fluvastatin sodium	Lescol	d03183
Clofibrate	Atromid-S	d00196	Gemfibrozil	Lopid	d00245
Colesevelam HCl	Welchol	d04695	Niacin	Niaspan	d00314
Colestipol	Colestid	d00744	Pravastatin	Pravachol	d00348
Ezetimibe	Zetia	d04824	Rosuvastatin Calcium	Crestor	d04851
Ezetimide/simvastatin	Vytorin	d05348	Simvastatin	Zocor	d00746
Fenofibric acid	Trilipix	d07371			

Dermatological Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Acyclovir Topical	Zovirax topical	d03201	Hydrocortisone Topical	Anucort/Proctozone/Anusol HC	d03205
Alclometasone Dipropionate	Aclovate	d01282	Hydrocortisone with Lidocaine	Anamantle	d04765
Alitretinoin Gel 0.1%	Panretin Gel	d04385	Hydrocortisone-pramoxine topical	Proctofoam	d03546
Amcinonide	Cyclocort	d01283	Imiquimod	Aldara	d04125
Ammonium lactate topical (Rx Strength Only)	Lac-Hydrin	d04049	Ketoconazole 2%	Nizoral Shampoo	d03202
Betamethasone-calcipotriene	Taclonex Scalp	d05044	Mupirocin Ointment.	Bactroban	d01267
Betamethasone-Clotrimazole Topical	Lotrisone	d03561	Nystatin/Triamcinolone	Mycolog II	d03562
Betamethasone-topical	Diprolene	d03197	Permethrine Topical	Elimite	d01279
Ciclopirox Olamine	Loprox	d01272	Pimecrolimus	Elidel	d04784
Clindamycin Gel	Cleocin T	d01241	Podofilox	Condylox	d01309
Clobetasol Propionate	Temovate	d01288	Selenium Sulfide	Exsel	d03210
Fluocinonide	Lidex	d01294	Tetracycline Topical	Achromycin	d03738
Fluticasone topical	Cutivate	d04284	Triamcinolone-Acetonide Topical	Kenalog	d03206

Anti-Hypertensive/Cardiac Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Acebutelol hcl	Sectral	d00128	Hydralazine	Apresoline	d00132
Aliskiren hemifumarate	Tekturna	d06665	Irbesartan	Avapro	d04222
Amiloride HCL/HCTZ	Moduretic	d03193	Isosorbide	Isosorbide	d00653
Amiodarone	Cordarone	d00002	Isosorbide Dinitrate	Isordil	d00268
Amlodipine	Norvasc	d00689	Isosorbide Mononitrate	Imdur	d00269
Amlodipine besylate/atorvastatin	Caduet	d05048	Labetalol HCL	Normodyne, Trandate	d00016
Amlodipine Besylate/Benazepril	Lotrel	d03829	Lisinopril	Prinivil, Zestril	d00732
Atenolol	Tenormin	d00004	Losartan potassium	cozaar	d03821
Benazepril	Lotensin	d00730	Metoprolol Succinate	Toprol-XL	d00134
Benazepril HCTZ	Lotensin HTCZ	d03265	Metoprolol Tartrate	Lopressor	d00134
Betaxolol	Kerlone	d00176	Minoxidil	Loniten	d00135
Bumetanide	Bumex	d00179	Nadolol	Corgard	d00018
Captopril	Capoten	d00006	Nicardipine	Cardene	d00315
Clonidine	Catapres	d00044	Nifedipine	Adalat	d00051
Carvedilol	Coreg	d03847	Nisoldipine	Sular	d03825
Clopidogrel Bisulfate	Plavix	d04258	Nitroglycerin	Nitroglycerin	d00321
Digoxin	Lanoxicaps	d00210	Olmesartan medoxomil	Benicar	d04801
Digoxin Immune	Digibind	d01410	Prazosin hcl	Minipress	d00138
Diltiazem HCL	Cardizem	d00045	Propranolol	Inderal	d00032
Dipyridamole/aspirin	Aggrenox	d04497	Quinapril	Accupril	d00365
Dipyridamole	Persantine	d00213	Ramipril	Altace	d00728
Doxazosin mesylate	Cardura	d00726	Spironolactone	Aldactone	d00373
Enalapril	Vasotec	d00013	Telmisartan	Micardis	d04364
Fosinopril	Monopril	d00242	Terazosin	Hytrin	d00386
Furosemide	Lasix	d00070	Triamterene	Dyrenium	d00396
Hydrochlorothiazide (HCT)	Hydrodiuril	d00253	Valsartan	Diovan	d04113
Hydrochlorothiazide-lisinopril	Prinzide	d03266	Verapamil	Covera HS	d00048
Hydrochlorothiazide-Triamterene	Maxzide, Dyazide	d03052			
HCT-valsartan-amlodipine	Exforge HCT	d07440			

Anti-Depressants/Psychotropic Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Acamprosate calcium	Campral	d04986	L-alpha-acetyl-methadol (LAAM),	Orlaam	d03187
Alprazolam	Xanax	d00168	Lamotrigine	Lamictal XR	d03809
Amitriptyline HCL	Elavil	d00146	Levetiracetam	Keppra	d04499
Amphetamine	Amphetamine	d00803	Lisdexamfetamine	Vyvanse	d06663
Amphetamine-Dextroamphetmine	Adderall	d04035	Lithium	Lithane, Eskalith	d00061
Aripiprazole	Abilify	d04825	Lorazepam	Ativan	d00149
Asenapine	Saphris	d07473	Lurasidone	Latuda	d07705
Atomexetine HCL	Strattera	d04827	Memantine hydrochloride	Namenda	d04899
Baclofen	Lioresal	d00967	Methocarbamol	Robaxin	d00965
Benztropine Mesylate	Cogentin	d00175	Methylphenidate HCL	Ritalin, Concerta	d00900
Buprenorphine-Naloxone	Suboxone Sublingual Film	d04819	Mirtazapine	Remeron	d04025
Bupropion HCL	Wellbutrin	d00181	Modafinil	Provigil	d04378
Buspirone	BuSpar	d00182	Naltrexone	Revia	d01406
Carbamazepine	Tegretol, Carbatrol	d00058	Nefazodone	Serzone	d03808
Carisoprodol	Soma	d00960	Nortriptyline HCL	Pamelor	d00144
Chlordiazepozide HCL	Librium	d00189	Olanzapine	Zyprexa	d04050
Chlorpromazine HCL	Thorazine	d00064	Olanzapine/fluoxetine hcl	Symbyax	d04917
Citalopram	Celexa	d04332	Oxazepam	Serax	d00040
Clomipramine	Anafranil	d00876	Oxcarbazepine	Trileptal	d04513
Clonazepam	Klonopin	d00197	Paliperidone	Invega	d06297
Cyclobenzaprine	Flexeril	d00963	Paroxetine	Paxil	d03157
Desipramine	Norpramin	d00145	Phenytoin	Dilantin	d00143
Desvenlafaxine	Pristiq	d07113	Pimozide	Orap	d00898
Diazepam	Valium	d00148	Pramipexole	Mirapex	d04145
Divalproex Sodium	Depakote	d03833	Quetiapine Fumarate	Seroquel	d04220
Donepezil	Aricept	d04099	Risperidone	Risperdal	d03180
Doxepin	Sinequan	d00217	Sertraline	Zoloft	d00880
Duloxetine	Cymbalta	d05355	Temazepam	Restoril	d00384
Escitalopram Oxalate	Lexapro	d04812	Topiramate	Topamax	d04115
Eszopiclone	Lunesta	d05421	Trazodone	Desyrel	d00395
Fluoxetine HCL	Prozac	d00236	Valproic Acid	Depakene	d00083
Fluvoxamine	Luvox	d03804	Venlafaxine	Effexor XR	d03181
Gabapentin	Neurontin	d03182	Zaleplon	Sonata	d04452
Haloperidol	Haldol	d00027	Ziprasidone	Geodon	d04747
Hydroxyzine HCL	Atarax	d00907	Zolpidem Tartrate	Ambien	d00910
Imipramine	Tofranil	d00259			

Antineoplastic Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Bleomycin	Blenoxane	d00177	Etoposide	Etopophus	d00230
Chlorambucil	Leukeran	d00188	Hydroxyurea	Hydrea	d01373
Cytarabine	Cytosar-U	d00201	Megestrol acetate	Megace	d01348
Cyclophosphamide	Cytoxan	d00036	Methotrexate	Trexall	d00060
Daunorubicin	Cerubidine	d00205	Paclitaxel	Taxol	d01376
Doxorubicin	adriamycin	d00218	Tamoxifen	Nolvadex	d00381
Daunorubicin Liposomal	DaunoXome	d04239			

Gastrointestinal Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Crofelemer	Fulyzaq	d07940			
Dicyclomine	Bentyl	d00999	Omeprazole (Prescription Strength)	Prilosec	d00325
Diphenoxylate/Atropine	Lomotil	d03506	Omeprazole-Sodium Bicarbonate (Prescription Strength)	Zegerid (powder only)	d05770
Esomeprazole	Nexium	d04749	Ondansetron	Zofran	d00867
Famotidine (Prescription Strength)	Pepcid	d00141	Pancrelipase	Pancreaze, Creon	d01002
Granisetron	Kytril	d03171	Pantoprazole Sodium	Protonix	d04514
Hyoscyamine Sulphate	Levsin	d00985	Prochlorperazine	Compazine	d00355
Lactulose	Kristalose	d01024	Rabeprazole Sodium	Aciphex	d04448
Lansoprazole (Prescription Strength)	Prevacid	d03828	Ranitidine HCL (Prescription Strength)	Zantac	d00021
Loperamide (Prescription Strength)	Imodium	d01025	Scopolamine (Transdermal)	Transderm Scop	d00986
Metoclopramide hcl	Reglan	d00298	Sucralfate	Carafate	d00377

Vaccines

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Haemophilus B Conjugate	HibTITER	d05341	Influenza Virus Vaccine (inactivated)	Fluarix	d01164
Haemophilus b Conjugate and Hepatitis B (Recombinant)	Comvax	d04059	Pneumococcal 23-valent Vaccine (individual doses)	Pneumovax	d05337
Hepatitis A Vaccine	Havrix	d05340	Pneumococcal 13-valent Vaccine (individual doses)	Prevnar 13	d07586
Hepatitis A Inactivated & Hepatitis B (Recombinant) Vaccine	Twinrix	d04685	Varicella Vaccine	Varivax	d03832
Hepatitis B Vaccine (Recombinant)	Engerix-B	d01166	Varicella zoster IG	VZIG	d01138
HPV Quadrivalent Vaccine	Gardasil	d05817	Varicella zoster IG	VZIG	d01138

Endocrine/Metabolic Agents (Steroids)

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Alendronate	Foxamax	d03849	Methimazole	Tapazole	d00290
Alendronate Sodium/ Cholecalciferol	Fosamax Plus D	d05526	Methylprednisolone	Medrol	d00293
Allopurinol	Zyloprim	d00023	Nandrolone decanoate	Deca-Durabolin	d00568
Betamethasone sodium phosphate	Celestone	d00628	Norethindrone	Aygestin	d00555
Congugated estrogens	Premarin	d00541	Oxandrolone	Oxandrin	d00566
Liothyronine sodium	Cytomel	d00658	Oxymetholone	Anadrol-50	d04295
Dexamethasone	Decadron	d00206	Pentazocine	Talwin	d00334
Dronabinol	Marinol	d00866	Prednisone	Deltasone	d00350
Estradiol-norethindrone	Activella, Combipatch	d04375	Probenecid	Benemid	d00031
Estradiol Topical	Vivelle	d04210	Propylthioracil	Propylthioracil	d00361
Estradiol Valerate	Delestrogen	d00537	Somatropin	Serostim	d00577
Fludrocortisone	Florinef acetate	d00608	Testosterone	Androgel,Testim	d00558
Hydrocortisone	Cortef	d00254	Testosterone Topical	Androderm Patch	d04273
Levothyroxine	Synthroid	d00278	Triamcinolone	Kenalog-40	d00620
Medroxyprogesterone	Depo-Provera	d00284			

Bronchial Dilators/Respiratory Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Albuterol/ipratropium	Combivent	d04066	Fluticasone	Flovent	d01296
Albuterol sulphate	Proventil	d00749	Fluticasone Propionate Nasal Spray	Flonase, Veramyst	d04283
Azelastine Hydrochloride	Astelin	d04068	Fluticasone-Salmeterol	Advair Diskus	d04611
Benzonatate	Tessalon	d00796	Ipratropium Bromide	Atrovent	d00265
Brompheniramine/Phenylephrine	Bromfed	d03311	Levalbuterol tartrate	Xopenex	d04427
Budesonide	Pulmicort Turbuhaler	d04276	Levocetirizine	Xyzal	d05851
Budesonide Nasal	Rhinocort AQUA	d03640	Mometasone	Asmanex Twisthaler	d05262
Desloratadine-pseudoephedrine	Clarinex D	d05473	Mometasone furoate monohydrate	Nasonex	d04223
Cyproheptadine	Periactin	d00790	Montelukast	Singulair	d04289
Desloratadine	Clarinex	d04785	Salmeterol	Serevent	d03759
Flunisolide inhaler	Aerobid	d00761	Tiotropium	Spiriva	d04829
Flunisolide nasal	Nasarel	d04279	Triamcinolone Nasal	Nasacort AQ	d04233

Diabetes Agents

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Acarbose	Precose	d03846	Insulin (Human Recombinant)	Humulin /Novolin	d00262
Exenatide	Byetta	d05529	Insulin Lispro	Humalog	d04373
Glimepiride	Amaryl	d03864	Insulin Lispro protamine	Humalog 50/50	d04510
Glipizide	Glucotrol	d00246	Metformin HCL	Glucophage	d03807
Glipizide-metformin	Metaglip	d04823	Metformin-rosiglitazone	avandamet	d04820
Glyburide	Micronase	d00248	Miglitol	Glyset	d04110
Glyburide/metformin	Glucovance	d04703	Nateglinide	Starlix	d04743
Insulin (Aspart (r DNA origin)	Novolog	d04697	Pioglitazone HCL	Actos	d04442
Insulin Aspart Protamine and Insulin Aspart (r DNA origin)	Novolog 70/30	d04839	Repaglinnide	Prandin	d04267
Insulin Detemir	Levemir	d05436	Rosiglitazone Maleate	Avandia	d04434
Insulin Glargine	Lantus	d04538	Sitagliptin	Januvia	d05896

Miscellaneous

Generic Name	Brand Name	Drug Code	Generic Name	Brand Name	Drug Code
Bimatoprost	Lumigan	d04754	Neomycin/polymyxin B/hydrocortisone	Cortisporin Ophthalmic	d03963
Brimonidine Tartrate	Alphagan P	do4048	Neomycin/polymyxin B/hydrocortisone	Cortisporin Otic	d03543
Brinzolamide	Azopt	d04301	Omega-3 Acid Ethyl Esthers	Lovaza	d00497
Calcium Acetate	Phoslo	d03689	Olapatadine Hydrochloride	Patanol	d04117
Carbachol	Miostat	d01189	Pilocarpine	Salagen	d04031
Cevimeline HCL	Evoxac	d04512	Potassium Acetate	Potassium Acetate	d03777
Cyanocobalamin	CaloMist	d00413	Potassium Chloride	K-DUR, Klor-Con	d00345
Dipivefrin opthalmic	Propine	d01184	Promethazine HCL	Phenergan	d00787
Dorzolamide	Trusopt	d03805	Tetracycline hydrochloride opth		d03738
Dorzolamide/timolol	Cosopt	d04303	Thalidomide	Thalomid	d04331
Epinephrine	Epipen	d00699	Timolol Maleate	Timoptic	d04037
Epoetin Alfa	Epogen, Procrit	d00223	Tobramycin ophthalmic	Tobrex	d03222
Filgrastim	Neupogen	d00512	Travatan	Travoprost	d04753
Fluorometholone Opthalmic	FML liquifilm	d03227	Tropicamide	Mydral	d01200
Homatropine Ophthalmic	Isopto Homatropine	d01199	Tuberculin Purified Protein Derivative (PPD)	Tubersol	d01171
Latanoprost	Xalatan	d04017	Varenicline	Chantix	d05807
L-Methylfolate /B12/B6/B2	Cerefolin	d03140	Warfarin Sodium	Coumadin	d00022

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Emergency Financial Assistance (EFA)
Service Standard

HRSA Definition: 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.

Limitations: Direct cash payments to clients are not permitted. No funds may be used for any expenses associated with the ownership or maintenance of a privately owned motor vehicle.

Services: Ryan White HIV/AIDS/State Services funds may be used to provide services in the following categories:

1. ADAP eligibility determination period;
2. Dispensing fee for ADAP medications; and/or
3. Emergency Financial Assistance (EFA).

EFA can be used during the ADAP eligibility determination period. Initial medications purchased for this use are not subject to the $800/client/year cap.

EFA can be used to reimburse dispensing fees associated with purchased medications. Dispensing fees are not subject to the $800/client/year cap.

EFA is an allowable support service with an $800/year/client cap.

- The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary.
- Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer-of-last-resort, and for limited amounts, limited use, and limited periods of time.

EFA provides funding through:

- Short-term payments to agencies
- Establishment of voucher programs

EFA to individual clients is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used.

- Assistance is provided only for the following essential services/subcategories:

- Utilities such as household utilities including gas, electricity, propane, water, and all required fees
- Housing such as rent, ~~mortgage payments~~, or temporary shelter. EFA can only be used if HOPWA assistance isn't available
- Food such as groceries and food vouchers
- Prescription medication assistance such as short term, one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit (30-day supply) ~~and the cost of corrective prescription eye wear~~

Program Guidance: It is expected that all other sources of funding in the community for EFA 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 EFA.

~~Agency Standards~~ This was moved to Universal Standards

~~Agency Standard~~	~~Expected Practice~~
~~**Payment Methodologies**~~ ~~Agency will establish payment method to include either direct payment to service providers/agencies or through a voucher program per HRSA National Monitoring Standards.~~	~~Emergency Financial Assistance payment will be made out to the appropriate vendor for the exact amount listed on the bill.~~ ~~Payment will be made directly to the service provider/agency or if authorization is obtained, for pick up by the client or agency staff.~~ ~~No payment shall be made directly to clients, family or household members.~~
~~**EFA Subcategories**~~ ~~The grantee must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory according to the HRSA National Monitoring Standards.~~	~~Assistance can be provided for the following essential services/subcategories:~~ ~~• Utilities~~ ~~• Housing~~ ~~• Food (including groceries and food vouchers)~~ ~~• Prescription assistance~~ ~~Administrative Agencies must prioritize and delineate a portion of the overall allocation for Emergency Financial Assistance in one or more of the above categories.~~

Payment Limitations Grantee will develop standard limitations on the provision of emergency assistance to eligible individuals/households and mandate their consistent application by all contractors in accordance with HRSA Monitoring Standards	Agency may assist each unduplicated client up to $800 per year per region. These limits will be applied consistently throughout the state. The Administrative Agency may set additional limitations on type of services covered within each subcategory.
Payer of Last Resort	The AA must establish or adopt the DSHS Payer of Last Resort policy for agencies in their region. Agencies providing EFA medications must develop policies and procedures to pursue all feasible alternative revenues systems (e.g., pharmaceutical company patient assistance programs) before requesting reimbursement through EFA.
Dispensing Fee	Agency may reimburse the pharmacy a minimal dispensing fee per prescription as outlined in a MOU.
Client confidentiality Maintained in accordance with DSHS HIV/STD Program Operating Procedures and Standards.	Agency has a procedure to protect client confidentiality when making payments for assistance, (e.g., checks that do not identify the agency as an HIV/AIDS agency).

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
~~**Purchasing Medications during ADAP application period:** No more than a 30-day supply of medication on the ADAP formulary can be purchased at a time for each client. If more than 30 days is needed, the medication can be refilled for another 30 days.~~ ~~If the ADAP denied the coverage, the agency staff should work with the client and the client's attending physician to find alternate funding sources which may include manufacturer's compassionate programs, religious groups, or other community resources~~. **Assisting Clients during ADAP eligibility determination period:** HIV+ clients with documented evidence of emergency need of HIV medications are able to receive short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (2 months or less). **Assisting Clients with Short-Term Medication Co-pays**: HIV+ clients with documented evidence of pending health insurance medication plan approval are able to receive short-term HIV medication co-pay assistance through EFA.	Percentage of clients that have documented evidence in the client primary record of short-term HIV medication assistance provided during ADAP application period. Percentage of clients that have documented evidence in the client primary record of short-term HIV medication copay assistance provided during health insurance application period.
Client Determination for Emergency Financial Assistance: Applicants must demonstrate an emergent need resulting in their inability to pay their utility bills or prescriptions without assistance and risk disconnection of service due to one or more of the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • ~~The cost of their shelter is more than 30% of the household income~~	Percentage of clients with documented evidence of determination of EFA need noted in client's primary record. Percentage of clients with documented service plan for EFA in the client's primary record that indicates emergent need, other resources pursued, and outcome of EFA provided.

• ~~The cost of their utility consumption is more than 10% of the household income~~ • They are unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the agency Agency staff will conduct an assessment of the presenting problems/needs of the client with emergency financial issue. A ~~hardship~~ service plan will be developed documenting client's emergent need resulting in their inability to pay bills/prescriptions without assistance, and other resources pursued noted prior to using EFA funding for assistance. Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. Resolution of the emergency status will be documented in the client record. ~~(see attached flowchart~~). • ~~An EFA request should trigger a needs assessment for case management services. This Needs Assessment should not be time intensive, but should determine client's current status and need for case management services.~~ • ~~Clients who do NOT need case management services do NOT need a care plan related to EFA~~. • ~~An Emergency Assistance Plan will be developed for clients who need case management services.~~ o ~~The goal of this plan is to reduce the need for emergency assistance~~.	Percentage of clients with documented evidence of resolution of the emergency status and referrals made (as applicable) with outcome results in client's primary record.

Emergency Financial Assistance Provided: ~~Determined in accordance with HRSA National Monitoring Standards.~~Short-term assistance will only be provided for: • Utilities • Housing • Food (groceries and food vouchers) • Prescription medication assistance All completed requests for assistance shall be approved or denied within three (3) business days. Assistance shall be issued in response to an essential need (as identified by the staff person providing EFA) within three (3) business days of approval of request. Payment for assistance made to service providers will protect client confidentiality. • Use of checks and envelopes that de-identify agency as HIV/AIDS provider to protect client confidentiality.	Percentage of clients with documented evidence of payments made by agency for resolution of ER status. *(copies of checks/vouchers available)*
~~**Agency Documentation:** Providers/agencies are required to record and track use of EFA funds under each subcategory as required by the Ryan White Services Report (RSR) in accordance with the HRSA National Monitoring Standards.~~ ~~Each agency will track and report type of assistance.~~ ~~Emergency funds will be tracked and reported by:~~ • ~~Number of clients receiving assistance during ADAP eligibility determination period~~ • ~~Number of clients receiving dispensing fee assistance~~ • ~~Number of clients and amount expended for each type of EFA~~ o ~~Summary of number of EFA services received by client~~	

~~o Methods used to provide EFA (e.g., payments to agencies, vouchers)~~	
~~**Client Documentation**: Client's case file will contain the following documentation:~~ ~~• Assistance given during the ADAP eligibility determination period~~ ~~• Assistance given for ADAP medication dispensing fees~~ ~~• Assistance given for emergency financial assistance~~ ~~o Eligibility criteria~~ ~~o Assessment of need for emergency~~ ~~o Date EFA was provided~~ ~~o Amount paid and method of payment (direct payment or voucher)~~ ~~o Ongoing assessment by agency staff of the outcome of the emergency assistance~~ ~~o Status/resolution of the emergency~~ ~~o Any referrals made and the results of those referrals~~ ~~Documentation in the client's primary record must include the attempts made to access client assistance programs with pharmaceutical companies, private or public insurance programs the client may have, and other community resources.~~	•

References

HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2013, page 29-30.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 29-30.

HRSA Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds, June 2017. Located at: https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

Texas Department of State Health Services HIV/STD Program Policies: DSHS Funds as Payment of Last Resort (Policy 590.001). Located at http://www.dshs.texas.gov/hivstd/policy/policies/590-001.shtm

~~Texas Department of Health HIV/STD Program Operating Policies, Chapter 12 Direct Emergency Financial Assistance Standards located at: http://www.dshs.state.tx.us/hivstd/pops/default.shtm~~

Health Education/Risk Reduction (HE/RR)
Service Standards

HRSA Definition: Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention;
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage);
- Health literacy; and
- Treatment adherence education.

Limitations: Health Education/Risk Reduction services cannot be delivered anonymously.

Services: This service category includes the provision of information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Activities of Health Education/Risk Reduction include, but are not limited to:

- Provision of information about available medical services, psychosocial support and counseling services;
- Education on HIV transmission and how to reduce the risk of transmission; and
- Risk reduction counseling on how to improve their health status and reduce the risk of HIV transmission to others.

~~Agency/Personnel /Staff Training~~ (Moved to Universal Standards)

~~Staff Qualification~~	~~Expected Practice~~
~~Agency Policies and Procedures~~	~~The agency shall have policies/procedures for each of the following:~~ • ~~Patient rights and responsibilities, including confidentiality guidelines~~ • ~~Patient grievance policies and procedures~~ • ~~Patient eligibility requirements~~ • ~~Data collection procedures and forms, including data reporting~~ • ~~Guidelines for language accessibility~~ • ~~Collection of patient satisfaction and methods to address~~

Health Education/Risk Reduction Curriculum According to the HRSA National Monitoring Standards risk reduction counseling will be defined.	Agency will develop health education/risk reduction curriculum to: - Define risk reduction counseling - Outline the types of information, education, and risk reduction counseling to be provided.
Staff Qualifications	Health Education/Risk Reduction staff shall have had at least six (6) months of relevant experience in the areas of outreach work, community service, supportive work with families and individuals, supportive work with youth, corrections, public relations or customer service. All staff and volunteers involved in the distribution of the HIV resources shall possess the ability to work productively with HIV/AIDS service providers and knowledge of community resources available to clients.
Staff Education	Within the first (3) months of hire, HE/RR staff must complete training that includes, at minimum, the following criteria: - HIV / AIDS Training • HIV Basics (i.e., getting tested, transmission, disease stages) • Understanding Laboratory results (i.e., reading lab results, understanding lab values) • Medication and Side Effects (i.e., understanding drug resistance, side effects and the goals of medications) • Adherence (i.e., adherence strategies) - Communication Skills • Active Listening • Asking Tough Questions • Non-Verbal Communication • Responding to Conflict • Culture and Cultural Competency • Boundaries disclosure - Substance Use and Mental Health Recognition and Referral - Risk reduction counseling Within three (3) months of hire, HE/RR staff must visit all of their program's collaborating agencies (including those not funded through Ryan White and those not HIV-specific agencies) Annual training of staff shall include updates for - Full complement of HIV/AIDS services within the

	~~area.~~ ~~- How clients access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals).~~ ~~Personnel records will reflect completion of training.~~
~~Supervision~~	~~All non-professional staff must be supervised by a degreed or licensed individual in the fields of health, social services, mental health or possess equivalent experience.~~ ~~Supervisors must review a 10 percent sample of each staff member's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery.~~ ~~Each supervisor must maintain a file on each staff member supervised and hold supervisory sessions at least monthly. The file on the staff member must include, at a minimum:~~ ~~- Date, time, and content of the supervisory sessions~~ ~~- Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.~~

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
~~Intake and Service Eligibility~~ ~~According to the HRSA HIV National Monitoring Standards, eligibility for services must be determined.~~	~~Agency will receive referrals from a broad range of HIV/AIDS service providers.~~ ~~Eligibility information will be obtained from the referral source and will include:~~ ~~- Contact and identifying information (name, address, phone, birth date, etc.)~~ ~~-Language(s) spoken~~ ~~-Literacy level (client self-report)~~ ~~-Demographics~~ ~~-Emergency contact~~ ~~-Household members~~ ~~-Pertinent releases of information~~ ~~-Documentation of insurance status~~ ~~-Documentation of income (including a "zero income" statement)~~ ~~-Documentation of state residency~~ ~~-Documentation of proof of HIV positivity~~ ~~-Photo ID or two other forms of identification~~ ~~-Acknowledgement of client's rights~~ ~~Agencies should attempt to get all relevant eligibility information from the referral source before providing services to client. If unsuccessful, the client may receive up to two (2) appointments.~~
~~Payor of Last Resort~~	~~Before assistance is provided there should be written documentation in the client's file that Ryan White/State Services funding is being used as the payor of last resort.~~
Health Educational Assessment and Service Plan: HE/RR staff will complete a health/HIV educational evaluation ~~Assessment and a~~	Percentage of clients with documented evidence in the client's primary record of a completed health/HIV

~~service~~ and plan that will indicate how the client's educational needs will be met. ~~Service~~ Plan must address: • Methods of HIV transmission • How to reduce risk of HIV transmission o Medication adherence • Available resources to meet needs for recently incarcerated • Available resources to meet client needs • Health literacy ~~A checklist will also be completed to verify that all necessary documentation has been completed.~~ ~~After assessments and service plans are completed with the client, they must be reviewed and approved by the HE/RR Supervisor~~.	education evaluation and plan. Percentage of clients with documented evidence in the client's primary record of a completed plan addressing methods of HIV transmission, risk reduction education, and resources available to meet client's needs.
Health Education/Risk Reduction: ~~According to the HRSA National Monitoring Standards clients will receive education regarding HIV transmission/risk reduction.~~ HE/RR staff will provide health education/risk reduction curriculum regarding: • Methods of HIV transmission and how to reduce the risk of transmission HE/RR staff will provide health education/risk reduction counseling regarding: • How to improve their health status and reduce their risk of transmission to others.	Percentage of clients with documented evidence in the client's primary record of HE/RR curriculum regarding methods of HIV transmission and how to reduce risk of transmission. Percentage of clients with documented evidence in the client's primary record of HE/RR counseling regarding how to improve health status and reduce risk of transmission.
Resources: ~~According to the HRSA National Monitoring Standards clients will receive information about support services.~~ HE/RR staff will provide information regarding available medical and psychosocial support services to reduce barriers to care.	Percentage of clients with documented evidence in the client's primary record of HE/RR education provided regarding available medical and support services in the community.

~~HE/RR staff will be remain knowledgeable regarding local resources~~.	
Evaluation of health education/risk reduction counseling: HE/RR staff will administer pre-post test to each client to assess changes in knowledge/attitudes as a result of the health education/risk reduction counseling. HE/RR Staff will ask each client to complete a brief program evaluation after each completion of a course/service plan to assess effectiveness of program. ~~These evaluations must be turned into the HE/RR Supervisor~~. ~~HE/RR Supervisor will evaluate pre-post test and program evaluations to improve program results~~.	Percentage of clients with documented evidence in the client's primary record of a pre test to assess client's understanding of disease process. Percentage of clients with documented evidence in the client's primary record of a post-test to assess client's understanding of disease process. Percentage of clients with documented evidence in the client's primary record of increased knowledge of disease process and risk reduction methods. Percentage of clients with documented evidence of participation in course/service plan satisfaction survey.
~~**Documentation**~~	~~Client eligibility for services, actual services provided by type of service, number of clients served and level of services will be collected.~~ ~~The following will be documented in the agency's client record.~~ ~~-All intake and eligibility documentation, to include at a minimum:~~ ~~• Documentation of HIV diagnosis~~ ~~• Proof of residency~~ ~~• Verification of financial eligibility~~ ~~• Intake and assessment information~~ ~~• Copy of referral from primary care provider~~ ~~• Referral/outcome if applicable~~ ~~- Information provided on available medical and support services~~ ~~-Information provided on HIV transmission~~ ~~-Counseling provided on improvement of health status and reduction of HIV risk.~~

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 32-33.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 30-31.

HRSA Policy Notice 16-02. Eligible Individuals & Allowable Uses of Funds. Located at: https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

Home Health Care
Service Standard

HRSA Definition: Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g., intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostic testing administered in the home
- Other medical therapies

Limitations: The provision of Home Health Care is limited to clients that are homebound. Home settings do NOT include nursing facilities or inpatient mental health/substance abuse treatment facilities. Excludes personal care and non-licensed in-home care providers.

Services: Home Health Care are 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 primary medical care provider. Home health care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals such as physicians, mid-level providers, nurses, and certified medical assistants.

~~Agency/Personnel /Staff Training~~ This was moved to Universal Standards.

~~Staff Qualification~~	~~Expected Practice~~
~~**Agency Qualifications**~~ ~~The agency shall be licensed and certified by the State of Texas to provide home health services.~~	~~License and /or certification is posted in a conspicuous place at the agency's main office.~~
~~**Agency System of Care**~~ ~~The agency shall provide access to its system of care for HIV/AIDS patients twenty-four (24) hours/day, and must provide mechanisms for urgent and/or emergency care.~~	~~Documented policy on operation and procedures to contact agency after hours for urgent and/or emergency care.~~

Agency Policies and Procedures	The agency shall have policies/procedures for the following: - Patient rights and responsibilities, including confidentiality guidelines - Patient grievance policies and procedures - Patient eligibility and admission requirements - Referral resources and procedures that ensure access to a continuum of services - All appropriate consent forms (e.g., consent to share information, shared patient data/registration system (ARIES), HIPAA requirements) - Data collection procedures and forms, including data reporting - Quality assurance/quality improvement - Guidelines for language accessibility
Staff Experience Agency shall employ clinical staff who are experienced regarding their area of clinical practice as well as knowledgeable in the area of HIV/AIDS clinical practice.	Personnel records/resumes/applications for employment will reflect requisite experience/education. Provider will document training received according to professional licensure requirements.
Staff Credentials Professional staff (nurses, physical therapists, and social workers) should have appropriate licenses and/or credentials set forth by the State of Texas per the HRSA National Monitoring Standards.	All agency professional staff, contractors, and consultants who provide direct care services, and who require licensure, shall be properly licensed by the State of Texas, or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act (or in the case of a nurse, the Nursing Practice Act), including satisfactory arrangements for malpractice insurance. with evidence of such in the personnel file.
Education The agency shall keep abreast of current treatment methodologies as outlined in the most recent version of the Public Health Service guidelines for persons living with HIV/AIDS.	Provider will document provision of in-service education to staff regarding current treatment methodologies and promising practices.
Billing Requirements Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third party payers.	Provider will provide evidence of third-party billing.

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
~~**Intake and Service Eligibility**~~ ~~According to the HRSA HIV National Monitoring Standards, eligibility for services must be determined~~. **Physician Orders:** The primary care provider has deemed home health care services necessary. The referring physician must: • Provide signed orders in writing to the agency prior to the initiation of care • Act as that client's primary care physician • Maintain a consistent plan • Communicate changes from the initial plan directly to the agency. In the event that the referring provider is unable to continue the provision of primary health care services, the provider must be willing to transfer the client to the care of a willing medical care provider.	Percentage of clients with documented evidence in the client's primary record of the ordering physician's signed orders for home health care services. Percentage of clients with documented evidence in the client's primary record of the physician's home health care plan as provided to the agency. ~~Eligibility information will be obtain from the primary care provider/case manager that includes~~ ~~- Contact and identifying information (name, address, phone, birth date, etc.)~~ ~~-Language(s) spoken~~ ~~-Literacy level (patient self-report)~~ ~~-Demographics~~ ~~-Emergency contact~~ ~~-Household members~~ ~~-All current health care and social service providers, including case management providers~~ ~~- Pertinent releases of information~~ ~~-Documentation of insurance status~~ ~~-Documentation of income (including a "zero income" statement)~~ ~~-Documentation of state residency~~ ~~-Documentation of proof of HIV positivity~~ ~~-Photo ID or two other forms of identification~~ ~~-Acknowledgement of patient's rights~~

	~~Consent for treatment and signed release for sharing information with other providers will be obtained to ensure coordination of services.~~ ~~The patient's eligibility must be recertified for the program every six (6) months.~~
Agency Refusal of referral: The home health agency may refuse a referral for the following reasons only: • Based on the agency's perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home setting. o The agency must document the situation in writing and immediately contact the client's primary medical care provider. • The agency has attempted to complete an initial assessment and the referred client has been away from home on three occasions. o The agency must document the situation in writing and immediately contact the referring primary medical care provider. • The client's home or current residence must be determined physically safe (if not residing in a community facility) before services can be offered or continued.	Percentage of clients with documented evidence of agency refusal of services with detail on refusal in the client's primary record AND if applicable, documented evidence that a referral is provided for another home health agency.
Initial Assessment: A preliminary needs assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. Client will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.	Percentage of clients with documented evidence of needs assessment completed in the client's primary record. Percentage of clients with documented evidence of a comprehensive evaluation completed by the home health care agency provider in the client's

A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of client's access to primary care • Adherence to therapies • Disease progression • Symptom management and prevention, and • Need for nursing services.	primary record.
Implementation of Care Plan ~~According to the HRSA National Monitoring Standards, all services are provided based on a written care plan signed by a health care provider~~. A care plan will be completed based on primary medical care provider's order and include: • Current assessment and needs of the client, including medication, dietary, treatment, and activities orders; • Need for home health services; • Types, quantity, and length of time services are to be provided o All planned services are allowable within this service category o Care plan is signed by clinical health care professional. Care Providers will update the plan of treatment at least every sixty (60) calendar days. Professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation. • Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services).	Percentage of clients with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the client's primary record. Percentage of clients with documented evidence of care plans reviewed and/or updated as necessary based on changes in the client's situation at least every sixty (60) calendar days as evidenced in the client's primary record.

• Monitor changes in client's physical and mental health, and level of functionality. • Work closely with client's other health care providers and to effectively communicate and address client service related needs, challenges, and barriers.	
Provision of Services: Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home health services. Progress notes will be kept in the primary client's record and must be written the day service rendered and incorporated into the client record within 14 working days per TAC (link: https://hhs.texas.gov/laws-regulations/handbooks/licensing-standards-home-community-support-services-agencies-handbook/lshcssa-subchapter-c-minimum-standards-all-hcss-agencies) The agency will maintain ongoing communication with the primary medical care provider in compliance with Texas Medicaid and Medicare Guidelines. The Home Health provider will document in the client's primary record progress notes throughout the course of the treatment, the client is not in need of acute care.	Percentage of clients with documented evidence of completed progress notes within 14 working days of the service rendered in the client's primary record. Percentage of clients with documented evidence of ongoing communication with the primary medical care provider as indicated in the client's primary record.

Transfer/Discharge: Transfer and discharge of clients from home health care services should result from a planned and progressive process that takes into account the needs and desires of the client and his/her caregivers, family, and support network. A transfer plan should be developed when one or more of the following criterion are met: • Agency no longer meets the level of care required by the client. • Client transfers services to another service program. • The client is not stable enough to be cared for outside of the acute care setting as determined by the agency and the client's primary medical care provider. • The client no longer has a stable home environment appropriate for the provision of home health services as determined by the agency. • Client is unable or unwilling to adhere to agency policies. • An employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a client's home, in the company of an escort or not. The agency may discontinue services or refuse the client for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. Per TAC, agency intending to transfer or discharge a client must: • Provide written notification to the client or the client's parent, family, spouse, significant other or legal representative; AND • Notify the client's attending physician or practitioner if he/she is involved in the agency's care of the client. • Written notification must be delivered no later than five (5) days before the date on which the client will be transferred or discharged. See TAC website link for specific program policies regarding mailing versus hand-delivery: https://hhs.texas.gov/laws-regulations/handbooks/licensing-standards-home-community-support-services-agencies-	Percentage of clients with documented evidence, as applicable, of a transfer plan developed and documented with referral to an appropriate service provider agency as indicated in the client's primary record. Percentage of clients with documented evidence of a discharge plan developed with client, as applicable, as indicated in the client's primary record.

handbook/lshcssa-subchapter-c-minimum-standards-all-hcss-agencies Client may be discharged if: • The client no longer medically requires home health care as determined by the agency or the primary medical care provider. • Client moves out of the area. • Client wishes to discontinue services (with or against medical advice).	
~~**Documentation in Patients Chart**~~	~~The following will be documented in the agency's patients record:~~ ~~- Documentation of proof of HIV positivity~~ ~~- Proof of residency~~ ~~- Verification of financial eligibility, if appropriate~~ ~~- Patient demographics~~ ~~- Intake and assessment information~~ ~~- The types, dates, and location of services provided~~ ~~- Documentation that services provided were consistent with the treatment plan~~ ~~- Signature of the professional who provided the service at each visit~~ ~~- Documentation that primary medical care provider was updated periodically regarding patient's progress~~ ~~- Documentation of reason for transfer/discharge.~~

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p.13-14.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, p. 13-14.

Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Standards of Care for HIV/AIDS Services 2009.

San Francisco EMA Home-Based Home Health Care Standards of Care February 2004.

Texas Administrative Code, Title 40, Part 1, Chapter 979, Subchapter B, Rule 97.211

Texas Health and Human Services, Licensing Standards for Home and Community Support Services Agencies Handbook, Subchapters C and D, Rules 97.201 through 97.407.

Linguistic Services
Service Standard

HRSA Definition: Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by a qualified linguistic services provider as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

Limitations: Services may only be provided by a qualified linguistic, both oral and written, provider.

Services: Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

DSHS Program Guidance: 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.

~~Agency/Personnel /Staff Training~~

~~Staff Qualification/Education/Experience~~	~~Expected Practice~~
~~**Staff Qualifications**~~ ~~According to HRSA National Monitoring Standards, services are to be provided by appropriately trained and qualified individuals holding appropriate State or local certification.~~ ~~.~~	~~Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI).~~ ~~Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), or the National Interpreter Certification (NIC) at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services.~~

Staff Education/Training Staff members are trained and knowledgeable and remain current in roles of interpreters and legislation/regulations.	Staff should have experience as a translator/ interpreter in a health care setting. Staff should have general medical knowledge of: -Anatomical terms for major body systems -Medical tests and diagnostics -Common specialties and medications -Acronyms and abbreviations -Routine medical equipment -Infection control -Mental/Substance Use Staff should be trained in: -Interpreting Skills: Consecutive Interpreting; Sight Translation; and Protocols (managing a session) -Code of Ethics for Health Care Interpreters -Standards of Practice for Health Care Interpreters -Roles of Health Care Interpreter -Cultural Awareness -Legislation and Regulations (Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act
Agency Policies and Procedures According to HRSA National Monitoring Standards, the agency will have a policy that clearly describes range and types of linguistic services to be provided.	The agency shall have policies/procedures for the following: -Client rights and responsibilities, including confidentiality guidelines -Client grievance policies and procedures -Client eligibility and admission requirements -Guidelines for language accessibility • Range and types of linguistic services to be provided in the client's preferred language, including oral interpretation and written translation -Objective interpretation of information • Staff speak in neutral language and tone • Language is understood by the client, capturing the content and spirit intended by the provider • Staff not provide advice or personal opinion and to avoid direct conversation with agency provider while rendering services • Staff takes into account client's age, history of impaired comprehension, substance use, mental health issues, level of literacy and medical condition

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
~~**Intake and Service Eligibility**~~ ~~According to the HRSA HIV National Monitoring Standards, eligibility for services must be determined.~~	~~Agency will receive referrals from a broad range of HIV/AIDS service providers.Eligibility information will be obtain from the referral source and will include:~~ ~~- Contact and identifying information (name, address, phone, birth date, etc.)~~ ~~- Language(s) spoken~~ ~~- Literacy level (client self-report)~~ ~~- Demographics~~ ~~- Emergency contact~~ ~~- Household members~~ ~~- Pertinent releases of information~~ ~~- Documentation of insurance status~~ ~~- Documentation of income (including a "zero income" statement)~~ ~~- Documentation of state residency~~ ~~- Documentation of proof of HIV status~~ ~~- Photo ID or two other forms of identification~~ ~~- Acknowledgement of client's rights~~ ~~The client's eligibility must be recertified for this service every six (6) months.~~
Provision of Services: Client files will have documented evidence of need of linguistic services for interpretation/translation needs in order to communicate with the healthcare provider and/or receive appropriate services. Agencies shall provide translation/interpretation services for the date of scheduled appointment per request submitted.	Percentage of clients with documented evidence of need of linguistic services. Percentage of client files with documented evidence of interpretive/translation services provided for the date of service requested.

Documentation in Clients Chart: A statement of need or documented evidence of linguistic services shall be maintained in the client's primary record. Documentation of the type of linguistic services provided shall be included in the client's primary record.	Percentage of clients with documented evidence of linguistic services provided.
~~**Documentation for Agency**~~	~~The following will be documented by the agency giving linguistic services:~~ ~~- Number and types of providers requesting and receiving services~~ ~~- Number of assignments~~ ~~- Languages involved~~ ~~- Type of services provided (oral interpretation, written translation, sign language and whether interpretation was for an individual client, family, or group)~~

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 37-38.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, p. 37-38.

Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP). Located at: http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html

Affected Community Committee Report

Affected Community Committee
2017 Community Events (as of 07/25/17)

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**,** Steven V. Shift 2 (2-4:30 pm) Alex, Allen, Isis Shift 3 (4:30-7 pm): **PP: John P.,** Rodney, Alex
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 and 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, Steven and Evelio
Sunday, October 22	MISS UTOPIA	Crowne Plaza Northwest-Brookhollow 12801 Northwest Freeway Houston, TX 77040	**Volunteers: PP: Skeet**, Curtis, Alex, Isis, Cecilia, Tana DISTRIBUTE LEAP FLYERS
Saturday in November Date TBD	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 Date TBD	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

2017 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE
(To be submitted July 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: Road to Success classes throughout the year.

2. In 2017, get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more.
   Special workgroup was Held. As part of How to Best Meet the Need.

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

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:
   Done the Publics Hearings in June 2017

5. Recruit Council applicants throughout the year.
   Status:
   Ongoing

6. Annually, review the status of committee activities identified in the current Comprehensive Plan.
   Status:
   To Be Done

Rodney Nutt
Committee Chairperson

July 24 2017
Date

Operations Committee Report

RYAN WHITE PLANNING COUNCIL
Presents

CROSS COMMITTEE TRAININGS

Monday, July 31, 2017 --- 12:00 p.m.

Learn the process and paperwork of the following committees:
Affected Community, Operations, & Quality Improvement Committees

Monday, August 14, 2017 --- 1:00 p.m.

Learn the process and paperwork of the following committees:
Priorities and Allocations & Comprehensive HIV Planning Committees

2223 West Loop South, Room 416
Houston, Texas 77027

Lunch will be provided ~ Please RSVP!

Council Members, External Members and LEAP Students
are encouraged to attend!

Training Topics for 2017 Ryan White Planning Council Meetings (updated: 07-20-17)
DRAFT

Shading = may be room on agenda for a second speaker

Month	Topic	Speaker
January 26 2017	Council Orientation	N/A
February 9	END HIV Houston Crosswalk: END HIV Houston and 2017 Houston Area HIV Prevention and Care Comp. Plan	Venita Ray, Coordinator, END HIV Houston, Legacy Amber Harbolt, Health Planner, Office of Support
March 9	2017 HIV Comprehensive Plan: Council Activities How To Best Meet the Need Process & Training	Amber Harbolt, Health Planner, Office of Support Robert Noble & Gloria Sierra, Quality Improvement
April 13	Houston HSDA HIV Care Continuum	Ann Dills, Texas Dept. of State Health Services
May 11	DSHS Legislative Update (include ADAP update)	Shelly Lucas, Texas Dept. of State Health Services
June 8	Project LEAP Presentation	Project LEAP 2017 Students
July 13	Priority Setting and Allocations Processes	Ella Collins-Nelson & Paul Grunenwald, Co-Chairs, Priority & Allocations
August 10	DSHS Budget & Program Update	Shelly Lucas, Texas Dept. of State Health Services
September 14	People First Language Intimate Partner Violence and HIV	Crystal Townsend, END HIV Houston RW Grant Administration staff
October 12	Results of the 2015-2017 SPNS Project EIIHA Update	Tom Giordano, MD, Baylor College of Medicine Amber Harbolt, Health Planner
November 9	We Appreciate Our External Members Election Policy	Chair, Ryan White Planning Council Operations Committee
December 14	Elections for the 2018 Officers	Co-Chairs, Operations Committee

Requests: DSHS Updates (2/year) Training in reading Council reports
Training in how to be a good committee participant: keep questions related to the topic

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

July 20, 2017

NAME
ADDRESS

Dear NAME,

We have missed seeing you at the Planning Council and the Affected Community Committee meetings. I hope everything is all right. If a member misses four meetings in a calendar year, they could be asked to resign. According to our records, you have missed four Planning Council meetings and three Affected Community Committee meetings this year.

Your input is important to us and to the process. If you are on a committee that is no longer compatible with your schedule, please let us know so that we can discuss an assignment to a different committee. In an effort to make it easier for you, funds are available to reimburse Council and external committee members for transportation, meals, and childcare during these meetings. Typically, members are also allowed to participate in committee meetings via speaker phone. (When needed, please contact staff for conference call instructions.) If you cannot attend due to a work commitment, illness or doctor's appointment, you can get an excused absence by calling the office at the number listed above and speaking with Rodriga.

Please call Tori Williams in the Office of Support to let us know if you wish to continue with this commitment in 2017.

With best wishes,

Cecilia Ross
Chair
Ryan White Planning Council

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

July 20, 2017

Taneisha Broaddus
3354 Rogerdale Road, # 3210
Houston, TX 77042

Dear Taneisha,

We have missed seeing you at the Comprehensive HIV Planning Committee meetings. I hope everything is all right. If a member misses four meetings in a calendar year, they could be asked to resign. According to our records, you have missed four Comprehensive HIV Planning Committee meetings this year.

Your input is important to us and to the process. If you are on a committee that is no longer compatible with your schedule, please let us know so that we can discuss an assignment to a different committee. In an effort to make it easier for you, funds are available to reimburse Council and external committee members for transportation, meals, and childcare during these meetings. Typically, members are also allowed to participate in committee meetings via speaker phone. (When needed, please contact staff for conference call instructions.) If you cannot attend due to a work commitment, illness or doctor's appointment, you can get an excused absence by calling the office at the number listed above and speaking with Rodriga.

Please call Tori Williams in the Office of Support to let us know if you wish to continue with this commitment in 2017.

With best wishes,

Cecilia Ross
Chair
Ryan White Planning Council

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

July 20, 2017

Shital Patel, MD
4249 Greely Street
Houston, TX 77006

Dear Dr. Patel,

We have missed seeing you at the Planning Council and the Comprehensive HIV Planning Committee meetings. I hope everything is all right. If a member misses four meetings in a calendar year, they could be asked to resign. According to our records, you have missed six Planning Council meetings and four Comprehensive HIV Planning Committee meetings this year.

Your input is important to us and to the process. If you are on a committee that is no longer compatible with your schedule, please let us know so that we can discuss an assignment to a different committee. In an effort to make it easier for you, funds are available to reimburse Council and external committee members for transportation, meals, and childcare during these meetings. Typically, members are also allowed to participate in committee meetings via speaker phone. (When needed, please contact staff for conference call instructions.) If you cannot attend due to a work commitment, illness or doctor's appointment, you can get an excused absence by calling the office at the number listed above and speaking with Rodriga.

Please call Tori Williams in the Office of Support to let us know if you wish to continue with this commitment in 2017.

With best wishes,

Cecilia Ross
Chair
Ryan White Planning Council

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

July 20, 2017

Amber David
8000 North Stadium Drive, 5th floor
Houston, TX 77054

Dear Amber,

We have missed seeing you at the Affected Community Committee meetings. I hope everything is all right. If a member misses four meetings in a calendar year, they could be asked to resign from the committee. According to our records, you have missed four Affected Community Committee meetings this year.

Your input is important to us and to the process. If you are on a committee that is no longer compatible with your schedule, please let us know so that we can discuss an assignment to a different committee. In an effort to make it easier for you, funds are available to reimburse Council and external committee members for transportation, meals, and childcare during these meetings. Typically, members are also allowed to participate in committee meetings via speaker phone. (When needed, please contact staff for conference call instructions.) If you cannot attend due to a work commitment, illness or doctor's appointment, you can get an excused absence by calling the office at the number listed above and speaking with Rodriga.

Please call Tori Williams in the Office of Support to let us know if you wish to continue with this commitment in 2017.

With best wishes,

Cecilia Ross
Chair
Ryan White Planning Council

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2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpcHouston.org

July 20, 2017

Arlene Johnson
2901 Fulton Street, #426
Houston, TX 77009

Dear Arlene,

We have missed seeing you at the Planning Council and the Affected Community Committee meetings. I hope everything is all right. If a member misses four meetings in a calendar year, they could be asked to resign. According to our records, you have missed six Planning Council meetings and four Affected Community Committee meetings this year.

Your input is important to us and to the process. If you are on a committee that is no longer compatible with your schedule, please let us know so that we can discuss an assignment to a different committee. In an effort to make it easier for you, funds are available to reimburse Council and external committee members for transportation, meals, and childcare during these meetings. Typically, members are also allowed to participate in committee meetings via speaker phone. (When needed, please contact staff for conference call instructions.) If you cannot attend due to a work commitment, illness or doctor's appointment, you can get an excused absence by calling the office at the number listed above and speaking with Rodriga.

Please call Tori Williams in the Office of Support to let us know if you wish to continue with this commitment in 2017.

With best wishes,

Cecilia Ross
Chair
Ryan White Planning Council

Houston Area HIV Services Ryan White Planning Council

Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpcHouston.org

DATE

ADDRESS
ADDRESS
Houston, TX 77071

Dear NAME,

We have missed seeing you at the _____ Committee meetings. I hope everything is all right. If a member misses four meetings in a calendar year, they could be asked to resign from the committee. According to our records, you have missed ____ _____ Committee meetings this year.

Your input is important to us and to the process. If you are on a committee that is no longer compatible with your schedule, please let us know so that we can discuss an assignment to a different committee. In an effort to make it easier for you, funds are available to reimburse Council and external committee members for transportation, meals, and childcare during these meetings. Typically, members are also allowed to participate in committee meetings via speaker phone. (When needed, please contact staff for conference call instructions.) If you cannot attend due to a work commitment, illness or doctor's appointment, you can get an excused absence by calling the office at the number listed above and speaking with Rodriga.

Please call Tori Williams in the Office of Support to let us know if you wish to continue with this commitment in 2017.

With best wishes,

Cecilia A. Ross

Cecilia Ross
Chair
Ryan White Planning Council

2017 RWPC Attendance Records (as of 07-15-17)													
a-absent, p-present, e-excused, re-resigned, shaded-do not include in count, Ssh-came but unable to stay, NMnm- no meeting													
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
Ted Artiaga		p	p	p	p	p	p						
Comp HIV Plan		p	p	nm	p	nm	p						
Quality Improvement		p	p	nm	p	nm	nm						
Connie Barnes		a	p	e	p	p	p						
Quality Improvement		p	p	nm	e	nm	nm						
Curtis Bellard		p	p	p	p	p	p						
Affected Community		p	p	nm	p	p							
Operations		p	p	p	p	nm							
Quality Improvement		p	p	nm	p	nm	nm						
Steering		p	p	p	p	p	p						
David Benson		e	e	e	p	p	e						
Quality Improvement		e	e	nm	p	nm	nm						
Skeet Boyle		p	e	p	p	e	p						
Affected Community		p	p	nm	p	p							
Operations		a	p	p	p	nm							
Bianca Burley		p	p	e	p	p	p						
Quality Improvement		p	e	nm	p	nm	nm						
Ella Collins-Nelson		p	p	p	p	p	p						
Priority & Allocations		a	nm	p	p	p							
Steering		a	p	p	p	p	p						
Amber David		p	p	p	p	e	p						
Affected Community		a	a	nm	a	a							
Quality Improvement		a	p	nm	a	nm	nm						
Johnny Deal		e	p	p	p	p	p						
Quality Improvement		p	p	nm	p	nm	nm						
Denny Delgado		e	a										
Comp HIV Plan		e	e										
Evelio Salinas Escamila		p	p	p	p	p	p						
Comp HIV Plan		p	p	nm	p	nm	p						
Herman Finley		p	e	p	a	p	p						
Affected Community		e	e	nm	a	e							
Comp HIV Plan		p	e	nm	a	nm	a						
Tracy Gorden		p	p	p	p	p	p						
Affected Community		p	p	nm	p	p							
Comp HIV Plan		p	p	nm	p	nm	p						
Steering							p						
Paul Grunenwald		e	p	e	e	p	p						
Priority & Allocations		p	nm	p	e	p							
Steering		p	p	e	p	p	p						
Angela F. Hawkins		p	p	p	p	p	p						
Priority & Allocations		p	nm	e	p	p							
Arlene Johnson		e	a	e	a	e	e						
Affected Community		e	a	nm	a	a							
J. Hoxi Jones		e	p	p	p	p	p						
Priority & Allocations		a	nm	p	p	p							
Denis Kelly		p	p	p	p	p	p						
Affected Community		p	p	nm	p	p							
Operations		p	p	p	p	nm							
John Lazo		p	e										
Priority & Allocations		p	nm										
Steering		p	e										
Peta-gay Ledbetter		e	p	p	p	e	e						
Priority & Allocations		p	nm	e	p	p							
Tom Lindstrom		p	p	p	e	p	p						
Quality Improvement		p	p	nm	p	nm	nm						
Osaro Mgbere		p	p	e	p	a	p						
Comp HIV Plan		p	p	nm	p	nm	p						
Nancy Miertschin		p	p	p	p	p	e						
Operations		p	p	p	p	nm							
Steering		p	p	p	p	p	e						
Rodney Mills		p	p	p	p	p	e						
Affected Community		p	p	nm	p	p							
Steering		p	a	e	p	p	p						
Allen Murray		p	p	p	p	p	p						
Affected Community		p	e	nm	e	p							
Comp HIV Plan		p	p	nm	p	nm	p						
Priority & Allocations					p	p							
Robert Noble		p	p	p	a	e	e						
Quality Improvement		p	p	nm	a	nm	nm						
Steering		p	p	p	a	a	e						

Shital Patel		e	e	e	e	a	e							
Comp HIV Plan		a	e	nm	e	nm	e							
John Poole		p	p	p	e	p	p							
Affected Community		p	a	nm	a	p								
Quality Improvement		e	p	p	p	nm	nm							
Tana Pradia		p	p	p	p	e	p							
Affected Community		p	p	nm	p	p								
Steering		e	p	p	p	p	p							
Teresa Pruitt		e	p	p	e	e	e							
Affected Community		p	p	nm	p	a								
Quality Improvement		p	p	nm	p	nm	nm							
Venita Ray		p	e	p	e	p	p							
Quality Improvement		p	e	nm	p	nm								
Cecilia Ross		e	p	p	p	p	p							
Steering		p	p	e	e	p	p							
Viviana Santibanez		p	p	p	p	p	p							
Quality Improvement		p	p	nm	p	nm	nm							
Gloria Sierra		p	p	p	p	p	p							
Quality Improvement		e	p	nm	p	nm	nm							
Steering		a	p	p	p	p	e							
Krystal Schultz		p	p	p	p	e	e							
Priority & Allocations		p	nm	p	p	p								
Carol Suazo		p	p	p	p	p	p							
Operations		p	p	p	p	nm								
Steering		p	p	p	p	p	p							
Isis Torrente		p	p	p	e	p	e							
Affected Community		p	p	nm	p	p								
Comp HIV Plan		p	p	nm	e	nm	e							
Operations		p	p	p	p	nm								
Steering		e	p	p	p	p	p							
Steven Vargas		p	p	p	p	p	p							
Comp HIV Plan		p	p	nm	p	nm	p							
Steering		p	p	p	e	p	e							

Larry Woods		p	a	e	e	p	p							
Comp HIV Plan		p	a	nm	e	nm	p							
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
EXTERNAL MEMBERS	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
Kevin Aloysius														
Quality Improvement			e	nm	p	nm	nm							
Taneisha Broaddus														
Comp HIV Plan		e	e	nm	e	nm	a							
Orfelinda Coronado														
Quality Improvement					p	nm	nm							
Billy Ray Grant Jr.														
Quality Improvement		p	p	nm	e	nm	nm							
Shamra Hodge														
Quality Improvement		p	e	nm	p	nm	nm							
Alex C. Moses														
Affected Community		p	p	nm	p	p								
Esther Ogunjimi														
Comp HIV Plan		p	a	nm	p	nm	a							
Oluseyi Orija														
Comp HIV Plan		p	p	nm	p	nm	p							
Samantha Robinson														
Quality Improvement		p	p	nm	e	nm	nm							
Jacob Sandler														
Affected Community		a	a	nm	a	a								
Veria Steptoe														
Affected Community					p	p								
Kris Sveska														
Comp HIV Plan			a	nm	a	nm	a							
Amana S. Turner														
Comp HIV Plan		p	p	nm	e	nm	e							
Quality Improvement		p	p	nm	p	nm	nm							
Bruce Turner														
Priority & Allocations		p	nm	p	p	p								
David Watson														
Comp HIV Plan		p	a	nm	a	nm	e							
Maggie White														
Comp HIV Plan		p	a	nm	a	nm	a							
Angelica Williams														
Quality Improvement		p	e	nm	p	nm	nm							
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		

Priority and Allocations Committee Report

Positive Links

Warm Technology Activates HIV Care Linkage and Engagement

A TAILORED MOBILE APP TO SUPPORT ENGAGEMENT IN HIV CARE SHOWS GREAT PROMISE FOR SCALABILITY AND REPLICATION IN MANY COMMUNITIES

Background

The stages of HIV care, also known as the HIV care continuum, demonstrate significant gaps in HIV services, and efforts are underway at the federal, state, and local levels to develop and implement strategies to improve health outcomes for people living with HIV (PLWH). The HIV care continuum can be described by the following sequential steps: (1) diagnosis of HIV infection, (2) linkage to care, (3) retention in care, (4) receipt of antiretroviral therapy (ART), and (5) achievement of viral suppression (a very low level of HIV in the body). In the United States, there are 1.2 million people living with HIV, and according to the Centers for Disease Control and Prevention (CDC), 30% had achieved viral suppression, which means that only 3 out of 10 people living with HIV had the virus under control. Viral suppression results in significantly improved health outcomes as well as dramatically decreased likelihood of HIV transmission (96% reduced risk of sexual transmission). The challenge of linking and retaining people living with HIV in care and treatment can be demonstrated by CDC data, which reveals that 14% of PLWH remain undiagnosed, and of those diagnosed, only 40% receive and stay in regular HIV medical care.[1] Successful retention in medical care is defined as one medical visit during each six month period of a 24-month interval, spaced more than 60 days apart, and this medical visit frequency improves survival, and allows people to be as healthy as possible.[2] Thus, the need to improve along the HIV care continuum plays a critical role in both care and prevention.

What Are We Doing?

Most people living with HIV/AIDS served by the University of Virginia Ryan White Clinic live in rural communities a significant distance from the clinic. Almost all face stigma. Substantial numbers struggle with depression, post-traumatic stress disorder, substance use, intimate partner violence, and poverty. Unsurprisingly, clients report high levels of perceived stress. To address clients' multiple adherence-to-care challenges, The University of Virginia created **Positive Links (PL)**, a smartphone app that supports people living with HIV with HIV education and management tools, wellness promotion strategies, and support through:

- **Social Support** via a positive virtual community
- **Self-Monitoring** of adherence and wellness behaviors
- **Warm Technology** that extends care beyond clinic visits

CLIENT STORY

Positive Links offers opportunities for increased awareness of mood and stress levels to its participants. A participant who has had consistent use of the app describes what Positive Links has meant to him:

> *"Because HIV is so stigmatized, especially around here, it gives a relief. It's where I can talk and I can release, and express myself with some of the responses like mood and stress. I feel free to talk about my HIV. It's kinda like a diary-like thing. I can go in there, there's support there that I don't have in my day-to-day life. Where I can express and discuss, because I haven't told my family or anyone about my HIV. The questions make me focus on my mood and my stress and makes me more in touch with myself you can say. When it pops up, it makes me stop and think. I usually don't think about that kind of thing."*

[1] "HIV/AIDS Care Continuum." AIDS.gov. U.S. Department of Health & Human Services, 6 Mar. 2015. Web. 11 May 2015.
[2] "HAB HIV Performance Measures." Health Resources and Services Administration. U.S. Department of Health & Human Services, Nov. 2013. Web. 11 May 2015.

UNIQUE FEATURES OF POSITIVE LINKS

Social Support via a positive virtual community

Key Features

- 24/7 availability of support through a specific request to the virtual community message board (VCMB) or by observing and relating to what is shared on the VCMB by others
- Leadership skills development within a virtual peer group
- A sense of belonging to a unique community — the "Positive Links Family"
- The app design allows for ownership of the development/management of parameters of interactions and social norms within the group

Self-Monitoring of adherence and wellness behaviors — a key aspect of living well with a chronic disease

Key Features

- Calendar for tracking medical appointments
- Daily medication, mood, and stress queries
- Dashboard feature to assess adherence and wellness

Warm Technology that extends care beyond clinic visits

Key Features

- Cost-effective service delivery mechanism with over 100 potential contact points per patient per month
- Strengths-based counseling: delivered over the phone and via text to reach participants who cannot not come into the clinic or make an appointment
- Real time feedback improves linkage between patient and appropriate clinical services

Added Value of Positive Links

- Participants see Positive Links not only as a project that they participate in, but also a community that they have helped to develop.
- The app design anticipated low literacy, which enables more users to benefit from the app.
- Privacy features, including secure data entry, are a unique feature differentiating it from other apps.
- Phone and data access have proven essential in participants accessing critical services and information.

Intervention Costs

Based on cost-analysis of the PL intervention, The University of Virginia has been able to determine that the PL intervention costs $3,112.20 to enroll a new participant for a year, and the same cost ($3,112.20) to continue the intervention for an existing participant for another year. Given that the cost per Positive Links participant is lower than recent modeling analyses, and our preliminary data analyses suggest greater than 40% improvement in retention by app users, we believe that Positive Links is cost-savings.

Clinic Overview

The University of Virginia Ryan White Clinic is the largest provider of HIV care in western Virginia, offering integrated HIV, gynecologic, mental health, substance abuse and specialty referral services to more than 700 people living with HIV/AIDS. The clinic benefits from strong links with the local AIDS service organization and the Virginia Department of Health.

UNIVERSITY of VIRGINIA HEALTH SYSTEM

PROGRAM CONTACT

University of Virginia Ryan White Clinic, 1300 Jefferson Park Ave., Charlottesville, VA 22908 – healthsystem.virginia.edu

This project was supported by a grant from AIDS United and the M·A·C AIDS Fund.

AIDS United

M·A·C AIDS FUND

AIDSUNITED.ORG

Ryan White Reallocations as of 07-28-17: Ryan White Part A and MAI* Funding

Part A Funds Available for Reallocation: $444,642

MAI Funds Available for Reallocation: $631,496

Control Number	Service Category	Amount Requested	Recommended Part A Reallocations	Recommended MAI Reallocations	Justification
1	Oral - General Dentistry	$30,000	$29,717	$0	To decrease wait time for appointments for new clients
2	Transportation	$40,000	$30,000	$0	To provide transportation for clients for whom public transportation is not accessible
3	Vision	$50,000	$0	$0	Reallocated funding to this service category in April 2017
4	Primary Care MD/NP/PA - $165,000 LPAP - $30,000 MCM - $37,500 CMSL - $14,000	$246,500	$81,500	$165,000	To increase the number of clients served MAI: MD/NP/PA - $165,000 Part A: LPAP - $30,000 MCM - $37,500 CMSL - $14,000
5	Vision	$39,975	$0	$0	Reallocated funding to this service category in April 2017
6	Primary Care Primary Care Visits - $199,925 MCM - $75,000 Disbursements - $63,425	$338,350	$128,425	$0	To increase the number of clients served Primary medical care visits coming from MAI Part A: MCM - $75,000 Disbursements - $53,425
7	Clinical Case Management	$60,000	$50,000	$0	To increase the number of clients served
8	Clinical Case Management	$75,000	$65,000	$0	To increase the number of clients served
9	Health Insurance Assistance Program	$300,000	$0	$0	Multiple funding streams; conflicting information provided for this service category
10	Medical Nutritional Therapy	$10,000	$10,000	$0	To increase the number of clients served
11	Emergency Financial Assistance	$100,000	$50,000	$50,000	To bridge the gap in medications for new clients while other payers are secured
1	**MAI** - Primary Care	$68,750	$0	$68,750	To decrease wait time for appointments for new clients
	TOTALS:	$1,358,575	$444,642	$283,750	
	REMAINING:		$0	$ 347,746	**

*MAI = Minority AIDS Initiative

** Earmark $347,746 in MAI for phone app program (pending QI)

Request Control Number	FY 17 Priority Rank	HRSA Service Category	Local Service Category or Subcategory	Amount of Request	Amount Approved by RWPC	FY 2016 Final Contract Amount	Expended 2016	Percent Expended	FY 2017 Contract Amount	FY 2017 Expended YTD	FY 2017 Percent YTD	FY 2017 Percent Expected YTD	Is agency currently in compliance with contract conditions and therefore eligible for increase?	Notes (Amount approved detail)
1	4.b	Oral Health	Oral Health - Rural	$30,000		$196,400	$196,400	100%	$166,404	$57,800	35%	25%	Yes	
2	14.a-b	Medical Transportation	Medical Transportation - Rural & Urban	$40,000		$389,885	$389,884	100%	$349,865	$80,640	23%	25%	Yes	
3	1.h	Primary Medical Care	Vision	$60,000		$166,000	$166,000	100%	$201,000	$53,600	27%	25%	Yes	
4	1.c-1.d	Primary Medical Care	Community-based Primary Medical Care targeted to African American, Hispanic and White	$246,600		$2,201,898	$2,125,206	97%	$1,732,903	$268,669	15%	25%	Yes	
5	1.h	Primary Medical Care	Vision	$39,975		$165,490	$162,890	98%	$151,000	$37,960	25%	25%	Yes	
6	1.c-1.d	Primary Medical Care	Community-based Primary Medical Care targeted to African American, Hispanic and White	$336,350		$3,407,256	$3,406,339	100%	$2,926,838	$620,895	21%	25%	Yes	
7	2.a	Medical Case Management	Clinical Case Management	$60,000		$269,325	$269,325	100%	$244,328	$60,125	25%	25%	Yes	
8	2.a	Medical Case Management	Clinical Case Management	$75,000		$244,325	$216,425	89%	$244,328	$74,160	30%	25%	Yes	
9	6	Health Insurance and Premium Cost Sharing	Health Insurance Assistance	$300,000		$1,029,422	$1,029,176	100%	$1,284,561	$286,177	22%	25%	Yes	

Request Control Number	FY 17 Priority Rank	HRSA Service Category	Local Service Category or Subcategory	Amount of Request	Amount Approved by RWPC	FY 2016 Final Contract Amount	Expended 2016	Percent Expended	FY 2017 Contract Amount	FY 2017 Expended YTD	FY 2017 Percent YTD	FY 2017 Percent Expected YTD	Is agency currently in compliance with contract conditions and therefore eligible for increase?	Notes (Amount approved detail)
10	10	Medical Nutritional Therapy	Medical Nutritional Therapy	$10,000		$341,395	$330,118	99%	$341,395	$85,394	25%	25%	Yes	To Reduce Wait Time and increase capacity
				$1,109,825	$0	$8,412,076	$5,392,143		$7,852,607	$1,823,420				

Confirmed Funds Avail. for Reallocation **$444,642** **Part A**

Source of Funds Available for Reallocation: **Explanation:**

FY 2016 Carryover Funds $444,642 Unspent FY 2016 program year funds

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**							
B.	Contract Number **(not provided to RWPC)**							
C.	Service Category Title (per RFP)	**ORAL HEALTH**				Control No.		
D.	Request for Increase under (check one):	Part A: **X**	or	MAI:				
	Request Period (check one):	April	July: **X**	Oct:	Final Qtr:			
E.	Amount of additional funding Requested	**$30,000.00**						
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)			
	General Dentistry	**1271**	**$100.00**	**300**	**$30,000.00**			
	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)				**$30,000.00**			
G.	Number of new/additional clients to be served with requested increase	**50**						
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"	**290**	**42% (raw# = 122)**	**32% (raw# = 94)**	**25% (raw# = 71)**	**68% (raw# = 196)**	**32% (raw# = 94)**	
	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	**170**	**35% (raw# = 59)**	**36% (raw# = 61)**	**27% (raw# = 46)**	**65% (raw# = 110)**	**35% (raw# = 46)**	

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 1-2 week of scheduling an appointment. With the steady increase in new patient appointments the appointment times could easily end up greater than 4 weeks to appt. The additional funding would also help us to increase seeing patients 5 days per week.**
	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, we would see patients five days a week.**
	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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	**MEDICAL TRANSPORTATION**				Control No.	
D.	Request for Increase under (check one):	Part A: **X**	or	MAI:			
	Request Period (check one):	April	July: **X**	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$40,000.00**					
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)		
	TRIPS	**161283**	**$2.00**	**20000**	**$40,000.00**		
	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):				**$40,000.00**		
G.	Number of new/additional clients to be served with requested increase.	**100**					
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"	**695**	**53% (raw# = 365)**	**18% (raw# = 127)**	**27% (raw# = 190)**	**71% (raw# = 493)**	**29% (raw# = 202)**
	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	**212**	**52% (raw# = 110)**	**15% (raw# = 32)**	**31% (raw# = 66)**	**69% (raw# = 146)**	**31% (raw# = 66)**

I	Additional Information Provided by Requesting Agency (subject to audit by RWGA). Answer all questions that are applicable to agency's current situation	a. Enter Number of Weeks in this column	b. How many Weeks will this be if full amount of request is received?	c. Comments (do **not** include agency name or identifying information)
	1. Length of waiting time (in weeks) for an appointment for a **new** client	**2**	**0**	**With the increase of new medical (25) and dental patients (15) agency is experiencing higher request of appoinments for the same week trips. Due to the increase in new patients lote have more complex needs that are requiring transportation services to and from medial and dental appointments and multiple primary care providers. Currently transportation has over $20,000 in units in the no pay.**
	2. Length of waiting time (in weeks) for an appointment for a **current** client	**1**	**0**	**Next day with a possibility of same day service with increased funding.**
	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

Request for Service Category Increase
Ryan White Part A and MAI

A	Name of Agency **(not provided to RWPC)**							
B	Contract Number **(not provided to RWPC)**							
C	Service Category Title (per RFP)	**VISION**				Control No.	3	
D	Request for Increase under (check one)	Part A **X**		or	MAI:			
	Request Period (check one)	April	July **X**		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)		
	Vision Service	**2010**	**$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	**412**	**53% (raw# = 217)**		**10% (raw# = 40)**	**36% (raw# = 149)**	**73% (raw# = 302)**	**27% (raw# = 110)**

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. Currently we have $31,200 in no pay we are unable to bill for. If we add in the no patient unduplicated clients served this far we have served a total of 529 patients in the first 4months of the contract.**
	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, we would see patients five days a week.**
	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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	**URBAN PRIMARY CARE**				Control No.	4
D.	Request for increase under (check one):	Part A: **X**	or	MAI			
	Request Period (check one):	April:	July: **X**	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$246,500.00**					
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. MD/NP/PA	2520	$275.00	**600**	**$165,000.00**		
	2 **LPAP TRANSACTIONS**	1562	$30.00	**1000**	**$30,000.00**		
	3. MCM	13232.48	$25.00	**1500**	**$37,500.00**		
	4. CMSL	6809.40	$20.00	**700**	**$14,000.00**		
	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)				**$246,500.00**		
G.	Number of new/additional clients to be served with requested increase.	**1,200**					
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"	**2280**	**62% (raw# = 1406)**	**11% (raw# = 245)**	**26% (raw# = 587)**	**73% (raw# = 1667)**	**27% (raw# = 613)**
	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	**1299**	**63% (raw# = 816)**	**8% (raw# =100)**	**27% (raw# = 357)**	**76% (raw# = 982)**	**24% (raw# = 317)**

Request for Service Category Increase
Ryan White Part A and MAI

I	Additional Information Provided by Requesting Agency (subject to audit by RWGA). Answer all questions that are applicable to agency's current situation	a. Enter Number of Weeks in this column	b. How many Weeks will this be if full amount of request is received?	c. Comments (do **not** include agency name or identifying information)
	1. Length of waiting time (in weeks) for an appointment for a **new** client	**2 - 3**	**0**	**The need for same day appointments for new patients is consitently increasing. Linkage to care for newly diagnosed is being completed daily, but we still have a limited number of new patient slots for same day appointments. We are seeing a average of 20-25 new patients each month. New patient appt timeframes is currently 2-3 weeks, but with the steady increase of new patients the timeframe could reach 3-4 weeks without the increase in funding. Currently we have $154,000.00 in no pay status. In addition, this includes meidcations and medication transactions. We are requesting additional medication transactions as we can't bill the medications without a transaction cost.**
	2. Length of waiting time (in weeks) for an appointment for a **current** client	**1 - 2**	**0**	**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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	Vision Care				Control No.	
D.	Request for Increase under (check one)	Part A: X	or	MAI:			
	Request Period (check one)	April:	August: X	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$39,975.00**					
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. Visits	2323	$65.00	615	$39,975.00		
	2.				$0.00		
	3.				$0.00		
	4.				$0.00		
	5.				$0.00		
	6.				$0.00		
	7				$0.00		
	8. Disbursements (list current **amount** in column a. and **requested**amount in column c.)		N/A		$0.00		
	9.Total additional funding (must match E. above):				**$39,975.00**		
G.	Number of new/additional clients to be served with requested increase						
H.	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female
	1. Number of clients that received this service under Part A (or MAI) in FY 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"	1235	41%	20%	39%	78%	22%
	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	524	42%	17%	41%	77%	23%

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:	4	3	The agency has a large number of Ryan White patients seeking vision services. The agency is requesting funding in order to sufficiently meet the continued demands for vision services for new Ryan White patients.
	2. Length of waiting time (in weeks) for an appointment for a **current** client:	3	2	The agency has a large number of Ryan White patients seeking vision services. The agency is requesting funding in order to sufficiently meet the continued demands for vision services for existing Ryan White patients.
	3. Number of clients on a "waiting list" for services (per Part A SOC):	0	0	The agency does not maintain a waiting list. The agency offers a limited number of same day appointment slots for patients.
	3. Number of clients unable to access services monthly (number unable to make an appointment) (per Part A SOC):	0	0	The agency offers a limited number of same day appointment slots for patients.

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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	Primary Care/MCM/SLW/LPAP/Outreach			Control No.		
D.	Request for Increase under (check one):	Part A X	or	MAI:			
	Request Period (check one):	April:	August X	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$338,350.00**					
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. Primary Health Care Visits	2,273	$275.00	727	$199,925.00		
	2. Medical Case Management	11174.68	$25.00	3000	$75,000.00		
	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.)	$119,549.00	N/A	$63,425.00	$63,425.00		
	9 Total additional funding (must match E. above):				**$338,350.00**		
G.	Number of new/additional clients to be served with requested increase:						
H.	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served. **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female
	1. Number of clients that received this service under Part A (or MAI) in FY 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"	2784	46%	20%	34%	82%	18%
	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	1631	46%	18%	36%	82%	18%

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:	4	3	The agency has a large number of Ryan White patients seeking primary care and medical case management services. The agency is requesting funding in order to sufficiently meet the continued demands for primary care and medical case management services for new Ryan White patients.
	2. Length of waiting time (in weeks) for an appointment for a **current** client:	3	2	The agency has a large number of Ryan White patients seeking primary care and medical case management services. The agency is requesting funding in order to sufficiently meet the continued demands for primary care and medical case management services for existing Ryan White patients.
	3. Number of clients on a "waiting list" for services (per Part A SOC):	0	0	The agency does not maintain a waiting list. The agency offers a limited number of same day appointment slots for patients.
	3. Number of clients unable to access services monthly (number unable to make an appointment) (per Part A SOC):	0	0	The agency offers a limited number of same day appointment slots for patients.

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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	**CLINICAL CASE MANAGEMENT**				Control No.	
D.	Request for Increase under (check one)	Part A: **X**	or	MAI:			
	Request Period (check one)	April:	July: **X**	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$60,000.00**					
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)		
	CCM	**7329**	**$25.00**	**2400**	**$60,000.00**		
	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):				**$60,000.00**		
G.	Number of new/additional clients to be served with requested increase.	**200**					
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"	**1060**	**61% (raw# = 651)**	**19% (raw# = 202)**	**18% (raw# = 189)**	**71% (raw# = 748)**	**29% (raw# = 312)**
	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	**391**	**64% (raw# = 252)**	**16% (raw# = 64)**	**17% (raw# = 68)**	**70% (raw# = 272)**	**30% (raw# = 119)**

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 weeks or greater.**
	2. Length of waiting time (in weeks) for an appointment for a **current** client:	**1-2 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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**							
B.	Contract Number **(not provided to RWPC)**							
C.	Service Category Title (per RFP)		Clinical Case Management			Control No.	8	
D.	Request for Increase under (check one):	Part A	or	MAI				
	Request Period (check one):	April:	July: X	Oct:	Final Qtr:			
E.	Amount of additional funding Requested:							
F.	Unit of Service (list only those units and disbursements where an increase is requested)	a. Number of units in current contract	b. Cost/unit	c. Number of additional units requested	d. Total (b x c)			
	1. CMLIC	6108	$30.00	2,500	$75,000.00			
	2.				$0.00			
	3.				$0.00			
	4.				$0.00			
	5.				$0.00			
	6.				$0.00			
	7.				$0.00			
	8. Disbursements (list current amount under a. and amount requested under c.)		N/A		$0.00			
	9. Total additional funding (must match E. above):				**$75,000.00**			
G.	Number of new/additional clients to be served with requested increase							
H.	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female	
	1. Number of clients that received this service under Part A (or MAI) in FY 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"	350	53%	32%	14%	84%	16%	

	2. Number of clients that have received this service under Part A (or MAI) in FY 2017. a. April Request Period = Not Applicable b. July 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	185	51%	34%	14%	82%	18%
I.	Additional Information Provided by Requesting Agency (subject to audit by RWGA). Answer only those questions that are applicable to agency's current situation	a. Enter Response in this column	b. What will this number be if full amount of this request is received?		c. Comment: We have not been able to enter May data or billing as our contract is not yet set up in CPCDMS so the data in #2 reflects our EHR data. June data is not due until after this deadline. Our contract was extended 2 months from CY 16 due to the County's desire to add a contractor to the category		
	1. Length of waiting time (in weeks) for a new appointment:			N/A	We serve everyone who presents for services. For 3.1.17 - 5.31.17, we had $6,075 in No Pay. So far in CY17 we have $4,545 representing 4 months. We expect to have a total of $60,000 in No Pay for this full year if no increase is awarded and we will have to reduce staff and the number of clients we serve by 30% thus creating a wait list. On the current contract, we are only able to fund our 3 CCMs at 65%		
	2. Number of clients on waiting list for services.	0		N/A	" "		
	3. Number of clients unable to access services monthly	0		N/A	" "		
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 (25 words or less):		
	1. Behavioral Case Management for consumers with active or a history of substance use	DSHS - Sustance	8/31/17	$440,245	Includes prison and recently released service linkage		
	2.						

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	Health Insurance Premium and Cost Sharing Assistance				Control No.	
D.	Request for Increase under (check one):	Part A: X	or	MAI:			
	Request Period (check one):	April:	August: X	Oct.	Final Qtr:		
E.	Amount of additional funding Requested:	**$300,000.00**					
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.				$0.00		
	2				$0.00		
	3				$0.00		
	4				$0.00		
	5				$0.00		
	6				$0.00		
	7				$0.00		
	8. Disbursements (list current **amount** in column a. and **requested**amount in column c.)	$1,046,001.00	N/A	$300,000.00	$300,000.00		
	9 Total additional funding (must match E. above):				**$300,000.00**		
G.	Number of new/additional clients to be served with requested increase						
H.	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served. **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female
	1. Number of clients that received this service under Part A (or MAI) in FY 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"	2101	45%	28%	27%	81%	19%
	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	1660	45%	27%	28%	80%	20%

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:	4	3	The agency has a large number of Ryan White patients seeking health insurance assistance services. The agency is requesting funding in order to sufficiently meet the continued demands for health insurance assistance services for new Ryan White patients.
	2. Length of waiting time (in weeks) for an appointment for a **current** client:	3	2	The agency has a large number of Ryan White patients seeking health insurance assistance services. The agency is requesting funding in order to sufficiently meet the continued demands for health insurance assistance services for existing Ryan White patients.
	3. Number of clients on a "waiting list" for services (per Part A SOC):	0	0	The agency does not maintain a waiting list. The agency offers a limited number of same day appointment slots for patients.
	3. Number of clients unable to access services monthly (number unable to make an appointment) (per Part A SOC)	0	0	The agency offers a limited number of same day appointment slots for patients.

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

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	Nutritional Therapy Services				Control No.	
D.	Request for Increase under (check one):	Part A: X	or	MAI:			
	Request Period (check one):	April:	August: X	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$10,000.00**					
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.				$0.00		
	2.				$0.00		
	3.				$0.00		
	4.				$0.00		
	5.				$0.00		
	6.				$0.00		
	7.				$0.00		
	8. Disbursements (list current **amount** in column a. and **requested** amount in column c.)	$231,845.00	N/A	$10,000.00	$10,000.00		
	9. Total additional funding (must match E. above):				**$10,000.00**		
G.	Number of new/additional clients to be served with requested increase						
H	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served. **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female
	1. Number of clients that received this service under Part A (or MAI) in FY 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"	505	41%	23%	36%	77%	23%
	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	365	40%	22%	38%	77%	23%

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:	4	3	The agency has a large number of Ryan White patients seeking nutrition therapy services. The agency is requesting funding in order to sufficiently meet the continued demands for nutrition therapy services for new Ryan White patients.
	2. Length of waiting time (in weeks) for an appointment for a **current** client:	3	2	The agency has a large number of Ryan White patients seeking nutrition therapy services. The agency is requesting funding in order to sufficiently meet the continued demands for nutrition therapy services for existing Ryan White patients.
	3. Number of clients on a "waiting list" for services (per Part A SOC):	0	0	The agency does not maintain a waiting list. The agency offers a limited number of same day appointment slots for patients
	3. Number of clients unable to access services monthly (number unable to make an appointment) (per Part A SOC):	0	0	The agency offers a limited number of same day appointment slots for patients.

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

FY 2016 RW PART A REQUESTS FOR ALLOCATION INCREASE (July 2016)

REVISED: 7/20/2017

Request Control Number	FY 17 Priority Rank	HRSA Service Category	Local Service Category or Subcategory	Amount of Request	Amount Approved by RWPC	FY 2016 Final Contract Amount	Expended 2016	Percent Expended	FY 2017 Contract Amount	FY 2017 Expended YTD	FY 2017 Percent YTD	FY 2017 Percent Expected YTD	Is agency currently in compliance with contract conditions and therefore eligible for increase?	Notes
1	1b-1.c	Primary Medical Care	Community-based Primary Medical Care targeted to African American, and Hispanic	$68,750		$772,410	$498,575	65%	$791,226	$193,050	24%	25%	Yes	Amount approved detail
				$68,750	$0	$772,410	$498,575		$791,226	$193,050				

Confirmed Funds Avail. for Reallocation **$631,496** **MAI**

Source of Funds Available for Reallocation: **Explanation:**

FY 2015 Carryover Funds $631,496 Unspent MAI funds from FY 16 program year

Request for Service Category Increase
Ryan White Part A and MAI

A	Name of Agency **(not provided to RWPC)**						
B	Contract Number **(not provided to RWPC)**						
C	Service Category Title (per RFP)	**ADULT COMPREHENSIVE PRIMARY CARE MAI**				Control No	1
D	Request for increase under (check one)	Part A	or	MAI **X**			
	Request Period (check one)	April	July **X**	Oct	Final Qtr		
E	Amount of additional funding Requested	**$68,750.00**					
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. MD/NP/PA	**2877**	**$275.00**	**250**	**$68,750.00**		
	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)				**$68,750.00**		
G	Number of new/additional clients to be served with requested increase	**50**					
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"	**790**	**64% (raw# = 507)**	**0% (raw# = 0)**	**35% (raw# = 276)**	**75% (raw# = 593)**	**25% (raw# = 197)**
	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	**537**	**62% (raw# = 332)**	**0% (raw# = 0)**	**38% (raw# = 203)**	**77% (raw# = 411)**	**23% (raw# = 126)**
	c. October Request Period = 03/01/17 - 09/30/17						
	d. 4th Qtr. Request Period = 03/01/17- 11/30/17						

I. Additional Information Provided by Requesting Agency (subject to audit by RWGA). Answer all questions that are applicable to agency's current situation	a. Enter Number of Weeks in this column	b. How many Weeks will this be if full amount of request is received?	c. Comments (do **not** include agency name or identifying information):
1. Length of waiting time (in weeks) for an appointment for a **new** client:	**2 - 3**	**0**	**The need for same day appointments for new patients is consitently increasing. Linkage to care for newly diagnosed is being completed daily, but we still have a limited number of new patient slots for same day appointments. We are seeing a average of 25 new patients each month. New patient appt timeframes is currently 2-3 weeks, but with the steady increase of new patients the timeframe could reach 3-4 weeks without the increase in funding.**
2. Length of waiting time (in weeks) for an appointment for a **current** client:	**1 - 2**	**0**	**Will be able to see patients same day 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

FYI

Meaningful Involvement of People with HIV/AIDS (MIPA)

"Nothing About Us Without Us"

The principle of meaningful involvement of people with HIV/AIDS (MIPA) was first articulated in the Denver Principles in 1983, and has also been endorsed by UNAIDS, the body that coordinates global action on the HIV/AIDS epidemic. *The National HIV/AIDS Strategy: Updated to 2020* supports MIPA as well, acknowledging the "persistent advocacy from people living with HIV" and "the engagement of affected communities."

Partnering with people living with HIV to make informed decisions about their own health care and treatment, research agendas that affect them, and creation and review of policies and programs that directly impact them are important cornerstones of the global response to HIV.

As UNAIDS explains, at its most basic level, MIPA does two important things:

1. recognizes the important contribution that people living with and affected by HIV/AIDS can have in the response to the epidemic as equal partners and
2. creates a space within society for involvement and active participation of people living with HIV in all aspects of that response.

WHY MIPA MATTERS

People living with HIV are likely to be intimately familiar with factors that place individuals and communities at risk for acquiring HIV in the first place; barriers to accessing care and treatment; and challenges to living a full and healthy life with dignity.

When people living with HIV are involved in program development and implementation, it can improve relevance and effectiveness of strategies. Moreover, raising visibility of people living with HIV and elevating their voices and experiences can help decrease HIV-related stigma and discrimination. Studies show that when individuals and communities are proactively engaged in ensuring their own wellbeing, improved health outcomes are more likely.[1]

MIPA IS ABOUT MORE THAN JUST HIV STATUS

Historically, there have been many barriers to meaningful inclusion of people living with HIV in decision-making roles within organizations and service delivery settings. Many of these ultimately lead back to a need to address systems of privilege that structure who has access to power — such as racism, misogyny, transphobia, formal education requirements, and decision-making processes that are unnecessarily bureaucratic.

MIPA today is about ensuring that the communities most affected by HIV are involved in decision-making, at every level of the response. Specifically, many organizations may need to re-envision their systems to involve young people, folks of trans experience, and Black and Latinx communities in decision-making.

> "Our PLHIV partner organization supported us in identifying meaningful ways to include patient voices at each stage of our transformation towards becoming a trauma-informed primary care clinic. We now have our patients at the table for every major programmatic decision. The result is a feeling and reality that our program is grounded in the actual needs and visions of our patients."
>
> —Edward Machtinger, MD
> Director, Women's HIV Program, University of California, San Francisco

[1]International HIV/AIDS Alliance and Horizons (2003). The Involvement of People Living with HIV/AIDS in Community-based Prevention, Care and Support Programs in Developing Countries.

AIDS United: www.aidsunited.org
U.S. People Living with HIV Caucus: www.hivcaucus.org

People living with HIV commit to treatment and prevention fully only when there is a commitment to involving and engaging them authentically.

Benefits of MIPA are vast:

Individual level. Involvement can build self-esteem, counter depression, increase HIV and health care knowledge, improve engagement in care, develop stronger connections to the community, increase empowerment, autonomy and self-advocacy, and improve health outcomes.

Organizational level. Involvement can improve: program processes and outcomes; cultural competency; responsiveness to client needs; client satisfaction; quality of care and services; organizational trust; and prevention, treatment, care, and support services for people living with and affected by HIV. Importantly, people feel more valued and invested in an organization when they are involved in decision-making.

Community level. MIPA can decrease HIV stigma, discrimination, and myths; develop safe spaces for marginalized populations; increase opportunities for collaboration; improve services available; decrease community viral load; and improve community pride.

MECHANISMS FOR INVOLVEMENT

People living with and affected by HIV can be engaged on a range of levels including executive leadership and governance; policymaking; program development and implementation; leadership development; peer support; policy and advocacy; designing campaigns; public speaking; and evaluation.

MIPA does not happen in a vacuum. Rather, it requires buy-in and dedication from organizational decision makers and intentional actions to ensure that people living with HIV, especially those from marginalized communities, are, in fact, meaningfully involved and set up for success.

This also includes investing in *capacity building* and technical assistance for people living with HIV, *enlisting these individuals on decision-making bodies*, ensuring those enlisted are *reflective of the epidemic* and marginalized communities, *hiring people living with HIV,* establishing a clear and objective *feedback loop*, educating staff and establishing policies to *counter stigma*, and *monitoring implementation* of recommendations. For government agencies and other funders, requirements and associated reporting on MIPA-centric policies and activities are important measures in ensuring their uptake and adherence.

Examples of organizational practices that can be put in place:

- minimum percentage of seats on the governance board for people living with HIV and in organizational leadership;
- minimum percentage of people living with HIV, people of color, and LGTBQ-identified folks in management roles;
- commitment to involve people living with HIV in development and design of new programs;
- protocols to take and act on input from clients or patients on an ongoing basis; and
- financial support for participation in meetings, such as travel stipends, honoraria, and per diems.

MIPA requires dedication, planning and assessment, organizational buy-in, and a champion to help usher its development and continued assessment. Decades of HIV work have shown MIPA's unique—and critical—role in addressing the HIV epidemic and advancing the lives and health of people living with and affected by it. This work takes time but this investment is critical, doable, and well worth the effort.

AIDS United and the United States People Living with HIV Caucus are here to help.

THE MIPA "LITMUS TEST"

ASK YOURSELF:

LEADERSHIP AND REPRESENTATION:

☐ What positions do people living with HIV and people of color hold in your organization?

__ To what extent are they represented in management and decision-making positions?

INTERSECTIONALITY:

☐ Have you considered how HIV stigma, racism, sexism, classism, and other forms of oppression may be operating in organizational practices? How might these be addressed?

☐ What practices and policies do you have in place to support trans and gender non-conforming staff and clients, including those who are in a transition process?

INPUT AND ENGAGEMENT:

☐ How do people living with HIV provide input into service delivery?

☐ How are client concerns about services resolved?

☐ Do you have formal mechanisms for input by clients?

__ Are people living with HIV represented and are they reflective of the constituency you serve?

__ Can they safely say, "no"?

__ Are their recommendations implemented?

__ Is there a mechanism for them to sign off on policies?

Learn more about technical assistance opportunities for you to advance MIPA in your own organization or community:

AIDS United: www.aidsunited.org

U.S. People Living with HIV Caucus: www.hivcaucus.org

AIDSinfo

Living with HIV

HIV and Nutrition and Food Safety

Last Reviewed: June 16, 2017

Key Points

- In people with HIV, good nutrition supports overall health and helps maintain the immune system. Good nutrition also helps people with HIV maintain a healthy weight and absorb HIV medicines.
- A healthy diet includes a variety of nutritious foods in the right amount to maintain a healthy weight. But HIV infection and its treatment can sometimes make it hard for a person to follow a healthy diet. For example, HIV-related infections can make it hard to eat or swallow.
- Food and water can be contaminated with germs that cause illnesses. Food safety refers to ways to handle, prepare, and store food to prevent foodborne illnesses (sometimes called food poisoning).
- Because HIV damages the immune system, foodborne illnesses are likely to be more serious and last longer in people with HIV than in people with a healthy immune system.
- People with HIV should take the following steps to prevent foodborne illnesses:
  - Wash hands, cooking utensils, and countertops often when preparing foods.
  - Keep raw meat, poultry, seafood, and eggs separate from foods that are ready to eat, including fruits, vegetables, and breads.
  - Cook food to safe temperatures.
  - Refrigerate or freeze foods to prevent spoiling.

What is nutrition?

Nutrition refers to the food we eat to grow and stay healthy. Nutrition also includes all the processes our body uses to take in and use that food (called metabolism).

Why is good nutrition important for people living with HIV?

Good nutrition supports overall health and helps maintain the immune system. Good nutrition also helps people with HIV maintain a healthy weight and absorb HIV medicines.

HIV attacks and destroys the immune system, which makes it harder for the body to fight off infections. Daily use of HIV medicines (called antiretroviral therapy or ART) prevents HIV from destroying the immune system. But a healthy diet also helps strengthen the immune system and keep people with HIV healthy.

What is a healthy diet for people living with HIV?

In general, the basics of a healthy diet are the same for everyone, including people with HIV.

- Eat a variety of foods from the five food groups: fruits, vegetables, grains, protein foods, and dairy.
- Eat the right amount of food to maintain a healthy weight.
- Choose foods low in saturated fat (found in animal products such as meat and dairy products), sodium (salt), and added sugars.

To learn more about how to maintain a healthy diet, visit the U.S. Department of Agriculture's (USDA's) ChooseMyPlate.gov website.

What are some nutrition-related problems that people with HIV may face?

HIV infection and its treatment can sometimes make it hard for a person to follow a healthy diet. The following are examples of nutrition-related issues that can affect people with HIV:

- HIV-related infections can make it hard to eat or swallow.
- Changes in metabolism can cause weight loss or weight gain.
- Side effects from HIV medicines such as loss of appetite, nausea, or diarrhea can make it hard to adhere to (stick to) an HIV regimen.

Browse the following resources to learn more about HIV and nutrition and how to manage nutrition-related problems:

- Nutrition and Health Issues: AIDS/HIV, from Nutrition.gov
- Diet and Health: AIDS/HIV, from USDA
- Side Effects Guide, from the U.S. Department of Veterans Affairs

In addition to eating healthy, people with HIV must pay attention to food safety.

What is food safety?

Food and water can be contaminated with germs that cause illnesses. Food safety refers to ways to handle, prepare, and store food to prevent foodborne illnesses (sometimes called food poisoning).

Why is food safety important for people living with HIV?

HIV attacks the immune system. A weakened immune system makes it hard for the body to fight off infections, including foodborne illnesses.

Following food safety guidelines reduces the risk of foodborne illnesses, which are likely to be more serious and last longer in people with HIV than in people with a healthy immune system.

What steps can people with HIV take to prevent foodborne illnesses?

People with HIV can reduce their risk of foodborne illnesses by avoiding certain foods and taking care to prepare and store foods safely. If you have HIV, follow these food safety guidelines:

Don't eat or drink the following foods:

- Raw or undercooked eggs, for example, in homemade mayonnaise or uncooked cookie dough
- Raw or undercooked poultry, meat, and seafood (especially raw shellfish)
- Unpasteurized milk, cheeses, and fruit juices
- Raw seed sprouts, such as alfalfa sprouts or mung bean sprouts

Water contaminated with human or animal waste can also cause illness. To be safe, never drink water directly from a lake or river and don't swallow water during swimming.

It is important to be careful about what you eat or drink if you are traveling outside of the United States, especially in developing countries. Before your trip, read this fact sheet for people living with HIV and traveling outside the United States from the Centers for Disease Control and Prevention (CDC).

Follow the four basic steps to food safety: clean, separate, cook, and chill.

- Clean: Wash your hands, cooking utensils, and countertops often when preparing foods.
- Separate: Separate foods to prevent the spread of any germs from one food to another. For example, keep raw meat, poultry, seafood, and eggs separate from foods that are ready to eat, including fruits, vegetables, and breads.
- Cook: Use a food thermometer to make sure that foods are cooked to safe temperatures.
- Chill: Refrigerate or freeze meat, poultry, eggs, seafood, or other foods that are likely to spoil within 2 hours of cooking or purchasing.

For more information, visit the U.S. Food and Drug Administration's (FDA's) Food Safety for People with HIV/AIDS webpage. The webpage includes information on the recommended safe

minimum internal temperatures for cooked foods, tips for eating in restaurants, and steps to take if you think you have food poisoning.

This fact sheet is based on information from the following sources:

From the AIDS Education and Training Center (AETC) National Coordinating Resource Center:

- Guide for HIV/AIDS Clinical Care: Nutrition

From CDC:

- HIV Treatment Works: Healthy Diet

From CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America:

- Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents: Appendix A. Recommendations to Help HIV-Infected Patients Avoid Exposure to, or Infection from, Opportunistic Pathogens

From FDA:

- Food Safety for People with HIV/AIDS

From USDA:

- ChooseMyPlate.gov

Vivir con el VIH

El VIH, la nutrición y la seguridad alimentaria

Última revisión: 28 junio, 2017

Puntos importantes

- En las personas con el VIH, la buena nutrición apoya el estado general de salud y ayuda a mantener el sistema inmunitario. La buena nutrición también ayuda a las personas con el VIH a mantener un peso saludable y absorber los medicamentos contra el VIH.
- Una alimentación saludable incluye una variedad de alimentos nutritivos en las cantidades adecuadas para mantener un peso saludable. Sin embargo, la infección por el VIH y su tratamiento pueden a veces hacer que sea difícil para la persona seguir una alimentación saludable. Por ejemplo, las infecciones relacionadas con el VIH pueden dificultar comer o tragar los alimentos.
- Los alimentos y el agua pueden estar contaminados con microbios que causan enfermedades. La seguridad alimentaria se refiere a la forma de manejar, preparar y almacenar los alimentos para prevenir las enfermedades transmitidas por los alimentos (intoxicación por alimentos).
- Como el VIH daña el sistema inmunitario, las enfermedades transmitidas por los alimentos tienen más probabilidad de ser más graves y durar más tiempo en las personas con el VIH que en las personas con un sistema inmunitario saludable.
- Las personas con el VIH debe tomar las siguientes medidas para prevenir las enfermedades transmitidas por los alimentos:
  - Lavarse las manos, lavar los utensilios de cocina y los mesones a menudo mientras preparan los alimentos.
  - Guardar la carne, el pollo, los mariscos y los huevos crudos separados de los alimentos que están listos para comer, como las frutas, las verduras y los panes.
  - Cocinar los alimentos a temperaturas seguras.
  - Refrigerar o congelar los alimentos para evitar que se pudran.

¿Qué es la nutrición?

La nutrición se refiere al alimento que comemos para crecer y permanecer sanos. La nutrición

también incluye todos los procesos que el cuerpo usa para recibir y utilizar ese alimento (llamado metabolismo).

¿Por qué es la buena nutrición importante para las personas con el VIH?

La buena nutrición apoya el estado general de salud y ayuda a mantener el sistema inmunitario. La buena nutrición también ayuda a las personas con el VIH a mantener un peso saludable y absorber los medicamentos contra el VIH.

El VIH ataca y destruye el sistema inmunitario, lo cual le dificulta al organismo combatir las infecciones. El uso diario de los medicamentos contra el VIH (conocido como tratamiento antirretroviral o TAR) evita que el VIH destruya el sistema inmunitario. Sin embargo, una alimentación saludable también ayuda a fortalecer el sistema inmunitario y a mantener a las personas con el VIH sanas.

¿Cuál es una alimentación saludable para las personas con el VIH?

En general, los fundamentos de una alimentación saludable son iguales para todas las personas, incluso para las que tienen el VIH.

- Consuma una variedad de alimentos de los cinco grupos de alimentos: frutas, verduras, granos, proteínas y productos lácteos.
- Consuma la cantidad adecuada de alimentos para mantener un peso saludable.
- Escoja alimentos bajos en grasa saturada (que se encuentra en los productos animales como carne y productos lácteos), en sodio (sal) y en azúcar agregada.

Para información adicional sobre cómo mantener una alimentación saludable, visite el sitio web ChooseMyPlate.gov del Departamento de Agricultura de los Estados Unidos (USDA).

¿Cuáles son algunos de los problemas relacionados con la nutrición que pueden enfrentar las personas con el VIH?

La infección por el VIH y su tratamiento pueden a veces hacer difícil para la persona seguir una alimentación saludable. Los siguientes son ejemplos de problemas relacionados con la nutrición que pueden afectar a las personas con el VIH:

- Las infecciones relacionadas con el VIH pueden dificultar comer o tragar los alimentos.
- Los cambios en el metabolismo pueden causar adelgazamiento o aumento de peso.
- Los efectos secundarios de los medicamentos contra el VIH, como la pérdida del apetito, las náuseas o la diarrea pueden dificultar el cumplimiento (seguir) del régimen de tratamiento.

Vea los siguientes recursos para aprender más sobre el VIH y la nutrición, y cómo manejar los problemas relacionados con la nutrición:

- Nutrición y la salud de Nutrition.gov
- Guía de efectos secundarios del Departamento de Asuntos de los Veteranos de los Estados Unidos (Disponible solamente en inglés)

Además de comer saludable, las personas con el VIH deben prestar atención a la seguridad alimentaria.

¿Qué es la seguridad alimentaria?

Los alimentos y el agua pueden estar contaminados con microbios que causan enfermedades. La seguridad alimentaria se refiere a la forma de manejar, preparar y almacenar los alimentos para prevenir las enfermedades transmitidas por los alimentos (intoxicación por alimentos).

¿Por qué es la seguridad alimentaria importante para las personas con el VIH?

El VIH ataca el sistema inmunitario. Un sistema inmunitario debilitado le dificulta al organismo luchar contra las infecciones, incluyendo las enfermedades transmitidas por los alimentos.

Seguir las pautas para la seguridad alimentaria reduce el riesgo de las enfermedades transmitidas por los alimentos, que tienen más probabilidad de ser más graves y durar más tiempo en las personas con el VIH que en las personas con un sistema inmunitario saludable.

¿Qué medidas pueden tomar las personas con el VIH para prevenir las enfermedades transmitidas por los alimentos?

Las personas con el VIH pueden reducir su riesgo de enfermedades transmitidas por los alimentos evitando ciertos alimentos y teniendo cuidado al preparar y almacenar los alimentos. Si usted tiene el VIH, siga estas pautas de seguridad alimentaria:

No coma ni beba los siguientes alimentos:

- Huevos crudos o no cocinados suficiente, por ejemplo, en mayonesa hecha en casa o masa para galletas cruda
- Pollo, carne y mariscos crudos (especialmente crustáceos crudos)
- Leche, quesos, y zumos de fruta sin pasteurizar
- Brotes crudos de semillas, como brotes de alfalfa o frijol chino (mung bean)

El agua contaminada con desechos humanos o animales también puede causar enfermedades. Para estar seguro, nunca beba agua directamente de un lago o de un río y no trague agua mientras está nadando.

Es importante que tenga cuidado con lo que come o bebe si está viajando fuera de los Estados Unidos, especialmente en países en vía de desarrollo. Antes de su viaje, lea esta Hoja informativa para las personas con el VIH que están viajando al extranjero, de los Centros para el Control y la Prevención de Enfermedades (CDC).

Siga los cuatro pasos básicos de seguridad alimentaria: Lavar, separar, cocinar y refrigerar.

- Lavar: Lávese las manos, lave los utensilios de cocina y los mesones a menudo mientras prepara los alimentos.
- Separar: Separe los alimentos para prevenir la propagación de microbios de un alimento a otro.

Por ejemplo, separe la carne, el pollo, los mariscos y los huevos crudos de los alimentos que están listos para comer, como las frutas, las verduras y los panes.

- **Cocinar**: Utilice un termómetro de alimentos para cerciorarse que los alimentos estén cocinados a temperaturas seguras.
- **Refrigerar**: Refrigere o congele la carne, el pollo, los huevos, los mariscos, u otros alimentos que se puedan dañar en un plazo de 2 horas de cocinarlos o de comprarlos.

Para información adicional, visite el sitio web Seguridad alimentaria para las personas con el VIH/SIDA de la Administración de Alimentos y Medicamentos (FDA) de los Estados Unidos. El sitio web incluye información sobre las temperaturas internas mínimas seguras recomendadas para los alimentos cocinados, consejos para comer en restaurantes y las medidas que debe tomar si piensa que tiene una intoxicación por alimentos.