DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL
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We envision an educated community where the needs of all persons living with and/or affected by HIV 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 living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.

AGENDA

12 noon, June 14, 2018
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

I. Call to Order — Cecilia Oshingbade, Chair, RW Planning Council
   A. Welcome and Moment of Reflection
   B. Adoption of the Agenda
   C. Approval of the Minutes
   D. Project LEAP Presentation — Project LEAP students
   E. Training: Updates from the Texas Dept. of State Health Services — Shelley Lucas, Manager, HIV/STD Prevention and Care Branch, Texas Department of State Health Services

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 status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to 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 — Ted Artiaga and Steven Vargas, Co-Chairs
      Item: 2018 Epidemiological Profile
      Recommended Action: **Motion:** Approved Chapter 1 of the 2018 Epidemiological Profile, which reports sociodemographic characteristics of the general population in the Houston area. See the attached chapter.

      Item: 2018 Epidemiological Profile
      Recommended Action: FYI: Staff will work jointly with the Houston Health Department's newly re-structured Disease

Prevention and Control Division of the Houston Health Department to complete the remaining chapters.

Item: Special Study: Social Determinants of Health
Recommended Action: FYI: Dr. Mgbere provided first-run social determinants of health data from the Houston Medical Monitoring Project. Dr. Mgbere will provide outstanding requested data in future runs.

Item: Evaluation Workgroup
Recommended Action: FYI: The Evaluation Workgroup met on May 10th and began review of Year 1 (2017) implementation of the 2017-2021 Comprehensive Plan. The Workgroup will resume the evaluation process on Tuesday, June 12th. Please see Diane if you would like to be added to the Evaluation Workgroup.

B. Affected Community Committee — Rodney Mills and Tana Pradia, Co-Chairs

Item: Community Events
Recommended Action: FYI: See the attached list of 2018 community events where members of the Affected Community Committee and others will be attending staffing a Ryan White booth. Please speak with Tori if you wish to help staff the booth at the Pride Festival.

Item: Greeters
Recommended Action: FYI: Many thanks to the people who serve as Greeters at our Council meetings.

Item: 2018 Quarterly Committee Report
Recommended Action: FYI: See the attached 2018 Quarterly Committee Report.

C. Quality Improvement Committee — Denis Kelly and Gloria Sierra, Co-Chairs

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

- FY 2017 Service Utilization, dated 05/23/18
- FY 2017 Procurement, dated 05/15/18

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

- 2017 Chart Reviews
- FY17/18 Part B Procurement, dated 05/09/18
- FY17/18 DSHS State Services Procurement, dated 05/09/18
- FY17/18 DSHS State Services-R Procurement, dated 05/09/18
- Health Insurance Assist. Service Utilization Report, dated 05/07/18
- Health Insurance Assist. Service Utilization Report, dated 03/05/18
- FY17/18 Part B Service Utilization, dated 05/09/18

Item: FY 2019 How To Best Meet the Need Recommendations
Recommended Action: **Motion:** Approve the attached FY 2019 Ryan White Part A, MAI, Part B and State Services service definitions and financial eligibility and create up to five service linkage worker positions targeting outpatient substance abuse treatment. Please note: the Referral for Health Care and Support Services service definition has been tabled until more information becomes available.

Item: Targeting Chart for FY 2019 Service Categories
Recommended Action: **Motion:** Approve the attached Targeting Chart for FY 2019 Service Categories for Ryan White Part A, B, MAI and State Services Funding.

Item: Checklist for the Assessment of the Administrative Mechanism
Recommended Action: **Motion:** Approve the attached checklist for the Houston Ryan White Administrative Mechanism.

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

Item: FY 2019 Service Priorities
Recommended Action: FYI: Although the Committee developed recommendations regarding the FY 2019 Ryan White Service Priorities, these will be presented to the Council, along with the recommended FY 2019 allocations, in July.

Item: FY 2018 Allocations
Recommended Action: **Motion:** Because the final notice of grant award arrived three months into the fiscal year, and because of the importance of allocating funds rapidly, the committee agreed to suspend its policy for allocating unobligated funds and asked the Ryan White Part A Administrative Agent to allocate $242,768 in unallocated funds to the ambulatory outpatient primary medical care service category.

Item: 2018 Quarterly Committee Report
Recommended Action: FYI: See the attached 2018 Quarterly Committee Report.

E. Operations Committee — Ella Collins-Nelson and Johnny Deal, Co-Chairs

Item: FY 2018 Council Support Budget
Recommended Action: **Motion:** Approve the transfer of funds in the FY 2018 Council Support Budget in the amount of $10,860 from the Resource Guide to Out of EMA travel in order to accommodate the cost of sending four individuals to the All Grantees meeting in Washington DC in December 2018.

Item: Budget for the 2020-2021 Blue Book
Recommended Action: **Motion:** Approve the attached budget for the 2020-2021 Blue Book.

Item: FY 2019 Council Support Budget
Recommended Action: **Motion:** Approve the attached FY 2019 Council Support Budget.

Item: Schedule of 2018 Council Training Topics
Recommended Action: FYI: See the attached schedule of 2018 Council Training Topics.

Item: 2018 Quarterly Committee Report
Recommended Action: FYI: See the attached 2018 Quarterly Committee Report.

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

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

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

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

VIII. New Business (30 seconds/report)

A. Ryan White Part C Urban and Part D — Dawn Jenkins
B. Community Development Advisory Council (CDAC) — Johnny Deal
C. HOPWA — Krystal Shultz
D. Community Prevention Group (CPG) — Denis Kelly
E. Update from Task Forces:
- Sexually Transmitted Infections (STI) — Herman Finley
- African American — Ella Collins-Nelson
- Latino — Gloria Sierra
- Youth — Gloria Sierra
- MSM — Ted Artiaga
- Transgender — Viviana Santibanez
- Hepatitis C — Steven Vargas
- Urban AIDS Ministry — Ella Collins-Nelson

F. HIV and Aging Coalition — Bruce Turner
G. Texas HIV Medication Advisory Committee — Bruce Turner
H. Positive Women's Network — Tana Pradia
I. Texas Black Women's Initiative — Sha'Terra Johnson-Fairly
J. Texas HIV Syndicate — Amber Harbolt
K. END HIV Houston — Venita Ray
L. Texans Living with HIV Network — Venita Ray
M. Legislative Updates — Denis Kelly

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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We envision an educated community where the needs of all persons living with HIV 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 living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.

MINUTES

12 noon, Thursday, April 12, 2018
Meeting Location: Ryan White Offices, 2223 W. Loop South, Rm 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Skeet Boyle, Vice Chair	John Poole	Gil Flores, Tarrant Co. TGA
Carol Suazo, Secretary	Viviana Santibanez	Lauren Donnell, Tarrant Co. TGA
Ted Artiaga	Bruce Turner	Lonnetta Wilson, Tarrant Co. TGA
Ruth Atkinson	Steven Vargas	Eddie Givens, External Member
Connie L. Barnes		Nancy Miertschin, HHS
Rosalind Belcher		Shabu Sam, AHF
Ella Collins-Nelson	**MEMBERS ABSENT**	Matilda Padilla, AHF
Bobby Cruz	David Benson, excused	Melvin Joseph, Project LEAP 2018
Johnny Deal	Angela F. Hawkins, excused	
Herman L. Finley III	Arlene Johnson	**STAFF PRESENT**
Ronnie Galley	J. Hoxi Jones, excused	*Ryan White Grant Administration*
Paul E. Grunenwald	Tom Lindstrom, excused	Carin Martin
Dawn Jenkins	Osaro Mgbere, excused	Heather Keizman
Daphne L. Jones	Robert Noble	Tasha Traylor
Denis Kelly	Cecilia Oshingbade, excused	
Peta-gay Ledbetter	Tana Pradia, excused	*The Resource Group*
Rodney Mills	Venita Ray, excused	Sha'Terra Johnson-Fairley
Allen Murray	Faye Robinson, excused	Crystal Townsend
Shital Patel	Gloria Sierra, excused	
Krystal Perez	Isis Torrente	*Office of Support*
		Tori Williams
		Amber Harbolt
		Diane Beck

Call to Order: Skeet Boyle, Vice Chair, called the meeting to order at 12:13 p.m.

During the opening remarks, Boyle said that there were a number of out of town meetings this week and Cecilia is at one of them, so he will chair the meeting today. He asked the three visitors from the Ft.

Worth Planning Council to introduce themselves and to please let members know if there is anything that they need during their visit.

Boyle thanked the Co-Chairs for the upcoming How To Best Meet the Need workgroup meetings. Please join them in participating in this important process. He also thanked Gloria and Denis, Co-Chairs of the Quality Improvement Committee since they are responsible for the How To Best Meet the Need process. Because the How To Best Meet the Need Training begins as soon as the Council meeting adjourns today, members were contacted earlier to let them know that all task force reports had to be submitted in writing. There will be no verbal task force reports so that the training can start on time. Lunch will be provided for those who attend the training.

Boyle then introduced Ann Dills, MSW, Systems Consultant, HIV/STD Care and Services, Texas Department of State Health Services. Ann came from Austin today to provide updated information on the Houston EMA/HSDA HIV Care Continuum which will be used in our How To Best Meet the Need process.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Barnes, Galley) to approve the March 8, 2018 minutes.* **Motion carried.** Abstentions: Atkinson, Grunenwald, Santibanez.

Public Comment and Announcements: Mikel Marshall, ViiV stated that HIV treatment is changing. The HIV population is aging and 50% will be over age 50 by 2020. The average number of years since diagnosis is now 35. Most of these individuals are dealing with health issues other than HIV and younger individuals will be on treatment for 30-40 years. Juluca is not for everyone, no drug is, but it is another option. He passed out literature on Juluca.

Reports from Committees

Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following:
2018 Epidemiological Profile: The Committee reviewed and approved Summary Data for the FY19 How to Best Meet the Need process with minor revisions. See the attached revised Summary Data.

2017-2021 Comprehensive Plan: The Committee reviewed the 2017 Comprehensive Plan feedback Summary Statement from HRSA/CDC. See the attached Summary Statement. Staff presented the Year 2 (2018) Comprehensive Plan activities relating to the Comprehensive HIV Planning Committee, and provided training on how to read the activities checklist. See the attached activities checklist. The Evaluation Workgroup will meet in May to review Year 1 (2017) implementation. Please see Diane to sign up for Evaluation Workgroup meeting reminders

Out of Care Special Study: As of the March Committee meeting, 17 key informant interviews were conducted and transcribed.

Public Hearing Topics: The Committee selected the Epidemiological Profile and the Out of Care Special Study as topics for the FY19 public hearings in May and July, with flexibility if there is a need to change the July topic.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
Training: How To Best Meet the Need Process: Tori Williams provided training on the FY 2019 How To Best Meet the Need process. Members signed up to participate in the different workgroup meetings.

2017-21 Comprehensive HIV Plan: Amber Harbolt reviewed committee tasks associated with The Houston Area Comprehensive HIV Prevention and Care Services Plan 2017 through 2021.

HIV and Aging Coalition: The committee agreed to provide volunteers for the Long-Term HIV Survivors event on June 3, 2018. The committee needs 3 additional volunteers to meet the goal of nine or more. Please see Rod if you wish to volunteer on behalf of the Council.

Greeters: Many thanks to the people who serve as Greeters at our Council meetings. See the attached list of those volunteers who come early to make sure that guests and colleagues are provided assistance and made to feel welcome when they attend our meetings.

Quality Improvement Committee: Denis Kelly, Co-Chair, reported on the following:
Reports from the Administrative Agent – Part B/SS: See the attached reports from the Part B/State Services Administrative Agent:

- FY17/18 SS-R Procurement Report, dated 02/15/18
- Health Insurance Assist. Service Utilization Report, dated 03/06/18

2017-21 Comprehensive HIV Plan: Amber Harbolt reviewed committee tasks associated with the Houston Area Comprehensive HIV Prevention and Care Services Plan 2017 through 2021.

FY 2019 How To Best Meet the Need Workgroup Schedule: Please see Rod to sign up to participate in any of the the FY 2019 How To Best Meet the Need workgroup meetings. See the attached schedule.

2018 Idea Forms: See two attached documents. ***Motion #3:*** *Approve the 2018 Criteria for Reviewing Ideas*, and the *2018 Proposed Idea Form*. **Motion Carried**.

Priority and Allocations Committee: No report.

Operations Committee: Johnny Deal, Co-Chair, reported on the following:
Waiver from Honorariums Policy 1200.00: See the attached request and copy of the policy. ***Motion #4:*** *it was moved and seconded (Collins-Nelson, Boyle) that the work of the CHATT Project is considered to be consulting work and therefore the Honorarium Policy does not apply.* **Motion Carried**. Abstentions: Finley, Ledbetter, Mills, Vargas.

Form for Requesting a Waiver from Petty Cash Policy 900.01: ***Motion #5:*** *Approve the attached form to be used for requesting a waiver from the Houston Ryan White Planning Council's Petty Cash Policy 900.01.* **Motion Carried.** Abstention: Collins-Nelson.

Ryan White Council and Committee Future Meeting Schedule: Per a number of requests from community members, and because more and more people living with HIV are going back to work, the Operations Committee is going to begin to collect information that will be used to explore the idea of possibly holding future Ryan White Council or committee meetings in the evening.

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

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

Report from The Resource Group: Sha'Terra Johnson-Fairly, Health Planner, summarized the attached report.

Medical Updates: Patel presented the attached report.

HIV and Aging Coalition: See the attached report submitted by Turner.

Texas HIV Medication Advisory Committee: See the attached report submitted by Turner.

Announcements: None.

Adjournment: The meeting was adjourned at 1:23 p.m.

Respectfully submitted,

_____ Date _____
Victoria Williams, Director

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for March 8, 2018

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** 2018 Idea Form and Criteria **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** 2018 Idea Form and Criteria **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
Skeet Boyle, Vice Chair				C				C				C	Viviana Santibanez		X				X				X		
Carol Suazo, Secretary		X				X				X			Bruce Turner		X				X				X		
Ted Artiaga		X				X				X			Steven Vargas		X				X				X		
Ruth Atkinson		X						X		X															
Connie L. Barnes		X				X				X															
Rosalind Belcher		X				X				X															
Ella Collins-Nelson		X				X				X															
Bobby Cruz		X				X				X			**MEMBERS ABSENT**												
Johnny Deal		X				X				X			David Benson												
Herman L. Finley III	X				X					X			Angela F. Hawkins												
Ronnie Galley		X				X				X			Arlene Johnson												
Paul E. Grunenwald		X						X		X			J. Hoxi Jones												
Dawn Jenkins		X				X				X			Tom Lindstrom												
Daphne L. Jones	X				X					X			Osaro Mgbere												
Denis Kelly		X				X				X			Robert Noble												
Peta-gay Ledbetter		X				X				X			Cecilia Oshingbade												
Rodney Mills		X				X				X			Tana Pradia												
Allen Murray		X				X				X			Venita Ray												
Krystal Perez		X				X				X			Faye Robinson												
Shital Patel		X				X				X			Gloria Sierra												
John Poole		X				X				X			Isis Torrente												

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #4** Waiver from Honorarium Policy 1200.00 **Carried**				**Motion #5** Waiver from Petty Cash Policy 900.01 **Carried**					**Motion #4** Waiver from Honorarium Policy 1200.00 **Carried**				**Motion #5** Waiver from Petty Cash Policy 900.01 **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Skeet Boyle, Vice Chair				C				C	Viviana Santibanez		X				X		
Carol Suazo, Secretary		X				X			Bruce Turner		X				X		
Ted Artiaga		X				X			Steven Vargas				X		X		
Ruth Atkinson		X				X											
Connie L. Barnes		X				X											
Rosalind Belcher		X				X											
Ella Collins-Nelson		X				X											
Bobby Cruz		X				X			**MEMBERS ABSENT**								
Johnny Deal		X				X			David Benson								
Herman L. Finley III				X		X			Angela F. Hawkins								
Ronnie Galley		X				X			Arlene Johnson								
Paul E. Grunenwald		X				X			J. Hoxi Jones								
Dawn Jenkins		X				X			Tom Lindstrom								
Daphne L. Jones		X				X			Osaro Mgbere								
Denis Kelly		X				X			Robert Noble								
Peta-gay Ledbetter				X		X			Cecilia Oshingbade								
Rodney Mills				X		X			Tana Pradia								
Allen Murray		X				X			Venita Ray								
Krystal Perez		X				X			Faye Robinson								
Shital Patel		X				X			Gloria Sierra								
John Poole		X				X			Isis Torrente								

Public Comment

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

PUBLIC COMMENT

Submitted 02-13, 2018
From email to Office of Support and Ryan White Grant Administration

Subject: Update on Substance Abuse Block Grant funds

There is legislation attached to this block grant that set aside 5% of the funding for HIV services for substance users. Due to poor wording in the enabling legislation from 1987 setting aside 5% of the block grant for HIV services, Texas has fallen under the AIDS case threshold for this set aside. (They used AIDS cases instead of HIV surveillance numbers.) The Center receives $1,332,214 for case management and outreach from this source. The set aside will end 8.31.19. We have been in conversations with the state about how this funding can be repurposed to capture the training and expertise that the staff has gained in the 22 years we have had this set aside but it will not be for HIV. We have 4 clinical case managers and part of a supervisor serving current or former substance users and those in treatment. AAMA has 1 plus part of a supervisor. We would like the council and grants administration to know this so that when the next round of allocations are done, they will understand that these positions will be lost starting 9.1.19. Please let me know what information you need to brief the council.

--

Ann J. Robison, PhD
Executive Director
The Montrose Center

UPDATE ON ADAP REPORT PRESENTED AT THE MEDICATION ADVISORY COMMITTEE IN APRIL 2018

From: Sanor,Rachel (DSHS) <Rachel.Sanor@dshs.texas.gov>
Sent: Monday, May 21, 2018 9:51 AM
Subject: Re: TRG ADAP-THMP App Upload Outline (Revised)

Thank you Marcus.
We did provide a report to the MAC last month that showed large numbers of clients dropping off the program, especially for youth. We have since found that there were errors in this report, and are working to get the most accurate information at the most detailed level possible for both the MAC and the local areas. Thank you so much for your patience.
Rachel.

Sent from my iPhone

On May 21, 2018, at 9:45 AM, mbenoit hivtrg.org <mbenoit@hivtrg.org> wrote:

Hi All,
There has been some discussion at the Ryan White Planning Council meetings regarding clients who are dropped from the Texas HIV Medication Program. A report was given to one of the council members at the ADAP Advisory meeting which showed a large number of client being dropped. After reviewing the report I explained to the Council that this number could be a reflection of the entire state and not just our region. The Ryan White Planning Council is requesting a monthly report that would detail the number of clients being dropped within our region and if we can key in on what agency that would be much more helpful. The overall factor is that the council believes that this could be a result of people falling out of care and if they are identified, this could be a chance to reengage them into care as well as back on treatment. The idea of having a note in ARIES or a letter uploaded into ARIES of a client being dropped has been discussed as a method to inform the AEWs of the client dropped status. As I explained to the council a dropped status could be of a person who starts to receives insurance, does not complete their 6 month or Annual update, or a person who goes without ordering their medication for a period of time. Considering all these indicators contribute to a client being dropped I explained the number could be inaccurate for identifying if someone is not in care anymore especially with the insurance and none ordering clients.

Good Things,
Marcus D. Benoit, MSW, LBSW
Ryan White Regional Liaison
Houston Regional HIV/AIDS Resource Group, Inc.

05-21-18: PER DSHS, THIS CHART IS BEING REVISED SINCE IT CONTAINS INACCURATE DATA

STATE of TEXAS

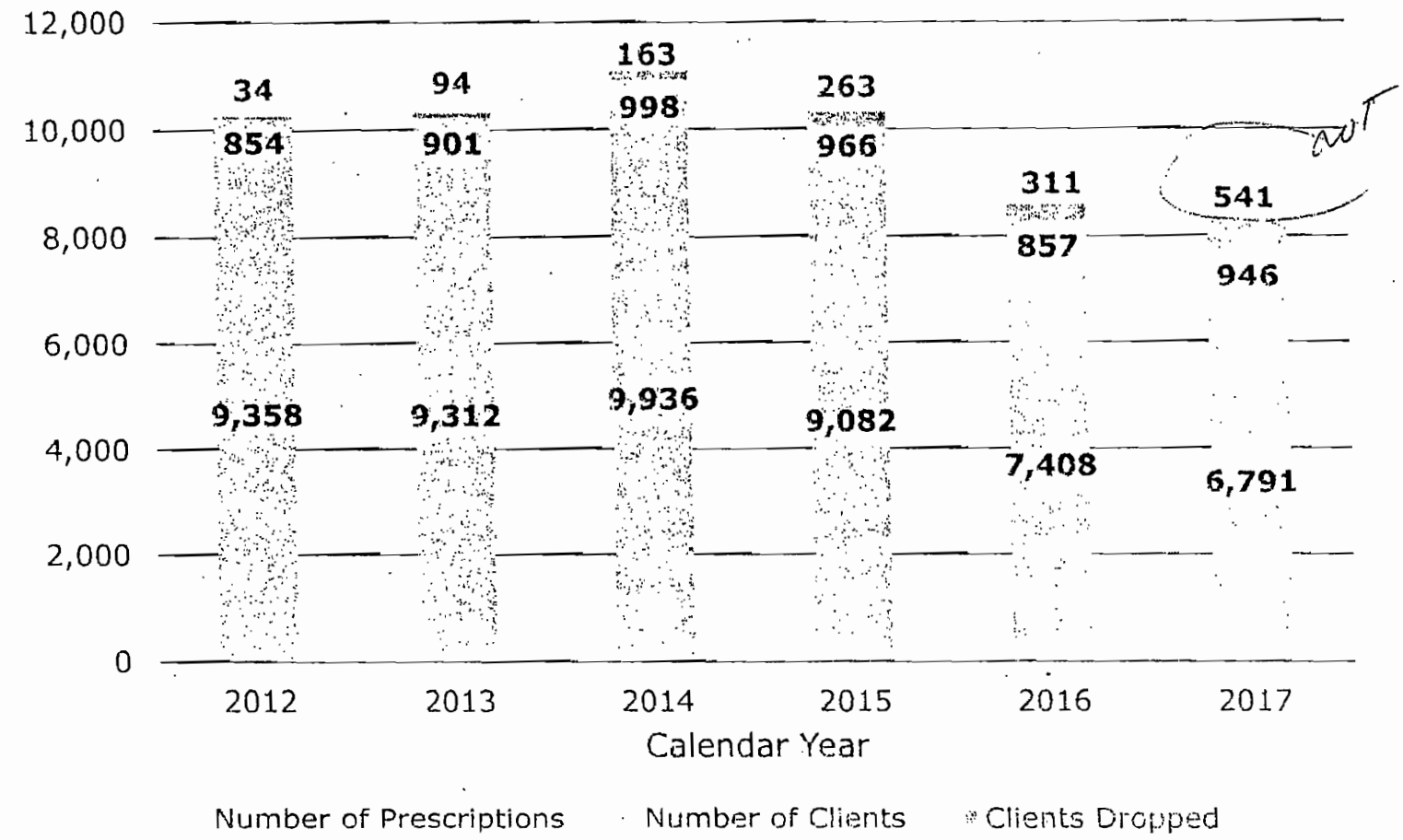
Percentage of Clients Dropped
All Clients and Clients 24 Years & Younger

Calendar Year	All Clients Served	Clients Dropped	% Dropped	24 & Under Clients	24 & Under Clients Dropped	% Dropped
2012	15,898	1,203	8%	854	34	4%
2013	16,838	1,803	11%	901	94	10%
2014	17,917	2,678	15%	998	163	16%
2015	17,256	3,443	20%	966	263	**27%**
2016	15,970	3,482	22%	857	311	**36%**
2017	17,506	5,118	29%	946	541	**57%**

RECENT

05-21-18: PER DSHS, THIS CHART IS BEING REVISED SINCE IT CONTAINS INACCURATE DATA

ADAP Clients Served
Clients 24 Years and Younger



Comprehensive HIV Planning Committee Report

Chapter 1: The Houston Area Population

What are the sociodemographic characteristics of the general population in the Houston Area?

"The Houston metro area is now the single most ethnically diverse urban region in the country [.]"

Kinder Institute for Urban Research, *The Kinder Houston Area Survey: Thirty-Six Years of Measuring Reponses to a Changing America*
May 2017

Distribution of Total Population By County

(**Table 1.1**) The Houston Eligible Metropolitan Area (**EMA**) consists of six counties in Southeast Texas: Chambers, Fort Bend, Harris (including the City of Houston), Liberty, Montgomery, and Waller. The Houston Health Service Delivery Area (**HSDA**) includes these and four additional counties: Wharton, Colorado, Austin, and Walker. In 2016, the total population of the EMA was 5,800,581, or 22% of the Texas population. Harris County remains the population center of the EMA with 76.4% of the population, though the EMA other counties' shares have increased, particularly in Fort Bend and Montgomery Counties. As a whole, the Houston EMA represents a larger proportion of the total Texas population today than in 2010.

TABLE 1-Distribution of Total Population in the Houston EMA by County, 2010 and 2016

County	Total Population-2010[a]	Total Population-2016[b]	County Percent of EMA-2010[a]	County Percent of EMA-2016[b]
Chambers	32,371	38,072	0.6%	0.7%
Fort Bend	541,983	683,756	10.7%	11.8%
Harris (incl. Houston)	3,950,999	4,434,257	77.9%	76.4%
Liberty	74,922	78,598	1.5%	1.4%
Montgomery	427,717	518,849	8.4%	8.9%
Waller	40,831	47,049	0.8%	0.8%
EMA Total	5,068,823	5,800,581	100.0%	100.0%
			EMA Percent of State-2010[a]	EMA Percent of State-2016[b]
Texas Total	24,311,891	26,956,435	20.8%	21.5%

[a]Source: U.S. Census Bureau, 2006-2010 American Community Survey. Retrieved on 02/16/2018

[b]Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

Committee Approved Draft 05/10/2018

Population Change

(**Table 2**) Since 2010, the population of the Houston EMA has grown by a higher percentage than the state of Texas as a whole. Over 730,000 more people live in the EMA today than in 2010. The largest percent change in population occurred in Fort Bend and Montgomery Counties, with 26.2% and 21.3% more people, respectively, in 2016 than in 2010. Liberty County experienced the least growth with a 4.9% increase over six years. The population size within the rural Houston EMA counties grew by 22.2%, acquiring almost a quarter of a million people between 2010 and 2016.

TABLE 2-Total Population Change in the Houston EMA by County, 2010 and 2016

			Change in Population	
County	Total-2010[a]	Total-2016[b]	#	%
Chambers	32,371	38,072	5,701	+17.6%
Fort Bend	541,983	683,756	141,773	+26.2%
Harris (incl. Houston)	3,950,999	4,434,257	483,258	+12.2%
Liberty	74,922	78,598	3,676	+4.9%
Montgomery	427,717	518,849	91,132	+21.3%
Waller	40,831	47,049	6,218	+15.2%
EMA	5,068,823	5,800,581	731,758	+14.4%
Rural EMA	1,117,824	1,366,324	248,500	+22.2%
Texas	24,311,891	26,956,435	2,644,544	+10.9%

[a]Source: U.S. Census Bureau, 2006-2010 American Community Survey. Retrieved on 02/16/2018
[b]Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

Committee Approved Draft 05/10/2018

Demographics By Total Population and County

(**Table 3**) In 2016, the population of the Houston EMA was 37.5% Hispanic, 35.8% White (non-Hispanic), 17.7% African American, and 9.0% all other race/ethnicities. This makes the Houston EMA a "minority majority" area, in which people of color (**POC**) comprise the majority of the population. Together, Hispanic, African American, and other race/ethnicity individuals comprise 64.2% of the total Houston EMA population.

TABLE 3-Distribution of Total Population in the Houston EMA by Sex, Race/Ethnicity, and Age, 2016

	Number	Percent of Total Population
Total EMA Population[a]	5,800,581	100.0%
Sex (at birth)[a]		
Male	2,879,519	49.6%
Female	2,921,062	50.4%
Transgender-Identified Estimate[b]	38,284	0.66%
Race/Ethnicity[a]		
White	2,076,659	35.8%
African American	1,027,467	17.7%
Hispanic/Latino	2,174,084	37.5%
Other	522,371	9.0%
Age[c]		
Under 2	187,060	3.1%
2 - 12	1,005,199	16.6%
13 - 24	1,010,682	16.7%
25 - 34	927,940	15.3%
35 - 44	860,924	14.2%
45 - 54	779,393	12.9%
55+	1,287,888	21.3%

[a]Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

[b]Estimated proportion of transgender-idetified people in Texas in using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS), applied to local total population. See Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). "How Many Adults Identify as Transgender in the United States?" Los Angeles, CA: The Williams Institute for more details on methodology

[c]Source: Texas Department of State Health Services, 2016 Houston EMA Population Denominators. Received on 09/14/2017

Committee Approved 05/10/2018 Draft

(**Table 4**) Several counties within the Houston EMA are also "minority majority" areas. People of color comprise the majority of the population in Fort Bend, Harris, and Waller Counties. In fact, Hispanic individuals comprise the largest single population group in Harris County today at 37.5% population. The Houston EMA is also more ethnically diverse than Texas as a whole, with smaller proportion White (non-Hispanic) individuals and a larger proportion of African American and Asian/Pacific Islander individuals than Texas. Within in the EMA, the largest proportion of African American individuals reside in Waller, and the largest proportion of Asian/Pacific Islander individuals reside in Fort Bend.

TABLE 4-Distribution of Total Population in the Houston EMA by County and Race/Ethnicity, 2016

		Percent of Total Population by Race/Ethnicity				
County	Total Population	White	African American	Hispanic/ Latino	Asian/Pacific Islander	Other Race
Chambers	38,072	68.1%	8.0%	21.1%	1.4%	1.3%
Fort Bend	683,756	34.9%	20.8%	24.0%	18.8%	1.6%
Harris	4,434,257	31.2%	18.9%	41.8%	6.7%	1.4%
Liberty	78,598	66.9%	10.3%	20.7%	0.7%	1.4%
Montgomery	518,849	68.7%	4.4%	22.4%	2.6%	1.8%
Waller	47,049	43.2%	25.4%	29.0%	0.9%	1.6%
EMA Total	5,800,581	35.8%	17.7%	37.5%	7.6%	1.4%
Texas Total	26,956,435	43.4%	11.9%	38.6%	4.4%	1.6%

Source: U.S. Census Bureau, 2006-2010 American Community Survey. Retrieved on 02/16/2018

(**Table 5**) Differences regarding age also occur between the Houston EMA and the state. Overall, the Houston EMA is younger than Texas, with a larger proportion of residents below age 55. Waller County has the largest proportion of people under 25 in the EMA, and Montgomery County has the largest proportion of people age 55 and over.

TABLE 5-Distribution of Total Population in the Houston EMA by County and Age, 2016

		Percent of Total Population by Age		
County	Total Population	Under 25	25 - 54	55+
Chambers	38,072	36.4%	41.0%	22.4%
Fort Bend	683,756	36.3%	42.0%	21.4%
Harris	4,434,257	37.0%	43.2%	19.9%
Liberty	78,598	34.6%	40.2%	23.1%
Montgomery	518,849	35.1%	40.4%	24.4%
Waller	47,049	46.1%	31.6%	22.3%
EMA Total	5,800,581	36.8%	42.7%	20.6%
Texas Total	25,145,561	36.6%	40.9%	22.4%

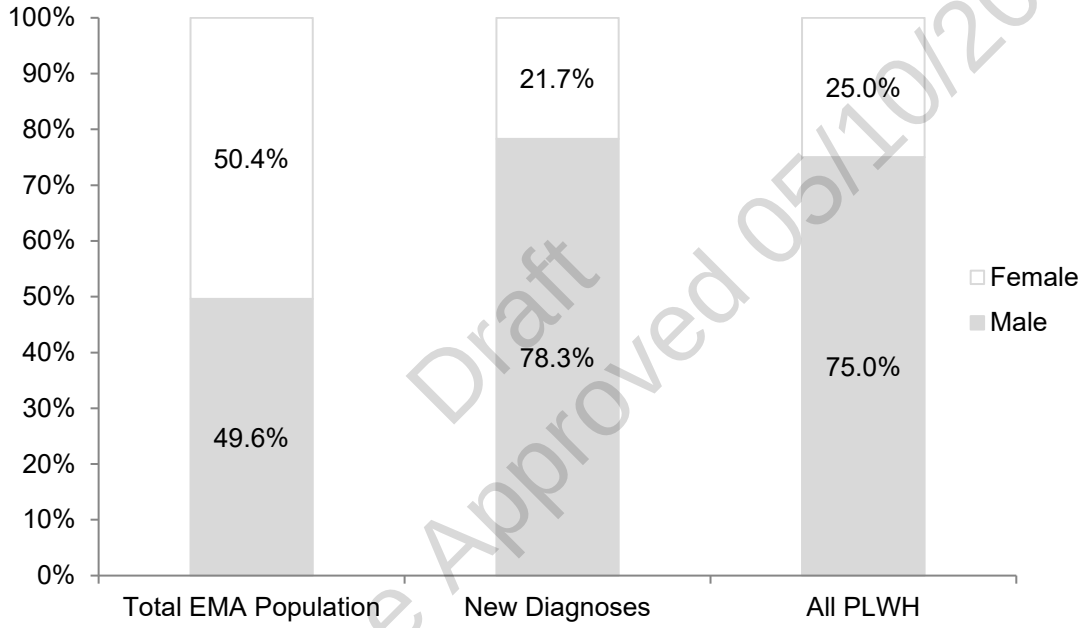
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

Committee Approved 05/10/2018 Draft

Comparison of Total Population to the Population Living with HIV

(**Graph 1**) The Houston EMA population is evenly divided by sex assigned at birth between males at birth and females at birth at 49.6% and 50.4%, respectively. However, a larger proportion of males at birth than females at birth were newly diagnosed with HIV in 2016 (78.3% vs. 21.7%), and more males at birth than females at birth comprised all diagnosed people living with HIV (**PLWH**) (75.0% vs. 25.0%). The distribution of newly diagnosed PLWH and all PLWH by sex assigned at birth shifted toward males at birth between 2011 and 2016, with decreases in new diagnoses (10.0% decrease from 24.1% in 2011) and HIV prevalence (4.94% decrease from 26.3% in 2011) among females at birth.

GRAPH 1-Comparison of Total Population[a] in the Houston EMA to PLWH[b] by Sex (at birth), 2016



[a]Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018
[b]Source: Texas eHARS. New HIV Diagnoses and diagnosed PLWH as of 12/31/16

Committee Approved 05/10/2018 Draft

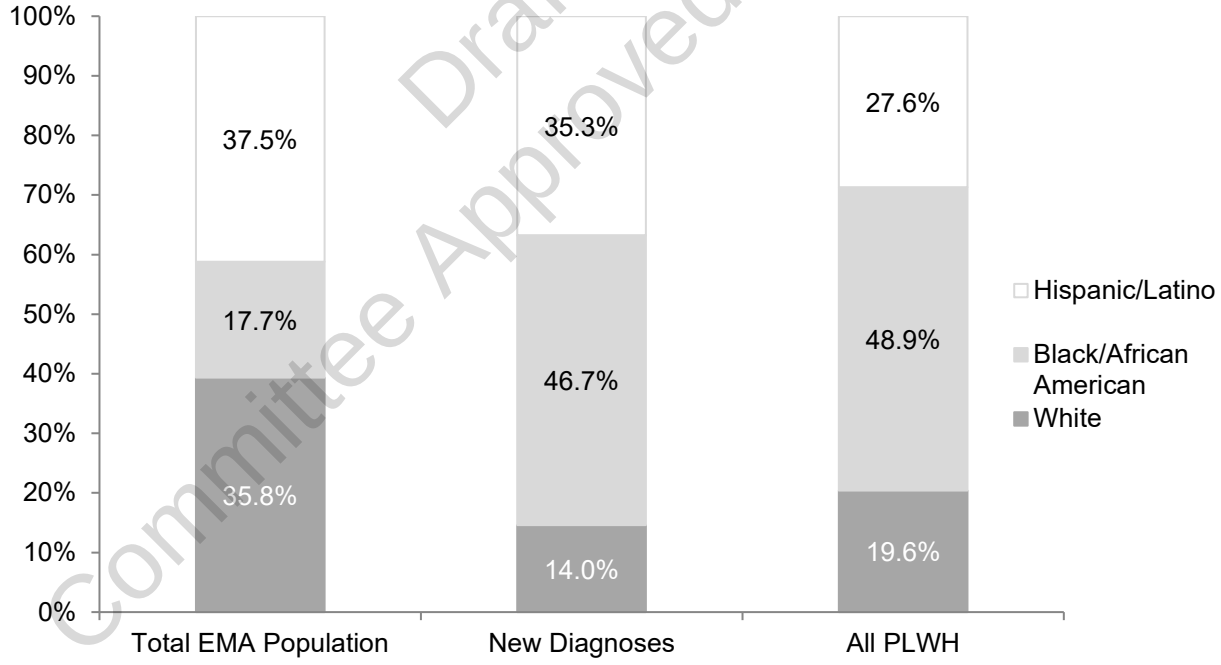
(**Graph 2**) Newly diagnosed and PLWH populations in the Houston EMA are more racially diverse than the general population, with POC experiencing higher proportions of new diagnoses and HIV prevalence. While African American and Hispanic individuals account for 55.2% of the total Houston EMA population, these groups constitute 82.0% of all new HIV diagnoses and 76.5% of all PLWH. Notably, African American individuals account for only 17.7% of the total Houston EMA population, but comprise a disproportionate amount of all new HIV diagnoses (46.7%) and nearly half of all PLWH (48.9%) in the region.

Trends in HIV among African American communities is somewhat smaller in the epidemic statewide. According to the Texas Department of State Health Services, HIV is more evenly distributed in Texas with African American individuals comprising 37% of all PLWH and 38% of new diagnoses.[1] Regardless, POC in both the Houston EMA and Texas as a whole share a disproportionate burden of new diagnoses and HIV prevalence relative to each race/ethnicity's size within the general population.

Between 2011 and 2016, new diagnoses among Hispanic individuals in the Houston EMA increased by 15.0% (from 30.7%), as did overall HIV prevalence by 17.9% (from 23.4%).

Draft
Committee Approved 05/10/2018

GRAPH 2- Comparison of Total Population[a] in the Houston EMA to the PLWH[b] by Race/Ethnicity, 2016



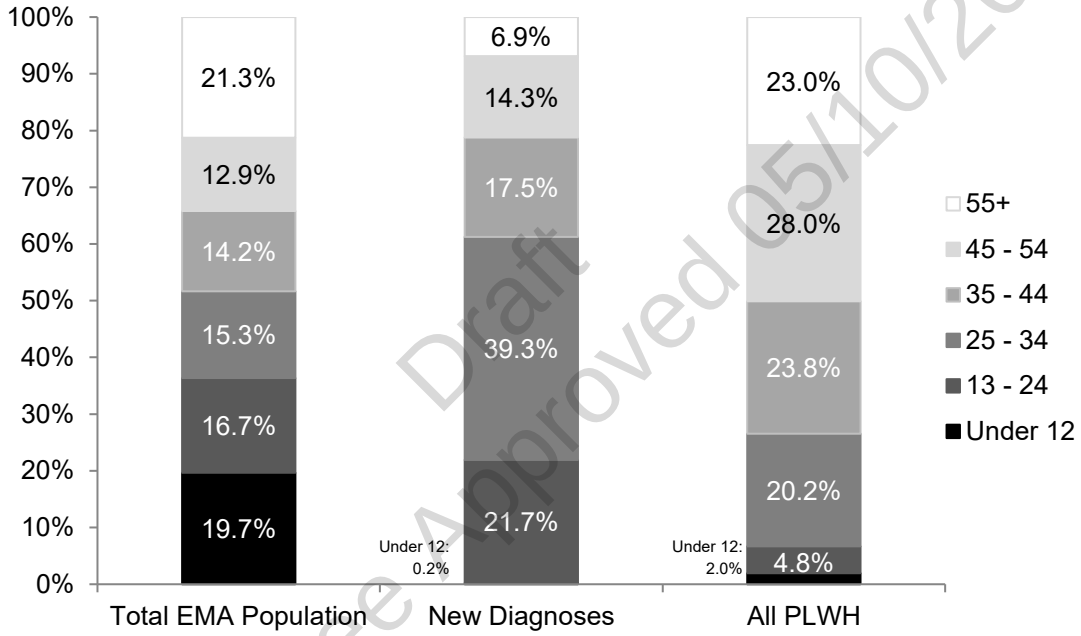
[a]Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018
[b]Source: Texas eHARS. New HIV Diagnoses and diagnosed PLWH as of 12/31/16

[1]Texas Department of State Health Services. *2017-2021 Texas HIV Plan*. Reporting Period: January 1 to December 31, 2014. The Texas HIV Plan is available at https://txhivsyndicate.org/texas-hiv-plan/

(**Graph 3**) When analyzed by age, people age 25 to 34 account for a larger proportion of new HIV diagnoses (39.3%) than their proportion within the general Houston EMA population in the Houston EMA (15.3%). Similarly, people age 45 to 54 account for a larger proportion of those living with HIV (28.0%) than their proportion within the general Houston EMA population in the Houston EMA (12.9%).

Trends reflect a shift toward more PLWH age 55 and over represented in overall HIV prevalence within the Houston EMA. Between 2011 and 2016, new diagnoses decreased by 11.5% (from 7.8%) among PLWH age 55 and over, while HIV prevalence increased by 36.9% (from 16.8%).

GRAPH 3- Comparison of Total Population[a] in the Houston EMA to the PLWH[b] by Age (Descending), 2016



[a]Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018
[b]Source: Texas eHARS. New HIV Diagnoses and diagnosed PLWH as of 12/31/16

Committee Approved 05/10/2018 Draft

Socioeconomic Characteristics

Socioeconomic conditions such as access to resources, educational attainment, and healthcare coverage can affect health, functioning, and quality of life outcomes,[2] including risk for HIV transmission and access to HIV prevention and care services.

Employment

(**Table 6**) In 2016, the percent of the eligible population unemployed in Texas was 9.0%, compared to an average of 7.1% for counties in the Houston EMA. Overall, unemployment has decreased in the EMA since 2011 by 11.5%. Within the EMA's counties, Liberty has the highest percentage of people unemployed at 9.2%, followed by Waller at 9.0%, while Fort Bend has the lowest unemployment rate at 5.4%. Between 2011 and 2016, the unemployment rate decreased for every county in the Houston EMA except Waller, which experienced an increase in the unemployment rate by 25.0%.

TABLE 6-Employment Status in the Houston EMA by County, 2016[a]

County	Percent of Eligible[b] Population *Employed*-2016	Percent of Eligible[b] Population *Unemployed*-2016	Change in Percent *Unemployed*-2011
Chambers	55.4%	6.4%	-11.1%
Fort Bend	63.2%	5.4%	-1.8%
Harris	63.5%	7.0%	-20.5%
Liberty	46.6%	9.2%	-32.8%
Montgomery	60.2%	5.4%	-28.0%
Waller	55.1%	9.0%	25.0%
EMA Average	57.3%	7.1%	-11.5%
Texas	60.1%	9.0%	5.9%

[a]Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 3/27/2018

[b]Population over the age of 16 and in the labor force

Committee Approved 05/10/2018 Draft

[2]U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020: Determinants of Health*. Located at: http://www.healthypeople.gov/2020/about/DOHAbout.aspx

Household Income

(**Table 7**) The average median household income in the Houston EMA continues to be higher than in Texas as a whole, though Texas experienced slightly higher household income growth between 2011 and 2016. On average, households in the EMA earn about $10,500 more per year compared to households statewide. Fort Bend County has the highest median household income at $91,152, while Liberty County has the lowest at $49,655 followed by Waller County at $53,508. Regardless, median household income growth occured in all Houston EMA counties except Chambers. Fort Bend County experienced the highest median household income growth at 13.0% between 2011 and 2016, while Chambers County experienced a decrease of 1.2%.

Comparison in supplemental income between the Houston EMA and Texas is variable. As a whole, fewer households in the Houston EMA receive cash public assistance and food stamp/Supplemental Nutrition Assistance Program (**SNAP**) benefits than statewide, while a greater proportion of Houston EMA households receive Social Security and Supplemental Security Income (**SSI**). Liberty County, which has the lowest median household income in the EMA, also has a larger percentage of households receiving Social Security (31.3% vs. 25.2%), SSI (7.5% vs. 5.0%), cash public assistance (1.9% vs. 1.2%), and food stamp/SNAP benefits (16.8% vs. 11.2%). Additionally, Waller County has highest proportion of households receiving food stamp/SNAP benefits at 17.5% of households.

Between 2011 and 2016, the Houston EMA experienced an increase in the proportion of households receiving supplemental income across Social Security (11.5% increase from 22.6%), SSI (38.9% increase from 3.6%), and food stamp/SNAP benefits (9.8% increase from 10.2%).

TABLE 7-Median Household Income by County and Supplemental Income, 2016

County	Median Household Income-2016[a]	Percent Change from 2011	Percent of Households Receiving Each Type of Supplemental Income: Social Security	Supplemental Security Income (**SSI**)	Cash Public Assistance	Food Stamp/SNAP Assistance
Chambers	$70,396	-1.2%	25.8%	3.7%	0.9%	5.6%
Fort Bend	$91,152	13.0%	19.8%	3.0%	1.1%	7.4%
Harris	$55,584	7.7%	19.6%	4.3%	1.5%	13.2%
Liberty	$49,655	6.4%	31.3%	7.5%	1.9%	16.8%
Montgomery	$70,805	8.6%	25.8%	3.9%	1.1%	6.7%
Waller	$53,508	6.7%	28.7%	7.3%	0.9%	17.5%
EMA Average	$65,183	7.0%	25.2%	5.0%	1.2%	11.2%
Texas	$54,727	8.9%	25.0%	4.9%	1.6%	13.1%

[a]Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 3/27/2018

Committee Approved Draft 05/10/2018

(**Table 8**) The percentage of households earning less than $15,000 per year can indicate low socioeconomic status within a particular area. In 2016 in the Houston EMA, 10.2% of households met this threshold compared to 11.9% of households statewide, an 11.3% decrease from 11.5% in 2011. Counties that exceed the Houston EMA and statewide percentages of households earning less than $15,000 annually are Liberty at 13.2% and Waller at 12.3%. However, between 2011 and 2016 both Liberty and Waller counties experienced decreases in this measure by 11.4% from 14.9%, and 16.3% from 14.7%, respectively.

TABLE 8-Percent of Total Households in the Houston EMA Earning Less than $15,000 Per Year by County, 2011 and 2016

	Percent of Households	
County	2011[a]	2016[b]
Chambers	9.1%	10.7%
Fort Bend	6.0%	5.3%
Harris	12.5%	11.1%
Liberty	14.9%	13.2%
Montgomery	9.0%	7.4%
Waller	14.7%	12.3%
EMA	11.5%	10.2%
Texas	13.4%	11.9%

[a]Source: U.S. Census. 2009-2011 American Community Survey 3-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 1/31/13

[b]Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 3/27/2018

Committee Approved 05/10/2018 Draft

Poverty

(**Table 9**) In 2016, the Houston EMA had a lower percentage of its population living below the federal poverty level (15.5%) compared to the state as a whole (16.7%). All counties in the Houston EMA except Chambers and Waller saw decreases between 2011 and 2016 in the percentage of the population living in poverty. Waller County had the highest level of poverty in the EMA at 19.0%, followed closely by Harris at 17.4% and Liberty at 17.3%, while Fort Bend had the lowest level of poverty at 8.2%. In 2016, 14.0% of males at birth and 17.0% of females at birth in the EMA live below the federal poverty level. One-fifth of females at birth in Waller (21.1%) and Liberty (20.2%) counties lived below the federal poverty level in 2016.

TABLE 9-Percent of Population Living Below Federal Poverty Level in the Houston EMA by County and Sex, 2016[a]

County	Percent Below Federal Poverty Level	Percent Change from 2011	Percent Below Poverty Level by Sex at Birth[b]	
			Male at Birth	Female at Birth
Chambers	11.7%	9.3%	11.0%	12.3%
Fort Bend	8.2%	-1.2%	7.5%	8.8%
Harris	17.4%	-5.9%	15.7%	19.1%
Liberty	17.3%	-6.0%	14.6%	20.2%
Montgomery	11.0%	-13.4%	10.1%	12.0%
Waller	19.0%	1.1%	17.1%	21.1%
EMA	15.5%	-8.3%	14.0%	17.0%
Texas	16.7%	-6.2%	15.2%	18.2%

[a]Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1701: POVERTY STATUS IN THE PAST 12 MONTHS. Retrieved on 3/27/2018

[b]Represents the percent of males/females at birth in the geographic area that is living in poverty; and not the male/female at birth distribution of people living in poverty in the geographic region.

Committee Approved 05/10/2018 Draft

(**Table 10**) Analysis of poverty by race/ethnicity reveals that, in general, more POC are living below the federal poverty level in the Houston EMA than are Whites. In 2016, 22.6% of African American and 23.0% of Hispanics individuals in the Houston EMA were living in poverty, compared to 14.1% of Whites. Across every county in the Houston EMA except Waller, Hispanic individuals experienced greater proportions of poverty than did White or African American individuals. A third of African American individuals (33.3%) in Waller County lived under the federal poverty level, as did nearly a third (31.6%) of Hispanic individuals.

TABLE 10-Percent of Population[a] Living Below Federal Poverty Level in the Houston EMA by Race/Ethnicity, 2016

County	White	African American	Hispanic[b]
Chambers	10.5%	12.5%	19.8%
Fort Bend	7.4%	9.2%	15.3%
Harris	15.5%	22.6%	23.6%
Liberty	16.8%	18.8%	31.6%
Montgomery	10.3%	16.1%	23.5%
Waller	14.8%	33.3%	27.6%
EMA	14.1%	20.6%	23.0%
Texas	15.5%	22.6%	24.2%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1701: POVERTY STATUS IN THE PAST 12 MONTHS. Retrieved on 3/27/2018

[a]Represents the percent of each race/ethnicity in the geographic area that is living in poverty; and not the racial distribution of people living in poverty in the geographic region.

[b]Hispanic is not mutually exclusive from the races presented in this table. Other races are not included because the sample case size by County is too small.

Draft
Committee Approved 05/10/2018

(**Table 11**) Analysis of poverty by age reveals that, in general, more minors (individuals under 18 years old) are living below the federal poverty level in the Houston EMA than are adults (individuals over age 18). In 2016, 23.0% of people under age 18 were living in poverty, compared to 13.4% of people age 18 to 64, and 10.4% of people age 65 and over. Larger proportions of minors in Harris (26.0%) and Waller (25.1%) counties were living in poverty compared to all minors, all adults 18 to 64, all seniors in the EMA and the state. However, the proportions of minors living below the federal poverty level in Harris and Waller counties decreased between 2011 and 2016 by 5.8% (from 27.6%) and 7.0% (from 27.0%), respectively.

TABLE 11-Percent of Population[a] Living Below Federal Poverty Level in the Houston EMA by Age, 2016

County	Under 18 years	18 to 64 years	65 years and older
Chambers	13.7%	10.7%	12.1%
Fort Bend	11.2%	7.0%	6.9%
Harris	26.0%	14.6%	11.3%
Liberty	23.3%	16.2%	10.6%
Montgomery	14.8%	10.0%	7.7%
Waller	25.1%	19.4%	10.1%
EMA	23.0%	13.4%	10.4%
Texas	23.9%	14.7%	10.8%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1701: POVERTY STATUS IN THE PAST 12 MONTHS. Retrieved on 3/27/2018

[a]Represents the percent of each age group in the geographic area that is living in poverty; and not the age distribution of people living in poverty in the geographic region.

Draft
Committee Approved 05/10/2018

Educational Attainment

(**Table 12**) Educational attainment in the Houston EMA skews slightly toward higher education levels in most counties. In 2016, 23.0% of Houston EMA residents attained a high school diploma or equivalency, 27.2% attended some college or attained an Associate's degree, and 31.6% attained a bachelor's degree or higher. The county with the highest educational attainment is Fort Bend, where 44.6% of residents had a bachelor's degree or higher, a 9.3% increase from 40.8% in 2011. The county with the lowest educational attainment was Liberty, where 23.8% of residents had less than a high school diploma or equivalency, though this was a 5.3% increase from 22.6% in 2011. Waller County followed with 21.6% of residents having less than a high school diploma or equivalency, a 24% increase from 17.4% in 2011. Overall, the Houston EMA displays a greater disparity in educational attainment through larger proportion of residents at both ends of the educational spectrum than Texas as a whole. In 2016, 18.2% of EMA residents had less than a high school diploma or equivalency (compared to 17.7% for the state), and 31.6% have a bachelor's degree or higher (compared to 28.1% of the state).

TABLE 12-Educational Attainment in the Houston EMA by County, 2016

	Percent of Total Population[a]			
County	Less than high school diploma	High school diploma or GED	Some college or Associate's degree	Bachelor's degree or higher
Chambers	16.2%	29.2%	33.5%	21.1%
Fort Bend	10.8%	17.5%	27.0%	44.6%
Harris	19.8%	23.3%	26.8%	30.1%
Liberty	23.8%	39.1%	27.1%	10.0%
Montgomery	13.2%	24.1%	29.7%	33.0%
Waller	21.6%	30.5%	29.1%	18.7%
EMA	18.2%	23.0%	27.2%	31.6%
Texas	17.7%	25.1%	29.2%	28.1%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1501: Educational Attainment. Retrieved on 3/27/2018

[a]Population aged 25 and over in the geographic region

Committee Draft Approved 05/10/2018

Health Insurance Coverage

(**Table 13**) The Houston EMA has a slightly higher proportion of residents who are uninsured compared to the state as a whole (20.4% vs. 19.3%). The EMA experienced a 19.2% drop in the proportion of uninsured residents from 25.3% in 2011. As of 2016, nearly 1.2 million people in the Houston EMA lack any kind of health insurance coverage. Harris County has the largest proportion of uninsured at 22.2% (higher than both the EMA and state), while Montgomery County has the lowest proportion of uninsured at 15.3%. All counties, the EMA, and Texas saw decreases in the percent of the population uninsured between 2011 and 2016. Within the EMA, Fort Bend experienced the greatest decrease in percent uninsured from 17.8% to 13.1%. Of the total Houston EMA population, more have private insurance than public. The county with the largest proportion of privately insured is Fort Bend (75.1%), while the county with the largest proportion of publicly insured is Liberty (33.2%), followed by Waller (29.6%).

TABLE 13-Health Insurance Coverage in the Total Population in the Houston EMA by County, 2016[a]

		Type of Health Insurance[b]				
County	Percent *with* Health Insurance	Private	Public	Number of People *Without* Insurance	Percent *Without* Health Insurance	Change in Percent *Uninsured* from 2011
Chambers	83.5%	66.3%	24.9%	6,247	16.5%	-0.6%
Fort Bend	86.9%	75.1%	17.9%	89,121	13.1%	-26.2%
Harris	77.8%	55.9%	27.9%	978,821	22.2%	-18.2%
Liberty	79.0%	53.8%	33.2%	15,121	21.0%	-15.6%
Montgomery	84.7%	69.9%	23.2%	78,770	15.3%	-21.3%
Waller	79.0%	57.2%	29.6%	9,824	21.0%	-25.6%
EMA	79.6%	59.5%	26.3%	1,177,904	20.4%	-19.2%
Texas	80.7%	60.5%	28.6%	5,114,811	19.3%	-17.5%

[a]Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 3/27/2018

[b]Denominator for type of helath insurance is civilian noninstitutionalized population regardless of coverage status; type of health insurance reflects the proportion among this population, not the proportion among those with coverage

Committee Approved 05/10/2018 Draft

Foreign Born and Linguistic Isolation

(**Table 14**) As anticipated given the ethnic diversity in the Houston EMA, in 2016 a larger proportion of the Houston EMA population was foreign-born than for Texas as a whole (24.3% vs. 16.7%). In Fort Bend and Harris counties, over a quarter of the population was born in another country. Chambers County experienced a substantial demographic shift between 2011 and 2016 as the percent of foreign-born residents increased by 66.0% to 10.5% from 6.30%. Liberty County closely followed with a 10.5% increase in foreign-born residents (from 6.9% to 7.6%).

In 2016, the majority of foreign-born individuals in the EMA were born in Latin America. This was true for all counties in the EMA, with the exception of Fort Bend County (50.3% foreign-born in Asia). The EMA as a whole had a population of individuals born in Asia that was a larger proportion in the EMA than in Texas (24.8% vs. 20.4%). The majority of foreign-born residents in the EMA are not naturalized citizens, though this percent is slightly lower than for the state as a whole.

TABLE 14-Percent of Population that is Foreign-Born in the Houston EMA by County, Citizenship, and Place of Birth, 2016[a]

			Citizenship[b]		Birth Place Among Foreign-Born[b]			
County	Percent Foreign-Born	Percent Change from 2011	Percent Naturalized Citizen	Not U.S. Citizen	Europe	Asia	Africa	Latin America
Chambers	10.5%	66.0%	19.5%	80.5%	6.0%	14.1%	5.5%	73.0%
Fort Bend	27.1%	7.0%	54.3%	45.7%	4.6%	50.3%	8.5%	34.4%
Harris	25.7%	2.2%	34.1%	65.9%	4.1%	21.4%	4.9%	68.5%
Liberty	7.6%	10.5%	22.9%	77.1%	3.4%	7.8%	--	87.3%
Montgomery	12.9%	2.5%	32.7%	67.3%	9.3%	15.4%	--	69.6%
Waller	14.4%	8.1%	23.7%	76.3%	3.8%	4.0%	--	89.3%
EMA	24.3%	2.8%	36.6%	63.4%	4.4%	24.8%	5.2%	64.3%
Texas	16.7%	2.3%	35.4%	64.6%	4.2%	20.4%	4.3%	69.8%

[a]Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP02: SELECTED SOCIAL CHARACTERISTICS IN THE UNITED STATES. Retrieved on 3/27/18. Dashes indicate data for this geographic area cannot be reported because the sample size is too small.

[b]Denominator is foreign-born population in Houston EMA

Committee Approved 05/10/2018 Draft

(**Table 15**) According to available data, a larger proportion of the population in the Houston EMA is both non-English speaking and linguistically isolated (**LI**) than statewide.

TABLE 15-Percent of Non-English Speaking Population that is Linguistically Isolated in the Houston EMA by County, 2016

County	Percent non-English Speaking at Home	Percent Linguistically Isolated (LI)[a]
Chambers	19.1%	10.4%
Fort Bend	38.4%	12.9%
Harris	43.4%	20.3%
Liberty	18.5%	6.9%
Montgomery	20.0%	7.7%
Waller	24.6%	11.6%
EMA	40.0%	18.0%
Texas	35.2%	14.1%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP02: SELECTED SOCIAL CHARACTERISTICS IN THE UNITED STATES. Retrieved on 3/27/2018.

[a]Linguistically isolated is defined as someone who reports speaking English less than "very well."

(**Table 16**) According to available data, 30.4% of the population in the Houston EMA speaks Spanish, 3.4% speak another non-English/Indo-European language, and 4.8% speak an Asian/Pacific Islander language. Of these, 14.5%, 0.9%, and 2.2% are also LI. Proportions of LI are higher in the EMA than statewide across all languages.

TABLE 16-Percent of Non-English Speaking Population that is Linguistically Isolated[a] in the Houston EMA by Language and County, 2016

	Spanish		Other Indo-European		Asian or Pacific Islander	
County	Percent Speaking Language	Percent Linguistically Isolated	Percent Speaking Language	Percent Linguistically Isolated	Percent Speaking Language	Percent Linguistically Isolated
Chambers	15.8%	9.2%	1.8%	0.6%	0.9%	0.5%
Fort Bend	18.2%	6.3%	7.8%	2.0%	10.1%	4.2%
Harris	34.4%	16.9%	3.1%	0.9%	4.5%	2.2%
Liberty	17.0%	6.4%	0.8%	--	0.6%	--
Montgomery	16.8%	7.0%	1.5%	--	1.4%	0.5%
Waller	23.2%	11.5%	0.6%	--	0.6%	--
EMA	30.4%	14.5%	3.4%	0.9%	4.8%	2.2%
Texas	29.5%	12.1%	2.1%	0.5%	2.8%	1.2%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP02: SELECTED SOCIAL CHARACTERISTICS IN THE UNITED STATES. Retrieved on 3/27/2018. Dashes indicate data for this geographic area cannot be reported because the sample size is too small.

[a]Linguistically isolated is defined as someone who reports speaking English less than "very well."

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Community Health Indicators

Data related to preventable disease, disability, and death help measure population health in a specific geographic area. Rankings of specific communities within each of these types of measures can provide valuable information about the population's overall health status, which may negatively or positively influence specific health conditions such as HIV. Taken together, these types of measures can help illustrate each community's overall health.[3]

Fertility and Mortality Rates

(**Table 17**) Tracking fertility and mortality in a specific geographic area provides information about potential population growth. Comparing these rates between areas, they can also reveal information about quality of life and life expectancy. In 2013 all but one county (Harris) had fertility lower than the statewide fertility rate. The rate in Harris County was 71.5 per 1,000 women of childbearing age (a 7.98% decrease from 77.7 births in 2009), compared to 69.8 statewide (a 7.0% decrease from 75.1 births in 2009). Fertility rates in all counties within the Houston EMA and statewide have declined since 2009. Chambers and Liberty counties have mortality rates that are higher than state mortality rates. Taken together, these rates suggest that the EMA has fewer births and more deaths compared to Texas as a whole.

TABLE 17-Fertility and Mortality Rates in the Houston EMA by County, 2009 and 2013

	Fertility Rate[a]		Mortality Rate[b]	
County	2009	2013	2009	2013
Chambers	71.4	61.3	866.2	874.1
Fort Bend	68.2	62.4	676.2	599.6
Harris	77.7	71.5	788.5	737.8
Liberty	65.9	66.4	1007.6	1027.1
Montgomery	71.2	67.1	822.8	693.3
Waller	67.4	60.0	944.5	748.5
Texas	75.1	69.8	781.2	749.2

Source: Texas Department of State Health Services. Center for Health Statistics. Health Facts Profiles, 2009 and 2013

[a]Fertility rates are per 1,000 women ages 15 - 50.

[b]Reflects deaths from all causes. Rates are age adjusted to the 2000 standard per 100,000 population. No age-adjusted rates were calculated if based on 20 or fewer deaths.

Committee Approved 05/10/2016 Draft

[3]Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps. Located at :http://www.countyhealthrankings.org/.

Selected Causes of Death

(**Table 18**) Tracking the leading causes of death in a defined geographic area provides information about the specific health conditions facing the population and can indicate needed preventive or acute health care interventions. In 2013, the highest rates of death in the Houston EMA occurred from cardiovascular disease (heart disease), cerebrovascular disease (stroke), and cancer. With the exception of Fort Bend County, all counties in the Houston EMA had rates of cancer mortality that exceeded the state.

TABLE 18-Rates[a] of Selected Causes of Death in the Houston EMA by County, 2013

County	Heart Disease	Stroke	Cancer	Lung Disease	Accidents	Diabetes	Suicide	Liver Disease
Chambers	175.3	--	218.9	--	--	--	--	--
Fort Bend	134.3	34.0	133.1	28.4	26.3	13.4	8.3	8.3
Harris	166.3	40.6	159.9	32.0	36.8	20.0	9.8	11.0
Liberty	302.5	45.5	197.7	80.8	61.3	--	--	--
Montgomery	154.1	29.6	160.6	50.3	30.3	11.8	15.5	8.9
Waller	201.7	--	170.4	--	58.9	--	--	--
Texas	170.7	40.1	156.1	42.3	36.8	21.6	11.6	12.8

Source: Texas Department of State Health Services. Center for Health Statistics. Health Facts Profiles 2013. Dashes indicate frequency too low to calculate rate.

[a]Rates are age adjusted per 100,000 population. No age-adjusted rates were calculated if based on 20 or fewer deaths.

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Disability

(**Table 19**) Tracking the level of disability in a specific geographic area provides information about the population's vulnerability to hearing, vision, cognitive, ambulatory, self-care, and independent living difficulty or impairment, all of which can affect access to resources and increase need for service assistance. In 2016, a smaller proportion of people living with a disability were in the Houston EMA (9.4%) than in the population of Texas as whole (11.6%). The proportion of people living with a disability in the Houston EMA has increased by 20.5% from 7.8% in 2011. Fort Bend County has the lowest percentage of people living with a disability at 7.8%, while Liberty County has the highest percentage at 17.8%.

TABLE 19-Percent Population Living with a Disability in the Houston EMA by County, 2016

County	Percent Living with a Disibility
Chambers	13.0%
Fort Bend	7.8%
Harris	9.3%
Liberty	17.8%
Montgomery	10.5%
Waller	14.2%
EMA	9.4%
Texas	11.6%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1810: DISABILITY CHARACTERISTICS. Retrieved on 3/27/2018.

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Additional Selected Community Health Indicators

(**Table 20**) The remaining indicators presented here are a selection of some of the most commonly used measures of vulnerability to poor health outcomes. These measures provide information about the behaviors of the population that may lead to health challenges over time, and reveal opportunities where preventive or acute health care interventions may reverse risk and improve long-term health outcomes. In 2016, most counties in the Houston EMA, with the exception of Waller County, experienced levels of risk comparable to the state of Texas as a whole. Compared to the rest of the state, the population in Waller County experienced higher proportions of poor to fair health, smoking, obesity, physical inactivity, and limited access to healthy foods. Chambers and Montgomery counties exceeded the state in excessive alcohol use. Slightly higher proportions of low birth weight, an indicator of risk for infant mortality and other health associations, occurred in Fort Bend, Harris, and Liberty counties compared to the rest of the state.

TABLE 20-Status of Selected Community Health Indicators in the Houston EMA by County, 2016[a]

County	In Poor or Fair Health	Low Birth Weight	Smoking	Obesity	Physical Inactivity	Limited Access to Healthy Foods	Excessive Alcohol Use
Chambers	15.0%	8.0%	15.0%	27.0%	31.0%	5.0%	21.0%
Fort Bend	14.0%	9.0%	12.0%	25.0%	22.0%	7.0%	18.0%
Harris	18.0%	9.0%	13.0%	27.0%	24.0%	6.0%	18.0%
Liberty	18.0%	9.0%	17.0%	28.0%	29.0%	8.0%	19.0%
Montgomery	14.0%	7.0%	14.0%	26.0%	26.0%	6.0%	21.0%
Waller	19.0%	8.0%	18.0%	36.0%	30.0%	11.0%	20.0%
Texas	18.0%	8.0%	14.0%	28.0%	24.0%	9.0%	19.0%

Source: County Health Rankings & Roadmaps. A project of the Robert Wood Johnson Foundation (RWJF) and the University of Wisconsin Population Health Institute. 2016. Retrieved on 3/27/18

[a]Percentage of the total population in each geographic region reporting the selected condition.

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Affected Community Committee Report

Affected Community Committee
2018 Community Events (as of 05-18-18)

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 4 1pm-Walk	AIDS Foundation Houston (AFH) AIDS Walk	Houston Park Downtown 1100 Bagby Street, 77002	Tana, Allen & Mona – distribute LEAP flyers
Sunday, June 3 Before 1 pm start time	Long-Term HIV Survivors Event	11410 Hempstead Road	**Need 10 volunteers (3 for PC booth):** Council: Johnny D., Ronnie, Cecilia, Veria, Crystal, Skeet, Herman, and Ma'Janae LEAP: Calvin, Roy, Erika, Felipe, Mel, Prince, Tony
Wednesday, June 20 6:00 – 9:00 pm	Pride Month Volunteer Day	Houston Food Bank 535 Portwall Street Contact Person: Mary Bethal – 832 369-9390 x 9251	**Need 3 volunteers: PP: Herman**, Crystal, Ma'Janae
Saturday, June 23 Noon – 7:00 pm	Pride Festival	Downtown near City Hall	Shift 1 (11:30 am-2 pm): **PP:Skeet,** Tana, Rod Shift 2 (2-4:30 pm): Allen, Skeet, Tana Shift 3 (4:30-7 pm): **PP: Skeet,** Allen
July	Road 2 Success	Thomas Street Health Center 2015 Thomas Street, 77009	**Need 5 Volunteers:**
August	Camino hacia tu Salud	Positive713 Leonel Castillo Community Center 2101 South Street, 77009	**Need 4 Volunteers:**
August or September	Road 2 Success	Collaborate with the Transition Summit for adolescents going off of Medicaid – Gloria	**Volunteers:**
October	MISS UTOPIA	Crowne Plaza Northwest-Brookhollow 12801 Northwest Freeway Houston, TX 77040	**Volunteers: PP: Skeet,** Cecilia, Ronnie, Johnny DISTRIBUTE LEAP FLYERS
October	Camino hacia tu Salud		**Volunteers:**
November	Road 2 Success		**Volunteers:**
Saturday, December 1	World AIDS Day Events		Most committee members attend events DISTRIBUTE LEAP FLYERS

Greeters for 2018 Council Meetings

(Revised: 05-16-18)

2018 Meeting Dates (**Please arrive at 11:45 a.m.** Unless otherwise noted, the meetings are held at 2223 W. Loop South)	**Greeter #1** External Member	**Greeter #2**	**Greeter #3**
Thurs. March 8	Mona	Skeet	Tana
Thurs. April 12	Eddie	Rodney	Allen
Thurs. May 10 **CANCELLED**	Lionel	Allen	Johnny
Thurs. June 14	Crystal	Tana	Ronnie
Thurs. July 12	Lionel	Allen	Johnny
Thurs. August 9	Tana	Rodney	Allen
Thurs. September 13	Crystal	Herman	Ma'Janae
Thurs. October 11			
Thurs. November 8 External Committee Member Appreciation			
Thurs. December 6			

2018 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE
(May 2018)

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: good

2. Continue to get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more. Need more

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

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: Great

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

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

Dana Gradia
Committee Chairperson

05/14/2018
Date

Quality Improvement Committee Report

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

FY 2017 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,795,737**	**50,000**	**53,425**	**-80,000**	**0**	**9,819,162**	**46.53%**	**9,819,162**	**0**		**9,493,063**	**97%**	**100%**
1.a	Primary Care - Public Clinic (a)	3,643,839	0	0	0		3,643,839	17.27%	3,643,839	0	3/1/2017	$4,215,640	116%	100%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	17,809	0		958,256	4.54%	958,256	0	3/1/2017	$1,151,049	120%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	17,808	0		804,232	3.81%	804,232	0	3/1/2017	$998,282	124%	100%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,038,843	0	17,808	0		1,056,651	5.01%	1,056,651	0	3/1/2017	$615,568	58%	100%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,166,658	0	0	-80,000		1,086,658	5.15%	1,086,658	0	3/1/2017	$910,407	84%	100%
1.f	Primary Care - Women at Public Clinic (a)	1,902,089	0	0			1,902,089	9.01%	1,902,089	0	3/1/2017	$1,238,982	65%	100%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2017	$11,400	74%	100%
1.h	Vision	302,000	50,000	0	0		352,000	1.67%	352,000	0	3/1/2017	$351,735	100%	100%
2	**Medical Case Management**	**2,215,702**	**0**	**227,500**	**0**	**0**	**2,443,202**	**11.58%**	**2,443,202**	**0**		**1,804,769**	**74%**	**100%**
2.a	Clinical Case Management	488,656	0	115,000	0		603,656	2.86%	603,656	0	3/1/2017	$456,995	76%	100%
2.b	Med CM - Public Clinic (a)	162,622	0	0	0		162,622	0.77%	162,622	0	3/1/2017	$269,571	166%	100%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	37,500	0		358,570	1.70%	358,570	0	3/1/2017	$340,640	95%	100%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	37,500	0		358,572	1.70%	358,572	0	3/1/2017	$161,868	45%	100%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	37,500	0		144,747	0.69%	144,747	0	3/1/2017	$99,616	69%	100%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.65%	348,760	0	3/1/2017	$183,569	53%	100%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.85%	180,311	0	3/1/2017	$75,416	42%	100%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.76%	160,051	0	3/1/2017	$96,814	60%	100%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.38%	80,025	0	3/1/2017	$68,934	86%	100%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.22%	45,888	0	3/1/2017	$51,347	112%	100%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,384,796**	**0**	**30,000**	**0**	**0**	**2,414,796**	**11.44%**	**2,414,796**	**0**	3/1/2017	**$5,151,631**	**213%**	**100%**
4	**Oral Health**	**166,404**	**0**	**29,717**	**0**	**0**	**196,121**	**0.93%**	**196,121**	**0**	3/1/2017	**165,150**	**84%**	**100%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	29,717			196,121	0.93%	196,121	0	3/1/2017	$165,150	84%	100%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,294,551**	**0**	**0**	**80,000**	**0**	**1,374,551**	**6.51%**	**1,374,551**	**0**	3/1/2017	**$1,374,549**	**100%**	**100%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.22%**	**45,677**	**0**	3/1/2017	**$45,663**	**100%**	**100%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**10,000**	**0**	**0**	**351,395**	**1.67%**	**351,395**	**0**	3/1/2017	**$344,852**	**98%**	**100%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**490,000**	**-70,000**				**420,000**	**1.99%**	**420,000**	**0**	**7/1/2017**	**$148,469**	**35%**	**100%**
13	**Non-Medical Case Management**	**1,231,002**	**0**	**14,000**	**0**	**0**	**1,245,002**	**5.90%**	**1,245,002**	**0**		**1,090,047**	**88%**	**100%**
13.a	Service Linkage targeted to Youth	110,793		0			110,793	0.53%	110,793	0	3/1/2017	$294,840	266%	100%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			0		100,000	0.47%	100,000	0	3/1/2017	$85,024	85%	100%
13.c	Service Linkage at Public Clinic (a)	427,000		0	0		427,000	2.02%	427,000	0	3/1/2017	$0	0%	100%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		14,000	0		607,209	2.88%	607,209	0	3/1/2017	$710,183	117%	100%
14	**Medical Transportation**	**527,362**	**-45,275**	**30,000**	**0**	**0**	**512,087**	**2.43%**	**512,087**	**0**		**379,864**	**74%**	**100%**
14.a	Medical Transportation services targeted to Urban	252,680	0	15,000	0		267,680	1.27%	267,680	0	3/1/2017	$294,840	110%	100%
14.b	Medical Transportation services targeted to Rural	97,185	0	15,000	0		112,185	0.53%	112,185	0	3/1/2017	$85,024	76%	100%
14.c	Transportation vouchering (bus passes & gas cards)	177,497	-45,275	0	0		132,222	0.63%	132,222	0	3/1/2017	$0	0%	0%
15	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
16	**Other Professional Services**	**125,000**	**-125,000**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
17	**Emergency Financial Assistance**	**0**		**50,000**			**50,000**	**0.24%**	**50,000**	**0**	NA		**0%**	**0%**
18	**Referral for Health Care and Support Services**	**0**					**0**	**0.00%**	**0**	**0**	NA		**0%**	**0%**
	Total Service Dollars	**18,617,626**	**-190,275**	**444,642**	**0**	**0**	**18,871,993**	**87.45%**	**18,871,993**	**0**		**19,849,588**	**105%**	**100%**
	Grant Administration	**1,658,827**	**16,220**	**0**	**0**	**0**	**1,675,047**	**7.94%**	**1,675,047**	**0**	**N/A**	**1,324,318**	**79%**	**100%**

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

FY 2017 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
BER27617	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.43%	1,146,388	0	N/A	$1,080,632	94%	100%
PC	RWPC Support*	512,439	16,220		0	0	528,659	2.51%	528,659	0	N/A	243,686	46%	100%
BER27931	**Quality Management**	495,000	0	0	0	0	495,000	2.35%	495,000	0	N/A	$478	0%	100%
		20,771,453	-174,055	444,642	0	0	21,042,040	97.73%	21,042,040	0		21,174,384	101%	100%
								Unallocated	Unobligated					
	Part A Grant Award:	20,656,176	***Carry Over:***	444,642		***Total Part A:***	21,100,818	58,778	0					

	Original Allocation	Award Reconciliation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent
Core (must not be less than 75% of total service dollars)	16,244,262	50,000	350,642	0	0	16,644,904	88.20%	16,644,904	88.20%
Non-Core (may not exceed 25% of total service dollars)	2,373,364	-240,275	94,000	0	0	2,227,089	11.80%	2,227,089	11.80%
Total Service Dollars (does not include Admin and QM)	18,617,626	-190,275	444,642	0	0	18,871,993		18,871,993	
Total Admin (must be ≤ 10% of total Part A + MAI)	1,658,827	16,220	0	0	0	1,675,047	7.94%		
Total QM (must be ≤ 5% of total Part A + MAI)	495,000	0	0	0	0	495,000	2.35%		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	2,057,949	59,936	233,750	0	0	2,351,635	85.53%	2,351,635	0		2,134,272	91%	100%
1.b (MAI)	Primary Care - CBO Targeted to African American	1,040,245	29,968	116,875	0	0	1,187,088	43.18%	1,187,088	0	3/1/2017	$1,217,847	103%	100%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	1,017,704	29,968	116,875	0	0	1,164,547	42.36%	1,164,547	0	3/1/2017	$916,425	79%	100%
17	**Emergency Financial Assistance**	0	0	50,000			50,000	1.82%	50,000	0	12/1/2017	$234,740	469%	100%
18	**Referral for Health Care and Support Services**	0	0	347,746			347,746	12.65%	347,746	0		$280,299	81%	100%
	Total MAI Service Funds	2,057,949	59,936	631,496	0	0	2,749,381	100.00%	2,749,381	0		2,649,311	96%	100%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
BEC27819	**Total MAI Funds**	2,057,949	59,936	631,496	0	0	2,749,381	100.00%	2,749,381	0		2,649,311	96%	100%
	MAI Grant Award	2,117,885	***Carry Over:***	631,496		***Total MAI:***	2,749,381							
	Combined Part A and MAI Orginial Allocation Total	22,829,402												

Footnotes:

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

THE RESOURCE GROUP
2017 CHART REVIEW
COMBINED PACKET

TABLE OF CONTENTS

EARLY INTERVENTION SERVICES - INCARCERATED
2017 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic, and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

In 2016, DSHS contracted with Germane Solutions to perform chart reviews of specific service categories. These chart reviews change from year-to-year and are determined at the beginning of each calendar year. TRG does not duplicate the chart reviews if a review was conducted Germane Solutions. Therefore, the chart review report for 2017 resulted in no chart review results. TRG will resume the monitoring process in 2018. However, to assist in the quality analysis of the EIS services, the 2016 data is presented below.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring each finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with one Subgrantee to provide Early Intervention Services in the Houston HSDA.

INTRODUCTION

Description of Service

Early Intervention Services-Incarceration (EIS) includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, establishment of THMP/ADAP post-release eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.

Tool Development

The Early Intervention Services review tool is based upon the established local standards of care.

Chart Review Process

The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

Using the ARIES database a file sample was created from a provider population of 927 who accessed Early Intervention Services in the measurement year. The records of 59 clients were reviewed (representing 6% of the unduplicated population). The demographic makeup of the provider was used as a key to file sample pull.

NOTE: DSHS has changed the file sample percentage which will result in a lower number of files being reviewed in 2016.

Demographics-Early Intervention Services

2015 Annual

Total UDC: 871 **Total New:** 293

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	55	6.31%
25 - 44 years	464	53.27%
45 - 64 years	340	39.04%
65 years or older	12	1.38%
Unknown	0	0.00%
	871	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	157	18.03%
Male	700	80.37%
Transgender FTM	0	0.00%
Transgender MTF	14	1.61%
Unknown	0	0.00%
	871	100%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	138	15.84%
Black	637	73.13%
Hispanic	90	10.33%
Asian	0	0.00%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	6	0.69%
Unknown	0	0.00%
	871	100%

From 01/01/15 - 12/31/15

2016 Annual

Total UDC: 927 **Total New:** 279

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	53	5.72%
25 - 44 years	492	53.07%
45 - 64 years	369	39.81%
65 years or older	13	1.40%
Unknown	0	0.00%
	927	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	148	15.97%
Male	766	82.63%
Transgender FTM	0	0.00%
Transgender MTF	13	1.40%
Unknown	0	0.00%
	927	100%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	156	16.83%
Black	661	71.31%
Hispanic	106	11.43%
Asian	1	0.11%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	3	0.32%
Unknown	0	0.00%
	927	100%

From 01/01/16 - 12/31/16

RESULTS OF REVIEW

Intake Assessment

Percentage of HIV-positive clients who had a completed intake assessment present in the client record.

	Yes	No	N/A
Number of client with a completed intake assessment in the client record.	56	1	2
Number of HIV-infected clients in early intervention services that were reviewed.	57	57	59
Rate	**98%**	2%	-

Intake Assessment

Percentage of HIV-positive clients that self-reports being in care (attending a medical appointment) in the last 6 months prior to incarceration.

	Yes	No	Unknown	N/A (New Dx)
Number of client with a completed intake assessment in the client record.	40	10	3	6
Number of HIV-infected clients in early intervention services that were reviewed.	53	53	53	59
Rate	**75%**	19%	6%	-

Health Literacy and Education: Risk Assessment

Percentage of HIV-positive clients that had documentation of the client being assessed for risk and provided targeted health literacy and education in the client record (including receipt of a blue book).

	Yes	No	Partial (blue book only)	N/A
Number of client records that documented health literacy and education.	38	4	12	5
Number of HIV-infected clients in early intervention services that were reviewed.	54	54	54	59
Rate	**70%**	7%	22%	-

Health Literacy and Education: Medication Adherence

Percentage of HIV-positive clients who had documentation of discussion of medication adherence by the EIS case manager in the client record.

	Yes	No	N/A
Number of client records who had documentation of discussion of medication adherence by the EIS case manager in the client record	34	20	5
Number of HIV-infected clients in early intervention services that were reviewed.	54	54	59
Rate	**63%**	37%	-

Linkage: Newly Diagnosed

Percentage of newly-diagnosed clients (incarcerated 30 days or longer) that initiate care through the EIS program

	Yes	No	N/A
Number of newly-diagnosed clients (incarcerated 30 days or longer) that initiate care through the EIS program	6	0	53
Number of newly-diagnosed HIV-infected clients in early intervention services that were reviewed.	6	6	59
Rate	**100.0%**	0.0%	-

Linkage: Medical Care

Percentage of HIV-positive clients that accessed a medical provider and obtained an appointment.

	Yes	No	N/A
Number of client records that document linkage to a medical provider and access to an appointment	55	0	4
Number of HIV-infected clients in early intervention services that were reviewed.	55	55	59
Rate	**100.0%**	0.0%	-

Multidisciplinary Team Conference

Percentage of HIV-positive clients who received early intervention services that had at least one multidisciplinary team conference

	Yes	No	N/A
Number of client records that showed evidence of at least one multidisciplinary team conference.	0	55	4
Number of HIV-infected clients in early intervention services that were reviewed.	55	55	59
Rate	**0%**	100.0%	7%

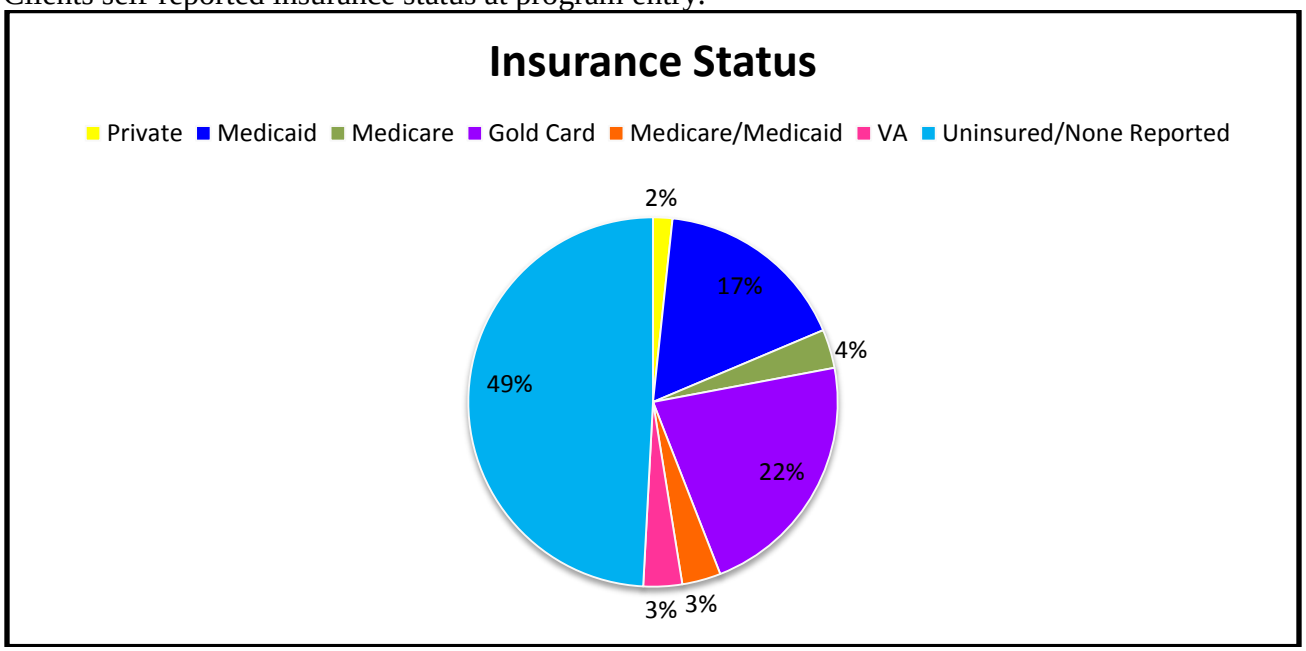
Discharge Planning

Percentage of HIV-positive clients who had a discharge plan present in the client record.

	Yes	No	N/A
Number of client with a completed discharge plan in the client record.	44	10	5
Number of HIV-infected clients in early intervention services that were reviewed.	54	54	59
Rate	**81%**	19%	8%

Insurance Status

Clients self-reported insurance status at program entry.



HISTORICAL DATA

Not applicable for 2016 Chart Review as this is the first time this service category has been presented.

CONCLUSIONS

Overall, quality of services is good. Through the chart review: 98% (56) of clients completed an intake assessment and 81% (44) developed a discharge plan. Of the clients enrolled into the EIS program 100% were linked accessed a care provider; with 100% (6) of the newly-diagnosed clients accessing care. However, only 50% (3) of the newly-diagnosed clients documented a discharge plan. 75% (40) of clients self-reported accessing medical care within the last six months of entering the EIS program and 51% (30) reported a third-party payer source (including the HCHD Gold Card)

HOME & COMMUNITY-BASED HEALTH SERVICES
2017 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic, and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring each finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with one Subgrantee to provide home and community-based health services in the Houston HSDA.

INTRODUCTION

Description of Service

Home and Community-based Health Services (facility-based) is defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. **Education:** Services to include instructional workshops of HIV related topics and life skills. *Inpatient hospitals services, nursing home and other long-term care facilities are NOT included.*

Tool Development

The TRG Oral Healthcare Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

Using the ARIES database, a file sample was created from a provider population of 28 who accessed home and community-based Health Services in the measurement year. The records of 35 clients were reviewed for the annual review process. The demographic makeup of the provider was used as a key to file sample pull.

NOTE: DSHS has changed the file sample percentage which will result in a lower number of files being reviewed in 2017.

DEMOGRAPHICS
HOME AND COMMUNITY BASED SERVICES

2016 Annual

Total UDC: 38 **Total New: 36**

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	0	0.00%
25 - 44 years	11	28.95%
45 - 64 years	24	63.16%
65 years or older	3	7.89%
Unknown	0	0.00%
	38	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	12	31.58%
Male	25	65.79%
Transgender FTM	0	0.00%
Transgender MTF	1	2.63%
Unknown	0	0.00%
	38	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	5	13.16%
Black	25	65.79%
Hispanic	7	18.42%
Asian	0	0.00%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	1	2.63%
Unknown	0	0.00%
	38	100%

From 01/01/16 - 12/31/16

2017 Annual

Total UDC: 28 **Total New: 3**

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	0	0.00%
25 - 44 years	4	14.29%
45 - 64 years	21	75.00%
65 years or older	3	10.71%
Unknown	0	0.00%
	28	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	9	32.14%
Male	18	64.29%
Transgender FTM	0	0.00%
Transgender MTF	1	3.57%
Unknown	0	0.00%
	28	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	2	7.14%
Black	21	75.00%
Hispanic	5	17.86%
Asian	0	0.00%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	28	100%

From 01/01/17 - 12/31/17

RESULTS OF REVIEW

Intake

Percentage of clients who have documentation of signed case manager and clinical health provider order for Home and Community-Based Health Services is located in client file.

	Yes	No	N/A
Number of client records that showed evidence of the measure	35	0	-
Number of clients records that were reviewed.	35	35	-
Rate	**100%**	**0%**	-

Implementation of Care Plan

Percentage of clients who have a care plan that has been written and signed by case manager and primary care provider that includes all planned services, quantity, and length of time services are to be provided

	Yes	No	N/A
Number of client records that showed evidence of the measure	34	1	-
Number of clients records that were reviewed.	35	35	-
Rate	**97%**	**3%**	-

Percentage of clients who have documentation that care plan was reviewed regularly and revised with any changes and signed by the professional

	Yes	No	N/A
Number of client records that showed evidence of the measure	33	1	1
Number of clients records that were reviewed.	34	34	35
Rate	**97%**	**3%**	-

Provision of Service

Percentage of clients who had clear, concise, and comprehensive progress notes in their record each visit and is signed by the professional giving service.

	Yes	No	N/A
Number of client records that showed evidence of the measure	34	1	-
Number of clients records that were reviewed.	35	35	-
Rate	**97%**	**3%**	-

Percentage of client records show documentation that care plan has been reviewed and updated at least every 60 days

	Yes	No	N/A
Number of client records that showed evidence of the measure	31	3	-
Number of clients records that were reviewed.	34	34	-
Rate	**91%**	**9%**	-

Percentage of client records show documentation that the patient's primary medical care provider has been updated about patient's condition.

	Yes	No	N/A
Number of client records that showed evidence of the measure	0	0	35

Number of clients records that were reviewed.	35	35	35
Rate	**0%**	**0%**	**100%**

Percentage of client record shows documentation of continued assessment ensuring patient does not need Acute Care

	Yes	No	N/A
Number of client records that showed evidence of the measure	35	0	-
Number of clients records that were reviewed.	35	35	-
Rate	**100%**	**0%**	-

Coordination of Services

Percentage of clients who show documentation that services provided are coordinated with other service providers to avoid duplication

	Yes	No	N/A
Number of client records that showed evidence of the measure	35	0	-
Number of clients records that were reviewed.	35	35	-
Rate	**100%**	**0%**	-

Percentage of clients who show a referral to an appropriate service provider is evident in the client's record if transferred.

	Yes	No	N/A
Number of client records that showed evidence of the measure	0	0	35
Number of clients records that were reviewed.	35	35	35
Rate	**0%**	**0%**	**100%**

Percentage of clients who have documentation of discharge when client meets discharge criteria.

	Yes	No	N/A
Number of client records that showed evidence of the measure	14	0	21
Number of clients records that were reviewed.	14	14	-
Rate	**100%**	**0%**	-

Documentation

Percentage of clients who had vital signs taken at least once a week.

	Yes	No	N/A
Number of client records that showed evidence of the measure	35	0	-
Number of clients records that were reviewed.	35	35	-
Rate	**100%**	**0%**	-

Percentage of clients who received services that showed evidence of periodic multidisciplinary team conference

	Yes	No	N/A
Number of client records that showed evidence of the measure	34	1	-
Number of clients records that were reviewed.	35	35	-
Rate	**97%**	**3%**	-

Comorbidities

Percentage of clients who have been diagnosed with elevated blood pressure.

	Yes	No	NA
Number of client records that showed evidence of the measure	14	21	0
Number of clients records that were reviewed.	35	35	-
Rate	**40%**	60%	-

Percentage of clients who have been diagnosed with elevated blood glucose levels and are taking diabetic medications.

	Yes	No	N/A
Number of client records that showed evidence of the measure	8	6	21
Number of clients records that were reviewed.	14	14	-
Rate	**57%**	**43%**	-

CONCLUSIONS

Overall, quality of services provided meets or exceeds minimum thresholds. Five indicators reviewed were in compliance at a 100%, with 100% of clients in HCBS having their vital signs taken at least once a week. Through the nursing assessment: 36% (14) were identified with a diagnosis of hypertension (+4% increase from last year) and 57% of those showed evidence that their hypertension was controlled (Systolic <140, Diastolic <90) in the past 6 months.

HOSPICE SERVICES
2017 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts one Subgrantee to provide hospice services in the Houston HSDA.

INTRODUCTION

Description of Service

Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Tool Development

The TRG Hospice Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a population of 51 who accessed hospice services in the measurement year. The records of 38 clients were reviewed, representing 75% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

NOTE: DSHS changed the file sample percentage which will result in a lower number of files being reviewed in 2017.

Demographics- Hospice

2016 Annual

Total UDC: 38 Total New: 33

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	0	0.00%
25 - 44 years	16	42.11%
45 - 64 years	22	57.89%
65 years or older	0	0.00%
Unknown	0	0.00%
	38	100.00%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	9	23.68%
Male	29	76.32%
Transgender FTM	0	0.00%
Transgender MTF	0	0.00%
Unknown	0	0.00%
	38	100.00%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	9	23.68%
Black	20	52.63%
Hispanic	8	21.05%
Asian	1	2.63%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	4.00%
Unknown	0	0.00%
	38	100.00%

From 01/01/16 - 12/31/16

2017 Annual

Total UDC: 51 Total New: 39

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	1	1.96%
25 - 44 years	17	33.33%
45 - 64 years	30	58.82%
65 years or older	3	5.88%
Unknown		0.00%
	51	100.00%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	9	17.65%
Male	42	82.35%
Transgender FTM	0	0.00%
Transgender MTF	0	0.00%
Unknown	0	0.00%
	51	100.00%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	19	37.25%
Black	24	47.06%
Hispanic	8	15.69%
Asian	0	2.63%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	51	100.00%

From 01/01/17 - 12/31/17

RESULTS OF REVIEW

ADMISSION ORDERS AND ASSESSMENT

Percentage of client records that have a Hospice Certificate Letter in the chart

	Yes	No	N/A
Client records that evidenced a Hospice Certificate Letter.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of client records that have admission orders

	Yes	No	N/A
Client records that showed evidence of an admission order.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of client records that had a Comprehensive Assessment completed within 48 hours

	Yes	No	N/A
Client records that evidenced a completed Comprehensive Assessment within 48 hours.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of HIV-positive client records that showed assessment for pain at each shift

	Yes	No	N/A
Client records that showed evidence of a pain assessment at each shift.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of client records that have symptom management orders

	Yes	No	N/A
Client records that evidenced symptom management orders.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

CARE PLAN, UPDATES AND MULTIDICPLINARY TEAM (MDT) DOCUMENTAITON

Percentage of client records that have a completed initial plan of care within 7 days of admission.

	Yes	No	N/A
Client records that evidence a completed initial plan of care within 7 days of admission	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of client records that have a completed plan of care reviewed and/or updated at least monthly.

	Yes	No	N/A
Client records that evidenced a completed plan of care that was updated at least monthly.	21	0	17
Clients in hospice services that were reviewed.	21	21	38
Rate	**100%**	**0%**	**45%**

Percentage of client records that showed weekly updates to the MDT care plan

	Yes	No	N/A
Client records that showed evidence of weekly updates to the MDT.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

SERVICES

Percentage of client records that evidenced daily nurse's notes

	Yes	No	N/A
Number of client records that evidenced daily nursing documentation.	38	0	-
Clients in oral health services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of client records that had bereavement care plans

	Yes	No	N/A
Client records that showed evidence of bereavement care plans.	37	0	1
Clients in oral health services that were reviewed.	37	37	38
Rate	**100%**	**0%**	3%

Percentage of client records that had dietary counseling

	Yes	No	N/A
Number of client records that evidenced dietary counseling	1	0	37
Clients in oral health services that were reviewed.	1	1	38
Rate	**100%**	**0%**	97%

Percentage of client records that had spiritual counseling

	Yes	No	N/A
Client records that evidenced spiritual counseling.	38	0	-
Clients in oral health services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

Percentage of client records that had pain management needs assessed each shift

	Yes	No	N/A
Number of client records that evidence a pain assessment each shift	38	0	-
Clients in oral health services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

FAMILY SUPPORT

Percentage of client records that showed end of life support services were given to the family.

	Yes	No	N/A
Client records that showed evidence of support services being offered to the family.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

HOMELESSNESS

Percentage of client records that show the client was homeless on admission

	Yes	No	N/A
Client records that showed evidence of homeless on admission.	3	35	-
Clients in hospice services that were reviewed.	38	38	-

Rate	**8%**	**92%**	-

SUBSTANCE ABUSE

Percentage of client records that showed the client had active substance abuse on admission.

	Yes	No	N/A
Client records that evidenced active substance abuse on admission.	3	35	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**8%**	**92%**	-

PSYCHIATRIC ILLNESS

Percentage of client records that showed the client had active psychiatric illness on admission (excluding depression).

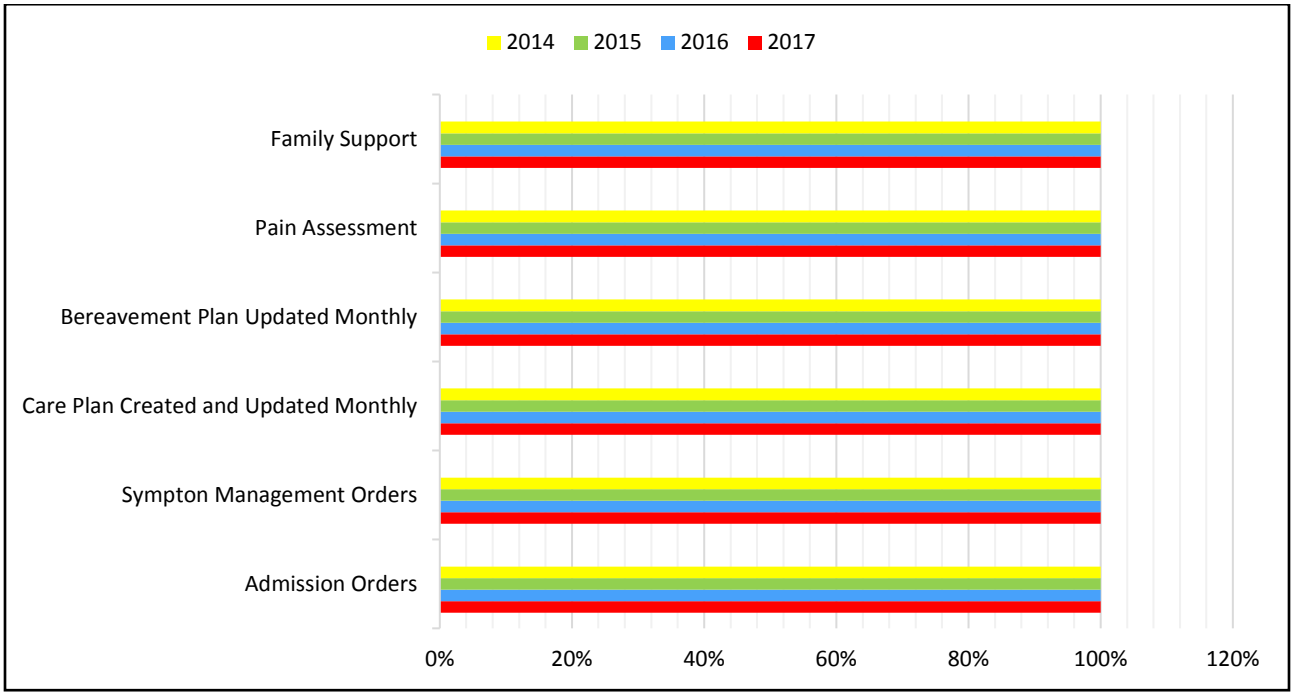
	Yes	No	N/A
Number of client records that evidenced active psychiatric illness	3	35	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**8%**	**92%**	-

DISCHARGE

Percentage of client records that showed completed discharge documentation

	Yes	No	N/A
Client records that evidenced completed discharge documentation.	38	0	-
Clients in hospice services that were reviewed.	38	38	-
Rate	**100%**	**0%**	-

HISTORICAL DATA



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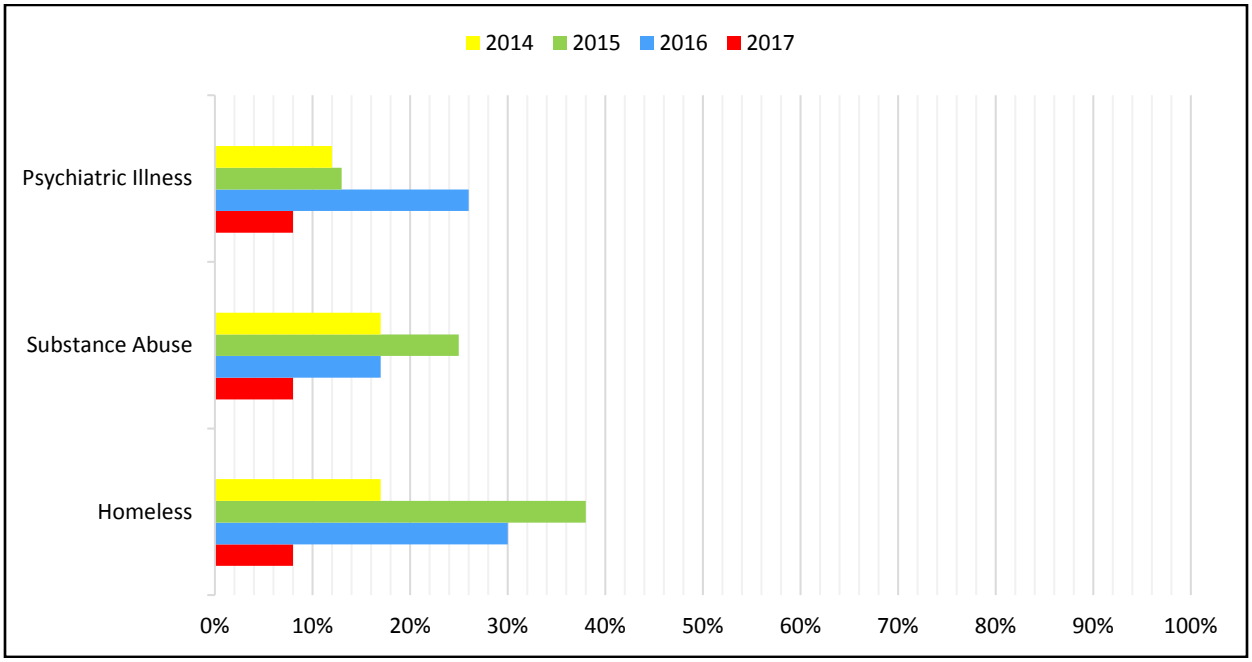


CONCLUSION

The review showed that Hospice Care continue to be delivered at a very high standard. All fifteen Standard of Care data elements were scored at 100% compliance, including care plan, symptom management and family support. Of the client records reviewed, 8% (3) of records indicated the client was homeless on admission. This is a significant decrease from 30% in 2016. Additionally, 8% (3) of records reviewed showed evidence that the client had active substance abuse on admission (decrease from 17% in 2015); 8% (3) of records reviewed showed evidence of active psychiatric illness on admission (excluding depression). This is a decrease from 26% in 2016. Demographically, the client's served in the age bracket 45 and up, is increasing with 15 (60%) clients in 2015, 22 (58%) clients in 2016 and 33 (65%) clients in 2017.

MENTAL HEALTH SERVICES
2017 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with one Subgrantee to provide hospice services in the Houston HSDA.

INTRODUCTION

Description of Service

Mental Health Services are treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. **Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person.

Tool Development

The TRG Mental Health Services Tool is based upon established local standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

Using the ARIES database, the file sample was created from a provider population of 293 who accessed mental health services in the measurement. The records of 59 clients were reviewed, representing 20% of the unduplicated population. The demographic makeup of the providers was used as a key to file sample pull.

NOTES: DSHS changed the file sample percentage which will result in a lower number of files being reviewed in 2017.

Demographics- Mental Health

2016 Annual

Total UDC: 404 Total New: 137

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	11	2.72%
25 - 44 years	176	43.56%
45 - 64 years	200	49.50%
65 years or older	17	4.21%
Unknown	0	0.00%
	404	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	43	10.64%
Male	354	87.62%
Transgender FTM	0	0.00%
Transgender MTF	7	1.73%
Unknown	0	0.00%
	404	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	157	38.86%
Black	148	36.63%
Hispanic	75	18.56%
Asian	23	5.69%
Hawaiian/Pacific Islander	1	0.25%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	404	100%

From 01/01/16 - 12/31/16

2017 Annual

Total UDC: 293 Total New: 104

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	5	1.71%
25 - 44 years	116	39.59%
45 - 64 years	159	54.27%
65 years or older	13	4.44%
Unknown	0	0.00%
	293	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	10	3.41%
Male	278	94.88%
Transgender FTM	0	0.00%
Transgender MTF	5	1.71%
Unknown	0	0.00%
	293	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	131	44.71%
Black	94	32.08%
Hispanic	67	22.87%
Asian	1	0.34%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	293	100%

From 01/01/17 - 12/31/17

RESULTS OF REVIEW

Psychosocial Assessment

Psychosocial Assessment completed no later than third counseling session.

	Yes	No	N/A
Clients with assessment completed no later than the 3rd appt.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Psychosocial Assessment: Required Elements

Psychosocial Assessment included assessment of all elements in the Mental Health Standards.

	Yes	No	N/A
Clients with assessment completed no later than the 3rd appt.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Treatment Plan

Treatment Plan completed no later than third counseling session.

	Yes	No	N/A
Clients with treatment plans completed no later than the 3rd counseling session.	52	-	7
Client records reviewed that included in this measure.	52	-	59
Rate	**100%**	-	12%

Treatment Plan: Signed by Therapist

Treatment Plan was signed by the mental health professional who rendered service.

	Yes	No	N/A
Clients with treatment plans signed by the mental health professional rendering service.	52	-	7
Client records reviewed that included in this measure.	52	-	59
Rate	**100%**	-	12%

Treatment Plan: Reviewed/Modified

Treatment Plan was reviewed and/modified at least every ninety (90) days.

	Yes	No	N/A
Clients with treatment plans reviewed/modified every 90 days.	50	2	7
Client records reviewed that included in this measure.	52	52	59
Rate	**96%**	**4%**	12%

Services Provided: Required Elements

Treatment included counseling covering all elements outlined in the Mental Health Standards.

	Yes	No	N/A

Clients who received counseling covering all elements.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Services Provided: Psychiatric Evaluation

Treatment included psychiatric evaluation was conducted/referral completed if needed.

	Yes	No	N/A
Clients who psychiatric evaluation was conducted/referral completed if needed.	1	-	58
Client records reviewed that included in this measure.	59	-	59
Rate	**100%**	-	-

Services Provided: Psychiatric Medication

Treatment included psychotropic medication management services, if needed.

	Yes	No	N/A
Clients who documented psychotropic medication management service was provided if needed.	-	-	59
Client records reviewed that included in this measure.	59	-	59
Rate	**0%**	-	100%

Services Provided: Progress Notes

Progress notes completed for each counseling session and contained all elements outlined in the Mental Health Standards.

	Yes	No	N/A
Clients with progress notes complete and containing all elements.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Services Provided: Medical Care Coordination

Evidence that care was coordinated as appropriate across all medical care coordination team members.

	Yes	No	N/A
Clients with care coordinated across team.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Referrals: Referrals Made As Needed

Documentation that referrals were made as needed to specialized medical/mental health providers/services.

	Yes	No	N/A
Clients with referral needed and made.	27	-	32
Client records reviewed that included in this measure.	27	-	59

Rate	**100%**	-	-

Referrals: Referrals Outcome

Documentation is present in client's record of the referral and the outcome of the referral.

	Yes	No	N/A
Clients with referral document with outcome of referral.	27	-	32
Client records reviewed that included in this measure.	27	-	59
Rate	**100%**	-	-

Discharge Planning

Documentation is present that discharge planning was completed with the client.

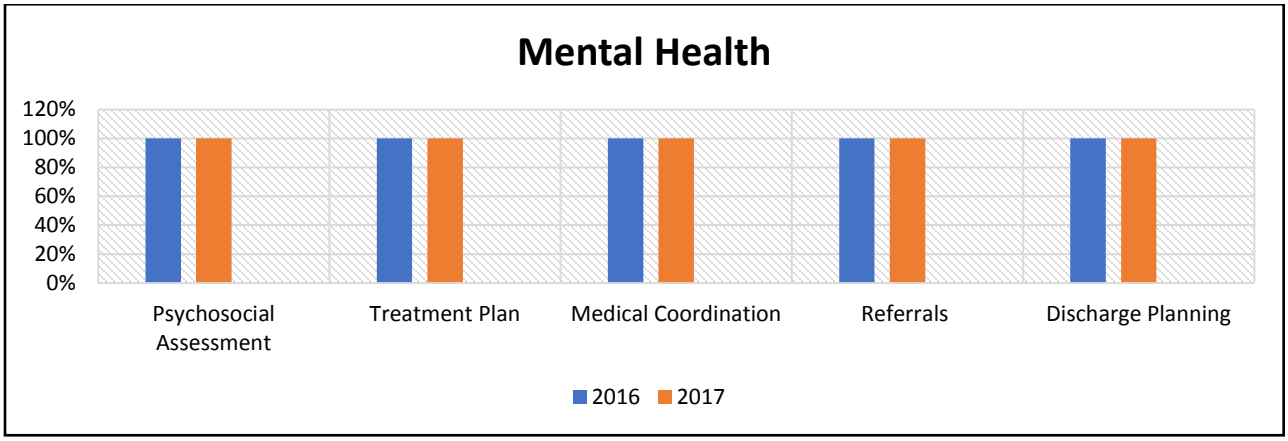
	Yes	No	N/A
Clients with documented discharge planning.	26	-	33
Client records reviewed that included in this measure.	26	-	59
Rate	**100%**	-	-

Discharge

Documentation is reason for discharge is located in the client's record and is consistent with agency policies.

	Yes	No	N/A
Clients with documented reason for discharge.	23	-	36
Client records reviewed that included in this measure.	23	-	59
Rate	**100%**	-	-

HISTORICAL DATA



CONCLUSION

Quality of mental health services continues to excellent. All clients reviewed (100%) completed a psychosocial assessment no later than the third counseling session, all clients had a treatment plan and medical care coordination was appropriate across all medical care coordination team members. Eleven data elements were met at 100%. Although 100% of clients had an appropriate treatment plan, 96% (50) had their plan reviewed and/or modified at least every ninety (90) days.

ORAL HEALTH CARE SERVICES
2017 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantee's comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantee's. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with two Subgrantees to provide oral health care services in the Houston HSDA.

INTRODUCTION

Description of Service

Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room.

Tool Development

The TRG Oral Healthcare Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a provider population of 2,918 clients who accessed oral healthcare services in the measurement year. The records of 160 clients were reviewed, representing 5% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

NOTE: DSHS has changed the file sample percentage which will result in a lower number of files being reviewed in 2017.

Demographics- Oral Healthcare Services

2016 Annual		
Total UDC: 3153	**Total New: 2088**	
Age	**Number of Clients**	**% of Total**
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	66	2.09%
25 - 44 years	1155	36.63%
45 - 64 years	1719	54.52%
65 years or older	213	6.76%
Unknown	0	0.00%
	3153	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	846	26.83%
Male	2288	72.57%
Transgender FTM	1	0.03%
Transgender MTF	18	0.57%
Unknown	0	0.00%
	3153	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	554	17.57%
Black	1600	50.75%
Hispanic	950	30.13%
Asian	37	1.17%
Hawaiian/Pacific Islander	3	0.10%
Indian/Alaskan Native	9	0.29%
Unknown	0	0.00%
	3153	100%

From 01/01/16 - 12/31/16

2017 Annual		
Total UDC: 2918	**Total New: 783**	
Age	**Number of Clients**	**% of Total**
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	66	2.26%
25 - 44 years	1091	37.40%
45 - 64 years	1565	53.62%
65 years or older	196	6.72%
Unknown	0	0.00%
	2918	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	759	26.01%
Male	2132	73.06%
Transgender FTM	1	0.04%
Transgender MTF	26	0.89%
Unknown	0	0.00%
	2918	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	473	16.21%
Black	1478	50.65%
Hispanic	917	31.43%
Asian	43	1.47%
Hawaiian/Pacific Islander	1	0.04%
Indian/Alaskan Native	6	0.20%
Unknown	0	0%
	2918	100%

From 01/01/17 - 12/31/17

RESULTS OF REVIEW

Client's HIV primary care provider contact information is documented in the client's oral health care record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	156	9	2
Number of clients records that were reviewed.	165	165	-
Rate	**95%**	**5%**	-

An initial or updated dental and medical history within the last year is documented in the client's oral healthcare record (HRSA HAB Measure)

	Yes	No	N/A
Number of client records that showed evidence of the measure	147	13	7
Clients records that were reviewed.	160	160	-
Rate	**92%**	**8%**	-

Periodontal Screening/Examination conducted within the last year is documented in the client's oral healthcare record (HRSA HAB Measure)

	Yes	No	N/A
Number of client records that showed evidence of the measure	126	17	24
Clients records that were reviewed.	143	143	-
Rate	**88%**	**12%**	-

Dental provider obtained an initial baseline blood pressure/pulse reading during the initial limited physical examination and is documented in the client's oral healthcare record. If not obtained, dental provider documented reason.

	Yes	No	N/A
Number of client records that showed evidence of the measure	149	11	7
Clients records that were reviewed.	160	160	-
Rate	**93%**	**7%**	-

Oral examination conducted within the last year is documented in the client's oral healthcare record

	Yes	No	N/A
Number of client records that showed evidence of the measure	138	11	18
Clients records that were reviewed.	149	149	-
Rate	**93%**	**7%**	-

Dental treatment plan to include specific diagnostic, preventive, and therapeutic was established or updated within the last year and signed by the oral healthcare professional providing the services (HRSA HAB Measure)

	Yes	No	N/A
Number of client records that showed evidence of the measure	117	18	32
Clients records that were reviewed.	135	135	-

Rate	**87%**	**13%**	-

Phase 1 treatment plan to include prevention, maintenance and/or elimination of oral pathology resulting from dental caries or periodontal disease was established within one year of initial assessment and signed by the oral healthcare professional providing the services (HRSA HAB Measure)

	Yes	No	N/A
Number of client records that showed evidence of the measure	114	18	35
Clients records that were reviewed.	132	132	-
Rate	**86%**	**14%**	-

Oral health education for oral hygiene instruction and smoking cessation if applicable conducted within the last year is documented in the patient's oral healthcare record (HRSA HAB Measure)

	Yes	No	N/A
Client records that showed evidence of an intraoral exam.	36	112	19
Clients in oral health services that were reviewed.	148	148	-
Rate	**24%**	**76%**	-

CONCLUSIONS

The 2017 data shows a continuation of excellent overall oral healthcare services. All indicators reviewed were modified for the Germane Solutions review, which has a threshold of 50%. All but one indicator was well above the established threshold for DSHS. Treatment plans and completed oral health examinations were well documented. Also, periodontal screening/examination were documented at 88%. The newest data element assessed oral instruction and smoking cessation, which was documented at a compliance rate of 24% will be re-examined this year assess how the provider(s) are documented the indicator.

Prepared by: Ryan White Grant Administration

FY 2017 Ryan White Part A and MAI Service Utilization Report

SUR - 4th Quarter Cumulative (3/1-2/28)

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**7,620**	**74%**	**26%**	**49%**	**15%**	**2%**	**34%**	**0%**	**1%**	**5%**	**26%**	**27%**	**13%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	3,525	69%	31%	52%	10%	2%	36%	0%	0%	3%	19%	27%	14%	34%	3%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,762	71%	29%	99%	0%	1%	0%	0%	1%	9%	37%	25%	10%	18%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,223	85%	15%	0%	0%	0%	100%	0%	1%	5%	31%	31%	13%	18%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	743	90%	10%	0%	89%	11%	0%	0%	0%	4%	27%	22%	16%	29%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	599	71%	29%	43%	25%	3%	29%	0%	0%	8%	29%	28%	11%	23%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	1,093	0%	100%	62%	8%	1%	28%	0%	0%	2%	14%	31%	16%	33%	4%
1.g	Primary Care - Pediatric (a)	7	12	75%	25%	67%	8%	0%	25%	33%	58%	8%	0%	0%	0%	0%	0%
1.h	Vision	1,600	2,478	76%	24%	48%	15%	2%	35%	0%	1%	4%	23%	23%	15%	31%	3%
2	**Medical Case Management (f)**	**3,075**	**5,445**														
2.a	Clinical Case Management	600	1,265	75%	25%	59%	20%	2%	19%	0%	1%	7%	28%	22%	13%	27%	3%
2.b	Med CM - Targeted to Public Clinic (a)	280	699	95%	5%	56%	12%	3%	29%	0%	2%	14%	22%	20%	11%	28%	2%
2.c	Med CM - Targeted to AA (a)	550	1,918	71%	29%	99%	0%	1%	0%	0%	1%	8%	34%	25%	11%	20%	2%
2.d	Med CM - Targeted to H/L(a)	550	930	87%	13%	0%	0%	0%	100%	0%	1%	7%	34%	29%	11%	16%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	480	88%	12%	0%	88%	12%	0%	0%	0%	4%	23%	20%	16%	33%	4%
2.f	Med CM - Targeted to Rural (a)	150	712	70%	30%	45%	28%	3%	24%	0%	0%	6%	24%	25%	12%	28%	3%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	315	0%	100%	66%	10%	1%	23%	0%	2%	7%	15%	30%	14%	29%	3%
2.h	Med CM - Targeted to Pedi (a)	125	89	56%	44%	76%	6%	0%	18%	60%	36%	4%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	189	96%	4%	69%	22%	1%	8%	0%	0%	0%	2%	3%	6%	69%	20%
2.j	Med CM - Targeted to Youth	120	113	96%	4%	62%	6%	4%	28%	0%	15%	85%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**4,653**	**78%**	**22%**	**49%**	**16%**	**2%**	**34%**	**0%**	**0%**	**6%**	**30%**	**28%**	**13%**	**21%**	**2%**
4	**Oral Health**	**200**	**322**	**66%**	**34%**	**39%**	**33%**	**2%**	**25%**	**0%**	**1%**	**4%**	**22%**	**30%**	**13%**	**28%**	**2%**
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	322	66%	34%	39%	33%	2%	25%	0%	1%	4%	22%	30%	13%	28%	2%
5	**Mental Health Services (d)**	**NA**	**NA**														
6	**Health Insurance**	**1,700**	**1,562**	**82%**	**18%**	**45%**	**28%**	**2%**	**25%**	**0%**	**0%**	**3%**	**17%**	**20%**	**15%**	**39%**	**6%**
7	**Home and Community Based Services (d)**	**NA**	**NA**														
8	**Substance Abuse Treatment - Outpatient**	**40**	**24**	**96%**	**4%**	**29%**	**46%**	**4%**	**21%**	**0%**	**0%**	**4%**	**29%**	**29%**	**13%**	**25%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**														
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**496**	**76%**	**24%**	**41%**	**24%**	**3%**	**32%**	**0%**	**0%**	**1%**	**11%**	**16%**	**19%**	**45%**	**8%**
11	**Hospice Services (d)**	**NA**	**NA**														
12	**Outreach**	**NA**	**387**	**77%**	**23%**	**60%**	**12%**	**2%**	**26%**	**0%**	**0%**	**7%**	**29%**	**26%**	**13%**	**24%**	**1%**
13	**Non-Medical Case Management**	**7,045**	**7,560**														
13.a	Service Linkage Targeted to Youth	320	178	79%	21%	61%	8%	3%	28%	0%	13%	87%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	138	71%	29%	57%	7%	2%	34%	0%	0%	0%	37%	22%	11%	28%	2%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	3,173	68%	32%	61%	11%	1%	27%	0%	0%	0%	18%	24%	14%	38%	5%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	4,071	77%	23%	53%	15%	2%	29%	1%	1%	7%	30%	24%	13%	23%	2%
14	**Transportation**	**2,850**	**3,173**														
14.a	Transportation Services - Urban	170	587	70%	30%	59%	11%	2%	27%	0%	0%	7%	28%	27%	10%	23%	4%
14.b	Transportation Services - Rural	130	169	69%	31%	35%	40%	2%	23%	0%	0%	4%	21%	28%	14%	30%	2%
14.c	Transportation vouchering	2,550	2,417														
15	**Linguistic Services (d)**	**NA**	**NA**														
16	**Other Professional Services (e)**	**NA**	**NA**														
17	**Emergency Financial Assistance (e)**	**NA**	**NA**														
18	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**														
Net unduplicated clients served - all categories*		**11,657**	**12,890**	**74%**	**26%**	**53%**	**16%**	**2%**	**29%**	**1%**	**1%**	**5%**	**24%**	**24%**	**13%**	**30%**	**4%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 17 App) (b)		**NA**	**22,830**	**74%**	**26%**	**49%**	**23%**	**3%**	**25%**	**0%**	**6%**		**18%**	**27%**	**30%**	**18%**	

***11,657** clients to be served is based on the number of unduplicated clients served in FY 2016 (update per CPCDMS)

Printed: 5/23/2018

FY 2017 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,849	73%	27%	99%	0%	1%	0%	0%	1%	10%	38%	25%	10%	16%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,252	86%	14%	0%	0%	0%	100%	0%	1%	6%	32%	31%	13%	17%	1%

RW Part A New Client Service Utilization Report

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**1,698**	**76%**	**24%**	**54%**	**15%**	**2%**	**29%**	**0%**	**2%**	**7%**	**35%**	**25%**	**11%**	**18%**	**2%**
2	**LPAP**	**1,200**	**758**	**81%**	**19%**	**54%**	**17%**	**1%**	**28%**	**0%**	**1%**	**8%**	**38%**	**24%**	**10%**	**17%**	**1%**
3.a	Clinical Case Management	400	216	84%	16%	55%	20%	3%	22%	0%	2%	13%	36%	19%	10%	20%	0%
3.b-3.h	Medical Case Management	1,600	1097	76%	24%	56%	16%	2%	25%	1%	3%	10%	34%	22%	10%	19%	2%
3.i	Medical Case Manangement - Targeted to Veterans	60	62	95%	5%	58%	29%	2%	11%	0%	0%	0%	2%	2%	11%	63%	23%
4	**Oral Health**	**40**	**46**	**65%**	**35%**	**41%**	**37%**	**2%**	**20%**	**0%**	**2%**	**7%**	**17%**	**33%**	**22%**	**20%**	**0%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**2,064**	**75%**	**25%**	**58%**	**14%**	**2%**	**26%**	**1%**	**2%**	**7%**	**32%**	**24%**	**11%**	**21%**	**3%**
12.b	**Service Linkage at Testing Sites**	**260**	**81**	**74%**	**26%**	**58%**	**5%**	**2%**	**35%**	**0%**	**2%**	**20%**	**37%**	**19%**	**6%**	**16%**	**0%**

Footnotes:

(a) Bundled Category

(b) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.

(d) Funded by Part B and/or State Services

(e) Not funded in FY 2017

(f) Total MCM served does not include Clinical Case Management

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1718 Ryan White Part B

Procurement Report

April 1, 2017 - March 31, 2018

Reflects spending through March 2018

(not the final)

Spending Target: 100%

Revised 5/9/2018

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Oral Health Care *	$2,370,346	71%	($434,450)	$1,935,896	67%	4/1/2017	$1,635,781	69%
7	Health Insurance Premiums and Cost Sharing	$726,885	22%	($16,122)	$710,763	25%	4/1/2017	$791,713	109%
9	Home and Community Based Health Services**	$232,000	7%	($3,840)	$228,160	8%	4/1/2017	$113,504	49%
	Total Houston HSDA	3,329,231	100%	($454,412)	$2,874,819	100%		2,540,998	76%

Note: Spending variances of 10% will be addressed:

* Services were disrupted during Hurricane Harvey and lack of full staff resulted in less services and less expenses.

** Services utilization has decreased. Changes in program have been implemented. Service category may need an allocation reduction.

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1718 DSHS State Services
Procurement Report
September 1, 2017- August 31, 2018

Chart reflects spending through March 2018

Spending Target: 58%

Revised 5/9/2018

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Mental Health Services*	$300,000	16%		$300,000	16%	9/1/2017	$96,722	32%
7	Health Insurance Premiums and Cost Sharing**	$937,694	50%		$937,694	50%	9/1/2017	$670,391	71%
9	Hospice	$414,832	22%		$414,832	22%	9/1/2017	$196,460	48%
11	EIS - Incarcerated	$170,000	9%		$170,000	9%	9/1/2017	$75,558	44%
16	Linguistic Services ***	$51,211	3%		$51,211	3%	9/1/2017	$23,427	46%
	Total Houston HSDA	1,873,737	100%	$0	$1,873,737	100%		1,062,559	57%

Note: Spending variances of 10% will be addressed:

* Service utilization is lagging

** Agency is focusing on State Services spending now that RWA and RWB closed in February and March respectively.

*** The March expense report has not been submitted.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1718 DSHS State Services Rebate

Procurement Report

September 1, 2017- August 31, 2018

Chart reflects spending through March 2018

Spending Target: 58%

Revised 5/9/2018

Priority	Service Category	Original Allocation per	% of Grant	Amendment	Contractual Amount	% of Grant	Date of Original	Expended YTD	Percent YTD
6	ADAP Eligibility Worker	$375,000	38%		$375,000	38%	9/1/2017	$199,361	53%
7	Emergency Financial Assistance**	$600,000	62%		$600,000	62%	9/1/2017	$123,976	21%
	Total Houston HSDA	975,000	100%	$0	$975,000	100%		323,337	33%

Note: Spending variances of 10% will be addressed

** The public clinic is yet to utilize services, however, DSHS has expanded statewide.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2017-03/31/2018

Revised: 5/7/2018

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	Dollar Amount of Requests	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1083	$99,760.59	455			*0*
Medical Deductible	67	$23,596.48	54			*0*
Medical Premium	3903	$1,529,514.54	828			*0*
Pharmacy Co-Payment	2289	$271,127.16	818			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	7	$1,417.00	14	*NA*	*NA*	*NA*
Totals:	7349	$1,922,581.77	2169	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2017-01/31/2018

Revised: 3/5/2018

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	Dollar Amount of Requests	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	529	$44,219.03	207			*0*
Medical Deductible	225	$34,743.54	138			*0*
Medical Premium	2736	$1,062,199.57	780			*0*
Pharmacy Co-Payment	1527	$163,091.35	545			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	7	$1,417.00	14	*NA*	*NA*	*NA*
Totals:	5024	$1,302,836.49	1684	0	$0.00	

Comments: This report represents services provided under all grants.

2017-2018 Ryan White Part B Service Utilization Report
4/1/2017 - 3/31/2018 Houston HSDA (4816)
4th Quarter

Revised 5/7/2018

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*941*	941	81.9%	17.8%	0.0%	0.3%	40.1%	28.8%	28.9%	2.2%	0.1%	0.1%	1.6%	14.0%	16.4%	15.5%	45.4%	6.9%
Home & Community Based Health Services	*40*	25	68.0%	32.0%	0.0%	0.0%	80.0%	4.0%	16.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.0%	20.0%	60.0%	12.0%
Oral Health Care	*4,180*	2,791	144.4%	197.7%	0.0%	2.3%	106.3%	29.3%	6.9%	3.2%	0.0%	0.2%	2.2%	17.0%	19.9%	13.3%	40.4%	7.0%
Unduplicated Clients Served By RW Part B Funds:	*NA*	**3,757**	**294.33%**	**247.43%**	**0.00%**	**2.65%**	**226.4%**	**62.1%**	**51.8%**	**5.4%**	**0.0%**	**0.1%**	**1.2%**	**10.4%**	**14.8%**	**16.3%**	**48.6%**	**8.6%**

Houston Area HIV Services Ryan White Planning Council
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713 572-3724 telephone; 713 572-3740 fax
www.rwpchouston.org

FY 2019 How to Best Meet the Need Service Category
Quality Improvement Committee Recommendations Summary (as of 05/16/18)

Those services for which no change is recommended include:

Ambulatory Outpatient Medical Care
Case Management (Medical and Non-Medical Service Linkage)
Early Intervention Services (targeting the Incarcerated)
Emergency Financial Assistance
Health Insurance Premium and Cost Sharing Assistance
Home and Community Based Health Services (Day Treatment)
Hospice Services
Linguistic Services
Local Pharmacy Assistance Program
Medical Nutritional Therapy/Supplements
Mental Health Services
Oral Health (Untargeted and Targeting the Northern Rural Area)
Outreach Services - Primary Care Re-Engagement
Substance Abuse Treatment
Transportation
Vision Care

Services with recommended changes include the following:

Case Management (Clinical)

- Create up to five (5) service linkage worker positions targeting outpatient substance abuse treatment.

Referral for Health Care and Support Services

- Table the discussion on this service category until more information is available.

Table of Contents

FY 2019 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2018 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be

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

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

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

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

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

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

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

	RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication

	refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those**

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=300% +500%, MCM=none, SLW=none.
1. Accept the service definition as presented.	
2. Keep the financial eligibility the same	
3.	

FY 2018 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without

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

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

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

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

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

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

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

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

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

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

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=300% +500%, MCM=none, SLW=none.
1. Accept the service definition as presented.	
2. Keep the financial eligibility the same	
3.	

FY 2018 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the

	subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA

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

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

	• Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements:

	• Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be

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

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

	independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with

	knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.**

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=300% +500%, MCM=none, SLW=none.
1. Accept the service definition as presented.	
2. Keep the financial eligibility the same	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1)

	office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex

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

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

	requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Medical Case Management Services:** Services include screening all

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

	medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and

	certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: PriCare=300%, MCM=none, SLW=none.
1. Accept the service definition as presented.	
2. Keep the financial eligibility the same	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Clinical Case Management** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies.

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

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

	Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term. **Applicant agency must be Medicaid and Medicare Certified**.
Staff Requirements:	Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules. *Must comply with applicable HCPHES/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* <u>Minimum Qualifications:</u> **Clinical Case Managers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish. <u>Supervision:</u> The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the applicant agency and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is <u>not</u> client specific is considered **indirect time** and is not billable.
Special Requirements: **RWGA Only**	Contractor must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent

	(FTE) CCM positions among other contracts or to employ part-time staff. **Contractor must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Contractor must inform RWGA in writing of any changes in personnel assigned to contract within seven (7) business days of change.** Contractor must comply with CPCDMS data system business rules and procedures. Contractor must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers in accordance with HCPHES/RWGA policies and procedures.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: **X**	If approved with changes list changes below:
1. Create up to five (5) service linkage worker positions targeting outpatient substance abuse treatment.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**		Date: **04/24/18**
Recommendations:	Financial Eligibility: None	
1. Explore the concept of bundling or complimenting Clinical Case Management with service linkage targeting HIV+ individuals with substance use disorders. Ask staff to provide the Quality Improvement committee details on how this could be done. It is recommended that the service linkage workers have experience working with substance abuse disorders.		
2. Keep the financial eligibility the same.		
3.		

FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Service Linkage at Testing Sites** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category	**A.** ***Service Linkage:*** Providing allowable Ryan White Program

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

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

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

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

	business rules for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. This service category does not routinely distribute Bus Passes. However, if so directed by RWGA, Contractor must issue bus pass vouchers in accordance with HCPHES/RWGA policies and procedures.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: None
1. Accept the service definition as presented.	
2. Keep the financial eligibility the same	
3.	

Service Category Definition - DSHS State Services
September 1, 2017 - August 31, 2018

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

	Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who are identified by testing in HCJ. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Early Intervention Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/25/18**
Recommendations:	Financial Eligibility: None
1. Accept the service definition as presented and keep the financial eligibility the same	
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FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Pharmacy Assistance** (Revised April 2017)	
HRSA Service Category Title: **RWGA Only**	Emergency Financial Assistance
Local Service Category Title:	Emergency Financial Assistance – Pharmacy Assistance
Budget Type: **RWGA Only**	Hybrid Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
HRSA Service Category Definition: **RWGA Only**	*Emergency Financial Assistance* provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	Emergency Financial Assistance – Pharmacy Assistance provides limited one-time and/or short-term 14-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 14-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed HIV medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA.
Services to be Provided:	Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program

	operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded Emergency Financial Assistance – Pharmacy Assistance or LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.
Service Unit Definition(s): **RWGA Only**	A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
Financial Eligibility:	Refer to the RWPC's approved *FY 2018 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management), Local Pharmacy Assistance Program (LPAP), and Emergency Financial Assistance-Pharmacy services.

Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 500%
1. Accept the service definition as presented.	
2. Keep the financial eligibility the same	
3.	

Service Category Definition - Ryan White Part B Grant
April 1, 2018 - March 31, 2019

Service Category Definition - DSHS State Services Grant
September 1, 2017 - August 31, 2018

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 0-400%; ACA plans must have a subsidy
1. Accept the service definition as presented and keep the financial eligibility the same	
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FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Health Insurance Co-Payments and Co-Insurance Assistance** (Revision Date: 5/21/15)	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.

Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV/AIDS service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review by RWGA. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 0-400%; ACA plans must have a subsidy
1. Accept the service definition as presented and keep the financial eligibility the same	
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Service Category Definition - Ryan White Part B Grant
April 1, 2018 - March 31, 2019

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/25/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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Service Category Definition - DSHS State Services
September 1, 2017 - August 31, 2018

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/25/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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Service Category Definition - DSHS State Services
September 1, 2017 - August 31, 2018

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

Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/25/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Medical Nutritional Therapy** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition: **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected persons living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).
Services to be Provided:	***Supplements:*** The provision of nutritional supplements to eligible clients with a written referral from a licensed physician or PA that specifies frequency, duration and amount and includes a written nutritional plan prepared by a licensed, registered dietician. *Nutritional Supplement Disbursement Counseling* is a component of

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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Service Category Definition - DSHS State Services Grant
September 1, 2017 - August 31, 2018

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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Service Category Definition - Ryan White Part B Grant
April 1, 2018 - March 31, 2019

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

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Oral Health/Rural** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – <u>Rural (North)</u>**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition: **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): **RWGA Only**	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Outreach Services – Primary Care Re-Engagement** Revised June 2017	
HRSA Service Category Title: **RWGA Only**	Outreach Services
Local Service Category Title:	Outreach Services – Primary Care Re-Engagement
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
HRSA Service Category Definition: **RWGA Only**	*Outreach Services* include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Local Service Category Definition:	Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL

	suppression, substance abuse, and ART treatment failure components.
Services to be Provided:	Outreach service is field based. Outreach workers are expected to coordinate activities with PLWHA, including locations outside of primary care clinic in order to develop rapport with individuals and ensuring intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Outreach patients are those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria. Contractor must document efforts to re-engage Primary Care Re-Engagement Outreach patients prior to closing patients in the CPCDMS.
Service Unit Definition(s): **RWGA Only**	TBD
Financial Eligibility:	Refer to the RWPC's approved *FY 2018 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Outreach Services must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Special Workgroup #1**		Date: **04/16/18**
Recommendations:	Financial Eligibility: None	
1. Accept the service definition as presented.		
2. Keep the financial eligibility the same		
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Service Category Definition - DSHS State Services - Rebate (SS-R)
September 1, 2017 - August 31, 2018

Local Service Category:	**Clinic-Based ADAP Enrollment Service Linkage Worker**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Service Linkage Workers (SLWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment SLWs will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with the submission of complete, accurate ADAP applications. ADAP Enrollment SLWs will submit annual re-certifications by the last day of the client's birth month and semi-annual Attestations six months later to ensure there is no the lapse in ADAP eligibility and loss of benefits. Other responsibilities will include: • Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible; • Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible; ADAP Enrollment workers must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program
Services to be Provided:	Services include but are not limited to completion of ADAP applications/six-month attestations/recertifications, gathering of supporting documentation for ADAP applications/six-month attestations/recertifications, submission of ADAP applications/six-month attestations/recertifications, and interactions with clients as part of the ADAP application process.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct client services or coordination of application process on behalf of client.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV in the Houston HDSA
Agency Requirements **(TRG Only)**:	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	The agency must comply with **the DSHS Referral to Healthcare Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_____ No: __X__ Approved With Changes: _____	If approved with changes list changes below:
1. Table the discussion on this service category until more information is available.		
2.		
3.		

Step in Process: **HTBMN Special Workgroup #2**		Date: **04/16/18**
Recommendations:	Financial Eligibility: 300%	
1. Accept the service definition with one change: change 'service linkage worker' to 'ADAP Enrollment Worker' and keep the financial eligibility the same.		
2.		
3.		

FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Substance Abuse Services - Outpatient** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
2.	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Medical Transportation (Van Based)** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report

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

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/25/18**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented and keep the financial eligibility the same	
2.	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Vision Care** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition: **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 10-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV infection, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y__**X**__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #1**	Date: **04/24/18**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same	
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DRAFT

TARGETING FOR FY 2019 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

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

* Geographic targeting in rural area only.

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

*** Geographic targeting in the north only.

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

2018 HHS Federal Poverty Guidelines

Effective Date: January 13, 2018

	Size of Family Unit							
Poverty Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
100%	12,140	16,460	20,780	25,100	29,420	33,740	38,060	42,380
133%	16,146	21,892	27,637	33,383	39,129	44,874	50,620	56,365
150%	18,210	24,690	31,170	37,650	44,130	50,610	57,090	63,570
200%	24,280	32,920	41,560	50,200	58,840	67,480	76,120	84,760
250%	30,350	41,150	51,950	62,750	73,550	84,350	95,150	105,950
300%	36,420	49,380	62,340	75,300	88,260	101,220	114,180	127,140
350%	42,490	57,610	72,730	87,850	102,970	118,090	133,210	148,330
400%	48,560	65,840	83,120	100,400	117,680	134,960	152,240	169,520
450%	54,630	74,070	93,510	112,950	132,390	151,830	171,270	190,710
500%	60,700	82,300	103,900	125,500	147,100	168,700	190,300	211,900

For family units with more than 8 members, add $5,400 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

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

(Quality Improvement Committee approved 05/18/17)

Background

The Ryan White CARE Act requires local Planning Councils to "[a]ssess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area" (Ryan White Part A [formerly Title I] *Manual*, Section V, Chapter 1, Page 4). To meet this mandate, a time-specific documented observation of the local procurement, expenditure, and reimbursement process for Ryan White funds is conducted by the local Planning Councils (*Manual*, Section VI, Chapter 1, Page 7). The observation process is not intended to evaluate either the local administrative agencies for Ryan White funds or the individual service providers funded by Ryan White (*Manual*, Section VI, Chapter 1, Page 8). Instead, it produces information about the procurement, expenditure, and reimbursement process for the local *system* of Ryan White funding that can be used for overall quality improvement purposes.

Process

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

Checklist

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

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

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

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process			
• To assess the timeliness of the AA in authorizing contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	Part A/MAI: (1) NGA; and (2) Commissioner's Court Agendas Part B/SS: (1) DSHS Contract Face Sheet; and (2) Contract Tracking Sheet
• To assess the timeliness of the AA in procuring funds to contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	b) What percentage of the grant award was procured by the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC
• To assess if the AA awarded funds to service categories as designed by the PC	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	c) Did the awarding of funds in specific categories match the allocations established by the PC at the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC Final PC Allocations Worksheet
• To assess if the AAs make potential bidders aware of the grant award process	Confirmation of communication by the AAs to potential bidders specific to the grant award process	d) Does the AA have a grant award process which: ☐ Provides bidders with information on applying for grants? ☐ Offers a bidder's conference?	RFP Courtesy Notices for Pre-Bid Conferences
• To assess if the AAs are requesting bids for service category definitions approved by the PC	Confirmation of communication by the AAs to potential bidders specific to PC products	e) Does the RFP incorporate service category definitions that are consistent with those defined by the PC?	RFP
• To assess if the AAs are procuring funds in alignment with allocations	Comparison of final amounts procured and total amounts allocated in each service category	f) At the end of the award process, were there still unobligated funds?	Year-end FY Procurement Reports provided by AA to PC
• To assess if the AAs are dispersing all available funds for services and, if not, are unspent funds within the limits allowed by the funder	Review of final spending amounts for each service category	g) At the end of the year, were there unspent funds? If so, in which service categories?	Year-end FY Procurement Reports provided by AA to PC

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

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process (con't)			
• To assess if the AAs are making the PC aware of the procurement process	Confirmation of communication by the AAs to the PC specific to procurement results	h) Does the AA have a method of communicating back to the PC the results of the procurement process?	MOU PC Agendas
Section II: Reimbursement Process			
• To assess the timeliness of the AA in reimbursing contracted agencies for services provided	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	a) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA? b) What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: ☐ Within 20 days? ☐ Within 35 days? ☐ Within 50 days?	Annual Contractor Reimbursement Report
Section III: Contract Monitoring Process			
• To assess if the AA is monitoring adherence by contracted agencies to PC quality standards	Confirmation of use of adopted SOC in contract monitoring activities	a) Does the AA use the SOC as part of the contract monitoring process?	RFP Policy and Procedure for Performing Site Visits Quality Management Plan

Priority and Allocations Committee Report

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

FY 2018 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured
1	**Outpatient/Ambulatory Primary Care**	**9,634,415**	**0**	**0**	**0**	**0**	**9,634,415**	**45.02%**	**9,634,415**	**0**	
1.a	Primary Care - Public Clinic (a)	3,520,995	0	0	0		3,520,995	16.45%	3,520,995	0	3/1/2018
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	0	0		940,447	4.39%	940,447	0	3/1/2018
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	0	0		786,424	3.68%	786,424	0	3/1/2018
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,003,821	0	0	0		1,003,821	4.69%	1,003,821	0	3/1/2018
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,127,327	0	0	0		1,127,327	5.27%	1,127,327	0	3/1/2018
1.f	Primary Care - Women at Public Clinic (a)	1,837,964	0	0			1,837,964	8.59%	1,837,964	0	3/1/2018
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2018
1.h	Vision	402,000	0	0	0		402,000	1.88%	402,000	0	3/1/2018
2	**Medical Case Management**	**2,535,802**	**0**	**0**	**0**	**0**	**2,535,802**	**11.85%**	**2,535,802**	**0**	
2.a	Clinical Case Management	488,656	0	0	0		488,656	2.28%	488,656	0	3/1/2018
2.b	Med CM - Public Clinic (a)	482,722	0	0	0		482,722	2.26%	482,722	0	3/1/2018
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	0	0		321,070	1.50%	321,070	0	3/1/2018
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	0	0		321,072	1.50%	321,072	0	3/1/2018
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	0	0		107,247	0.50%	107,247	0	3/1/2018
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.63%	348,760	0	3/1/2018
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.84%	180,311	0	3/1/2018
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.75%	160,051	0	3/1/2018
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.37%	80,025	0	3/1/2018
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2018
3	**Local Pharmacy Assistance Program (a) (e)**	**1,934,796**	**0**	**0**	**0**	**0**	**1,934,796**	**9.04%**	**1,934,796**	**0**	3/1/2018
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.78%**	**166,404**	**0**	3/1/2018
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.78%	166,404	0	3/1/2018
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**
6	**Health Insurance (c)**	**1,244,551**	**500,000**	**0**	**0**	**0**	**1,744,551**	**8.15%**	**323,627**	**1,420,924**	3/1/2018
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.21%**	**45,677**	**0**	3/1/2018
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.60%**	**170,698**	**170,698**	3/1/2018
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.96%**	**420,000**	**0**	**3/1/2018**
13	**Non-Medical Case Management**	**1,231,002**	**0**	**0**	**0**	**0**	**1,231,002**	**5.75%**	**1,231,002**	**0**	
13.a	Service Linkage targeted to Youth	110,793		0			110,793	0.52%	110,793	0	3/1/2018
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			0		100,000	0.47%	100,000	0	3/1/2018
13.c	Service Linkage at Public Clinic (a)	427,000		0	0		427,000	2.00%	427,000	0	3/1/2018
13.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		0	0		593,209	2.77%	593,209	0	3/1/2018
14	**Medical Transportation**	**482,087**	**0**	**0**	**0**	**0**	**482,087**	**2.25%**	**349,865**	**132,222**	
14.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.18%	252,680	0	3/1/2018

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

FY 2018 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured
14.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.45%	97,185	0	3/1/2018
14.c	Transportation vouchering (bus passes & gas cards)	132,222	0	0	0		132,222	0.62%	0	132,222	3/1/2018
15	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**
16	**Emergency Financial Assistance**	**450,000**		**0**	**0**	**0**	**450,000**	**2.10%**	**0**	**450,000**	3/1/2018
17	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA
BES27516	**Total Service Dollars**	**18,486,129**	**500,000**	**0**	**0**	**0**	**18,986,129**	**86.76%**	**16,812,286**	**2,173,844**	
	Grant Administration	**1,675,047**	**0**	**0**	**0**	**0**	**1,675,047**	**7.83%**	**1,675,047**	0	**N/A**
BES27517	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.36%	1,146,388	0	N/A
PC	RWPC Support*	528,659			0	0	528,659	2.47%	528,659	0	N/A
BES27521	**Quality Management**	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.31%**	**495,000**	**0**	**N/A**
		20,656,176	**500,000**	**0**	**0**	**0**	**21,156,176**	**96.90%**	**18,982,333**	**2,173,844**	
								Unallocated	Unobligated		
	Part A Grant Award:	**21,398,944**	***Carry Over:***	**0**		***Total Part A:***	**21,398,944**	**242,768**	**2,173,844**		

		Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent
	Core (must not be less than 75% of total service dollars)	**15,903,040**	**500,000**	**0**	**0**	**0**	**16,403,040**	**86.39%**	**14,811,419**	**85.15%**
	Non-Core (may not exceed 25% of total service dollars)	**2,583,089**	**0**	**0**	**0**	**0**	**2,583,089**	**13.61%**	**2,583,089**	**14.85%**
	Total Service Dollars (does not include Admin and QM)	**18,486,129**	**500,000**	**0**	**0**	**0**	**18,986,129**		**17,394,508**	
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,675,047**	**0**	**0**	**0**	**0**	**1,675,047**	**7.83%**		
	Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.31%**		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment
1	**Outpatient/Ambulatory Primary Care**	**1,797,785**	**24,530**	**0**	**0**	**0**	**1,822,315**	**84.10%**	**1,797,785**	**24,530**	
1.b (MAI)	Primary Care - CBO Targeted to African American	910,163	12,265		0	0	922,428	42.57%	910,163	12,265	3/1/2017
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	887,622	12,265		0	0	899,887	41.53%	887,622	12,265	3/1/2017
2	**Medical Case Management**	**320,100**	**24,528**	**0**	**0**	**0**	**344,628**	**15.90%**	**320,100**	**24,528**	
2.c (MAI)	MCM - Targeted to African American	160,050	12,264				172,314	7.95%			
2.d (MAI)	MCM - Targeted to Hispanic	160,050	12,264				172,314	7.95%	160,050	12,264	
	Total MAI Service Funds	**1,797,785**	**49,058**	**0**	**0**	**0**	**2,166,943**	**100.00%**	**1,797,785**	**369,158**	

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

FY 2018 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured
	Grant Administration	0	0	0	0	0	0	0.00%	0	0	
	Quality Management	0	0	0	0	0	0	0.00%	0	0	
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	
BEO 27516	**Total MAI Funds**	**1,797,785**	**49,058**	**0**	**0**	**0**	**2,166,943**	**100.00%**	**1,797,785**	**369,158**	
	MAI Grant Award	**2,166,944**	***Carry Over:***	**0**		***Total MAI:***	**2,166,944**				
	Combined Part A and MAI Orginial Allocation Total	**22,453,961**									

Footnotes:

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

Operations Committee Report

PROPOSED REVISED TRAVEL EXPENSES

Houston Ryan White Planning Council
FY 2018 Council Support Budget
(Prepared 05-09-18)

		Subtotal	Total
PERSONNEL			
RWPC Manager (V. Williams) ($6621/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$79,446	**$258,002**	
RWPC Health Planner (A. Harbolt) ($6068/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$72,820		
RWPC Coordinator (D. Beck) ($4,718/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$56,611		
Assistant Coordinator (R. Avila) ($4094/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$49,125		
FRINGE		**$118,605**	
Social Security @ 7.65%	$19,737		
Health Insurance (4 x $13,650/FTE)	$54,600		
Retirement @ 14.5%	$37,410		
Workers Compensation @ 0.94%	$2,425		
Supplemental Death Insurance @ 0.50	$1,290		
Unemployment Insurance @ 0.23%	$593		
Incentives/allowances	$2,550		

PROPOSED REVISED TRAVEL EXPENSES

Houston Ryan White Planning Council
FY 2018 Council Support Budget
(Prepared 05-09-18)

		Subtotal	Total
EQUIPMENT Replacement computers to replace obsolete units	$2,000	**$2,000**	
TRAVEL Local travel @ $0.535/mile for Planning Council Support Staff	$500	**$14,360**	
Out of EMA travel: Two out of state trips for Office of Support staff for HIV planning meeting and five in State trips for staff and/or volunteer Council members for statewide HIV Planning meetings	$13,860		
SUPPLIES General consumable office supplies including materials for Council Members and Public Meetings	$5,000	**$5,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$99,077**	
Resource Guide	$2,921		
Needs Assessment Activities	$5,000		
Reimbursement for PC member expenses: Reimbursement for travel, childcare, meals and other eligible expenses resulting from participation in Council approved/ HRSA grant required activities.	$23,686		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (phone, pagers): For local and long distance phone expenses and internet charges.	$3,500		
Web Page Technical Assitance Costs: For additional training/consultation to staff in order to update/improve web site.	$500		

PROPOSED REVISED TRAVEL EXPENSES

Houston Ryan White Planning Council
FY 2018 Council Support Budget
(Prepared 05-09-18)

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

Proposed
Budget for the
2020-2021 Blue Book

FY 2019 Budget – Prepare the new Blue Book for printing

Graphic Design	5,000
Updating the Book (in house)	0
Spanish Translation	2,000
Software	1,000
FY 2019 TOTAL	**$ 8,000**

FY 2020 Budget – Print and release the new Blue Book

Advertising	3,000
App Support	1,000
Postage	4,000
Storage Unit ($180/month x 10 months)	1,800
Printing 30,000 copies ($1.50/book)**	45,000*
FY 2020 TOTAL	**$ 54,800**

TOTAL COST OF THE 2019-2020 BLUE BOOK **$62,800**

* The exact cost of reproducing the 2020–2021 Blue Book is not available at this time since the largest budget item, which is the cost of printing, fluctuates with the price of oil/ink.

** Historically, the Office of Support has printed 50,000 copies of the Blue Book and another 15,000 in reprints. In 2018, requests for hard copies of the book have decreased significantly, possibly because the book is being accessed online.

Comparison of FY 2018 and 2019 Council Support Budgets

(Prepared 05-09-18)

Item	Current FY 2018 Budget	Proposed FY 2019 Budget	Difference Between FY 2018 and FY 2019 Budgets
Salaries	$258,002	$258,002	
Fringe	118,605	118,605	
Equipment	2,000	2,000	
Travel	14,360	3,500	- 10,860
Supplies	5,000	5,000	
Blue Book	2,921	8,000	+ 5,079
Needs Assessment	5,000	10,700	+ 5,700
Planning Council Expenses	23,686	23,686	
Advertising	6,000	6,000	
Communications	3,500	3,500	
Web Page	500	500	
Council Education	4,000	4,000	
Project LEAP	15,000	15,000	
Consumer Education	16,220	11,220	- 5,000
Translation	2,500	2,500	
Fees and Dues	500	500	
Postage	10,000	10,000	
Copier	9,250	9,250	
TOTAL	$497,044	$491,963	- 5,081

Houston Ryan White Planning Council
FY 2019 Council Support Budget
(Prepared 05-09-18)

		Subtotal	Total
PERSONNEL			
RWPC Manager (V. Williams) ($6621/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$79,446	**$258,002**	
RWPC Health Planner (A. Harbolt) ($6068/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$72,820		
RWPC Coordinator (D. Beck) ($4,718/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$56,611		
Assistant Coordinator (R. Avila) ($4094/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$49,125		
FRINGE		**$118,605**	
Social Security @ 7.65%	$19,737		
Health Insurance (4 x $13,650/FTE)	$54,600		
Retirement @ 14.5%	$37,410		
Workers Compensation @ 0.94%	$2,425		
Supplemental Death Insurance @ 0.50	$1,290		
Unemployment Insurance @ 0.23%	$593		
Incentives/allowances	$2,550		

Houston Ryan White Planning Council
FY 2019 Council Support Budget
(Prepared 05-09-18)

		Subtotal	Total
EQUIPMENT Replacement computers to replace obsolete units	$2,000	**$2,000**	
TRAVEL		**$3,500**	
Local travel @ $0.535/mile for Planning Council Support Staff	$500		
Out of EMA travel: Two out of state trips for Office of Support staff for HIV planning meeting and five in State trips for staff and/or volunteer Council members for statewide HIV Planning meetings	$3,000		
SUPPLIES General consumable office supplies including materials for Council Members and Public Meetings	$5,000	**$5,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$104,856**	
Resource Guide	$8,000		
Needs Assessment Activities	$10,700		
Reimbursement for PC member expenses: Reimbursement for travel, childcare, meals and other eligible expenses resulting from participation in Council approved/ HRSA grant required activities.	$23,686		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (phone, pagers): For local and long distance phone expenses and internet charges.	$3,500		
Web Page Technical Assitance Costs: For additional training/consultation to staff in order to update/improve web site.	$500		

Houston Ryan White Planning Council
FY 2019 Council Support Budget
(Prepared 05-09-18)

		Subtotal	Total
Council Education: For speakers & training costs primarily for room rentals & the cost of speakers for ongoing training to insure that key decision-makers receive necessary & relevant information. This includes the January Orientation and one Council meeting to be held off-site in Harris County.	$4,000		
Project LEAP Student Reimbursement: 30 participants for 17 week course including travel, childcare and other eligible expenses resulting from participation in Council approved training activities related to the HRSA grant.	$5,500		
Project LEAP Education: Training costs for 17 weeks including speaker fees, room rental for off-site meetings & educational materials.	$9,500		
Consumer Education: Training costs for 5 seminars including speaker fees & room rental for off-site meetings & educational materials.	11,220		
Interpreter Services For Spanish-speaking and sign-language interpretation services during public meetings, focus groups, etc.	$1,500		
Fees and Dues Registration costs for attending meetings, trainings and conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council materials into Spanish.	$1,000		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$10,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used for Council and Office of Support.	$9,250		
TOTAL			**$491,963**

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL

EST. JULY 10, 2008 **REV JANUARY 1, 2018** **POLICY No. 400.03**

PROCESS FOR APPROVING THE COUNCIL SUPPORT BUDGET

PURPOSE

This policy is to establish the process used to review and approve the annual budget for the Houston Area HIV Health Services Ryan White Planning Council and the Council Support Staff.

AUTHORITY

The authority given to the Operations Committee by the Council regarding adoption and approval of By-laws Rev. 01/18 and under the order of the Chief Elected Official (CEO) of Harris County, initiate procedures by which day to day business of the Council is to take place. According to the Ryan White HIV/AIDS Treatment Extension Act of 2009, and a letter of guidance issued by the HIV/AIDS Bureau (April 26, 2007) "Section 2604(h) specifies that the chief elected official of an eligible area shall not use in excess of 10 percent of amounts received under a Part A grant for administrative expenses. The amounts may be used for administrative activities that include all activities associated with the grantee's contract award procedures, including activities carried out by the HIV Health Services Planning Council as established under section 2602 (b) of the Act… While Part A Planning Councils may use Ryan White Program funds to support certain activities related to carrying out required functions, the Planning Council must also work with the grantee to agree on a budget for Planning Council support activities. Reasonable and necessary activities include both tasks directly related to legislative functions and the following costs that support multiple functions:

- Staff support (professional and clerical)
- Expenses of Planning Council members as a result of their participation
- Activities publicizing the Planning Council's activities for people living with HIV and efforts to substantively enhance community participation in Planning Council activities
- Developing and implementing Planning Council grievance procedures for decisions related to funding."

INTENT

Create an atmosphere of mutual respect and transparency as the Council works with the CEO and the grantee to agree on the annual Council Support budget.

PROCEDURE

The following describes the steps to be followed in order to secure approval of the Council Support budget:

1. The Manager of the Office of Support prepares a proposed budget.
2. The Manager distributes the proposed budget to members of the Operations Committee, the liaison to the CEO and the manager of Harris County Public

Health/Ryan White Grants Administration Section (the "grantee").

3. The grantee reviews the budget in terms of Ryan White Program guidelines and discusses any concerns with both the Manager of the Office of Support and the assigned liaison to the CEO.
4. The Manager conveys this input to the Operations Committee when they meet to review and make recommendations on the proposed budget.
5. The Operations Committee reviews the budget to make sure that it supports activities related to carrying out the legislatively mandated role of the Council and prepares a committee recommendation regarding the proposed budget.
6. The Steering Committee and Council review and vote on the recommendations of the Operations Committee regarding the Council Support budget.
7. The Manager provides the grantee with the Council approved budget.
8. The grantee reviews the budget and provides written confirmation to the Manager of the Office of Support and the liaison with the County Judge's Office stating that the budget is consistent with HRSA requirements and County rules and no changes are necessary. If the budget is not consistent with HRSA requirements and County rules, the budget is returned to the Manager of the Office of Support who revises the budget and begins the process at Step 1 as described above.

Training Topics for 2018 Ryan White Planning Council Meetings (updated: 05/07/18)

DRAFT

Shading = may be room on agenda for a second speaker

Month	Topic	Speaker
January 25 2018	Council Orientation	See Orientation agenda
February 8	Open Meetings Act Requirements	Venita Ray, Legacy Community Health
March 8	2018 HIV Comprehensive Plan: Council Activities How To Best Meet the Need Training & Process	Amber Harbolt, Health Planner, Office of Support Denis Kelly & Gloria Sierra, Co-Chairs, Quality Improvement Committee
April 12	Houston HSDA HIV Care Continuum	Ann Dills, Texas Dept. of State Health Services
May 10 **CANCELLED**	**Postponed:** Molecular HIV Surveillance: Cluster Response and Community Engagement	Camden Hallmark, Analyst, Houston Health Department
June 14	Project LEAP Presentation Updates from DSHS* (10 min.)	2018nProject LEAP Students Shelley Lucas, Texas Dept. of State Health Services (DSHS)
July 12	Priority Setting and Allocations Processes	Peta-gay Ledbetter & Bruce Turner, Co-Chairs, Priority & Allocations Committee
August 9	Molecular HIV Surveillance: Cluster Response and Community Engagement	Camden Hallmark, Analyst, Houston Health Department
September 13	To be determined	
October 11	EIIHA Update TENTATIVE: Intimate Partner Violence and HIV	Amber Harbolt, Health Planner Heather Keizman, RN, RW Grant Administration
November 8	We Appreciate Our External Members Election Policy	Cecilia Oshingbade, Chair, Ryan White Planning Council Ella Collins-Nelson and Johnny Deal, Co-Chairs, Operations Committee
December 6	Elections for the 2019 Officers Updates from DSHS* (30 min.)	Ella Collins-Nelson and Johnny Deal, Co-Chairs, Operations Committee Shelley Lucas, Texas Dept. of State Health Services (DSHS)

Requests: *Dept. of State Health Services (DSHS Updates) (2 x per year)
Transgender Health Issues by Dr. Lake – recommended by Dr. Patel
Training in how to be a good committee participant: keep questions related to the topic

2018 QUARTERLY REPORT
OPERATIONS COMMITTEE
(submit May 2018)

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

1. Design and implement Orientation for Council members and new external committee members in January and February 2018.
   Status: Completed

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

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

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

5. *Investigate and make recommendations regarding complaints and grievances brought before the committee in order to assure member/staff compliance with bylaws, policies, and procedures.
   Status: No complaint or grievance received

6. *Resolve any grievances brought forward.
   Status: see above

7. *Make nominations to the CEO, which ensure the reflectiveness and representativeness of the Council.
   Status: do in FALL 2018

8. Evaluate the performance of the Manager in conjunction with the Planning Council Chair and CEO.
   Status: Due in Dec. 2018

9. Ensure that the Council is complying with HRSA, County and other open meeting requirements.
   Status: on going

10. Annually, review the status of Committee activities identified in the Comprehensive Plan.
    completed in Feb. 2018

Status of Tasks on the Timeline:

Committee Chairperson

5-22-18
Date

FYI

Hosted by
Positive713

Educational
Social Group

** Attention **

Free Educational
Dinner Program

For people
Living with
HIV

An Option to Maintain Viral Suppression for Patients

WHEN: Monday, June 11, 2018
6:00pm Dinner Presentation

WHERE: Saltgrass Steak House
1803 Shepherd Drive. Houston, TX 77007
Held in Private Meeting Room

RSVP: To RSVP or more information
Contact: Chris
713-965-4483 or chris77038@yahoo.com

HIV and Older Adults | Understanding HIV/AIDS

HIV and Older Adults

Last Reviewed: April 2, 2018

Key Points

- According to the Centers for Disease Control and Prevention (CDC), in 2014, an estimated 45% of Americans living with diagnosed HIV were aged 50 and older.
- Many HIV risk factors are the same for adults of any age, but older people are less likely to get tested for HIV.
- Treatment with HIV medicines (called antiretroviral therapy or ART) is recommended for everyone with HIV. Life-long treatment with HIV medicines helps people with HIV live longer, healthier lives.
- Many older adults have conditions such as heart disease or diabetes that can complicate HIV treatment.

Does HIV affect older adults?

Yes, anyone—including older adults—can get HIV. According to the Centers for Disease Control and Prevention (CDC), in 2014, an estimated 45% of Americans living with diagnosed HIV were aged 50 and older.

The population of older adults living with HIV is increasing for the following reasons:

- Many people who received an HIV diagnosis at a younger age are growing older. Life-long treatment with HIV medicines (called antiretroviral therapy or ART) is helping these people live longer, healthier lives.
- Thousands of older people become infected with HIV every year.

For these reasons, the population of people living with HIV will increasingly include older adults.

Are the risk factors for HIV the same for older adults?

Many risk factors for HIV are the same for adults of any age. But like many younger people, older adults may not be aware of their HIV risk factors. HIV is most commonly spread by:

- having sex without using a condom with someone who is HIV positive or whose HIV status you don't know; or
- injecting drugs and sharing needles, syringes, or other drug equipment.

Some age-related factors also put older adults at risk for HIV infection. For example, older adults who begin dating again after a divorce or the death of a partner may not use condoms if they are unaware of the risk of HIV.

Age-related thinning and dryness of the vagina may increase the risk of HIV infection in older women. In addition, women who are no longer concerned about pregnancy may not use a female condom or ask their partners to use a male condom during sex.

Talk to your health care provider about your risk of HIV infection and ways to reduce your risk.

Should older adults get tested for HIV?

CDC recommends that everyone 13 to 64 years old get tested for HIV at least once and that people at high risk of infection get tested more often. Your health care provider may recommend HIV testing if you are over 64 and at risk for HIV infection.

For several reasons, older people are less likely to get tested for HIV:

- Health care providers may not think to ask older adults about their HIV risk factors, including sexual activity, and may not recommend HIV testing.
- Some older people may be embarrassed to discuss HIV testing with their health care providers.
- In older adults, signs of HIV infection may be mistaken for symptoms of aging or of age-related conditions. Consequently, HIV testing is often not offered to older adults.

For these reasons, HIV is more likely to be diagnosed at an advanced stage in many older adults. When diagnosed late, HIV is more likely to advance to AIDS.

Ask your health care provider whether HIV testing is right for you. Use these questions from healthfinder.gov to start the conversation: HIV Testing: Questions for the doctor.

Is HIV treatment the same for older adults?

Treatment with HIV medicines is recommended for everyone with HIV, and HIV treatment recommendations are the same for older and younger adults. However, age-related factors can complicate HIV treatment in older adults.

- Liver and kidney functions decline with age. This decline may make it harder for the body to process HIV medicines and increase the risk of side effects.
- Older adults with HIV may have other conditions, like diabetes and heart disease, that can make it more difficult to manage HIV infection. In addition, HIV may affect the aging process and increase the risk of age-related conditions such as dementia, bone loss, and some cancers. Taking HIV medicines and medicines for other conditions at the same time may increase the risk of drug-drug interactions and side effects.
- The immune system may not recover as well or as quickly in older adults taking HIV medicines as it does in younger people.

Despite these age-related factors, some studies have shown that older adults are more adherent to their HIV medicine regimens—meaning they take their HIV medicines every day and exactly as prescribed—than younger adults.

Where can I find more information about HIV and aging?

Click on the links below to find more information about HIV and aging. This fact sheet is based on information from these sources:

From CDC:

- HIV Among People Aged 50 and Over

From the Department of Health and Human Services:

- Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV: HIV and the Older Patient

From the National Institute on Aging:

- HIV, AIDS, and Older People

The Truth About the 7,000

Why are there still so many AIDS-related deaths?

April 2, 2018 By Mark S. King

A friend of mine, Antron-Reshaud Olukayode, died of an AIDS-related illness a few months ago. He was an Atlanta-based writer and HIV advocate. The news was quite a shock for me because an empowered person living with HIV isn't supposed to die at age 33. Or so I believed.

During Antron's last hospital stay, his friend Nina Martinez brought him food and comfort. "Antron was having trouble getting on his feet. Something was hurting," she tells me during a conversation in which she doubted her choice to be open about the details, to tell the truth of it. "And then Antron pulled down his sock and showed me a black lesion on the bottom of his foot."

Nina immediately recognized the spot as Kaposi's sarcoma, known as KS, an often deadly AIDS-defining cancer. You can regularly see it on the faces and bodies of people with AIDS in old photos and documentaries. People think it doesn't happen anymore. They're wrong.

Nina herself is HIV positive. She contracted the virus through a blood transfusion when she was a few weeks old. She knows all too well the cunning ways that HIV can damage a body. Because people on effective treatment don't just end up with late-stage complications, she realized that Antron had not been taking his medications, probably for a long time. Looking at Antron's foot, Nina asked him whether the spot was KS.

"Antron looked at me and said yes," Nina recalls, with the exhaustion of fresh grief in her voice, "and then there was this release, like a pressure cooker, and he started to cry. Antron was afraid of being judged. I wasn't going to judge him, but he knew his community would."

Antron had been a visible HIV advocate and volunteer, even appearing in a national media campaign by the Centers for Disease Control and Prevention as someone living with HIV. But somewhere along his journey, things changed. He seemed depressed. Medications stopped. Very few of his friends understood what was happening, much less what to do about it. Antron was an AIDS death hiding in plain sight.

A few days after his conversation with Nina, Antron lost his ability to speak. His family took him home to die in the town he had once escaped. His obituary did not mention AIDS.

I wasn’t going to judge him.

But he knew his community would.

Antron became one of the nearly 7,000 HIV-positive people who die of causes directly attributable to the virus every year in the United States. It’s a stunning number to reconcile in this day and age, and its effects multiply many times over when you include the grieving families and confused friends and frustrated clinicians. Each one of those 7,000 people represents a life that wasn’t supposed to end, at least not to incredulous onlookers who don’t understand how or why anyone with HIV could die anymore.

It’s a fair question, the why of it. Why would anyone never get an HIV test, ignore symptoms, stop their medications or hide their illness? Who exactly are these 7,000 people? What the hell happened?

In search of answers, I talked to workers on the front lines, in clinics and hospitals and community agencies. I talked to patients and activists and people in waiting rooms. Most of them were eager to share what they have seen. Very few wanted to be identified. The truth can be uncomfortable.

What I discovered is that when you ask why, there are so many, so terribly many, answers to the question.

In the first decades of AIDS, testing HIV positive meant joining a community in which you were embraced by an enormous support network. We had no choice but to be open about our HIV status because our very lives were at stake. Long-term survivors and community elders passed along shared history and survival skills.

Not anymore. People who test positive for the virus today often face the health care labyrinth alone. Some prefer it that way because they have a good doctor and pharmacy benefits and their status is none of your business. They are entitled, yes, indeed, to their privacy and to their limited interaction with what passes for an HIV community these days by showing up once a year for a walkathon that has stripped AIDS from its name and replaced the disfigured gay men in wheelchairs with baby strollers and French bulldogs and chicken on a stick.

Welcome to the public face of HIV in 2018. It is a parade, and it is warranted because there is so much to celebrate, after all. The parade has billboards at busy intersections and posts on Instagram. It has the pretty faces of empowered HIV-negative people taking pre-exposure prophylaxis, or PrEP, and people living with HIV taking pride in their undetectable viral load.

There are T-shirts and ball caps and posters. There are online memes and funny web videos and signs you hold up when you smile for the camera and blogs with names like—God, help me—My Fabulous Disease.

It is a parade we have all helped to create. It is a privileged affair, with few people talking about the homelessness and poverty and drug addiction that percolate upward from the forlorn and the forgotten. Meanwhile, HIV stigma keeps spreading over the spectacle like a rolling fog.

The 7,000 people who will die this year can't hear the happy jamboree from the lonely confines of their apartment or hospital bed or shelter or prison cell. If they could, they might think we have all lost our fucking minds.

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Campaigns that seek to normalize people living with HIV are missing an important truth, according to long-term survivor and activist Matt Ebert. "U=U feels like a lie," he tells me, referring to the award-winning "Undetectable Equals Untransmittable" campaign heralding the fact that people with an undetectable viral load cannot transmit HIV. Matt believes the science of it, but the word standing in the middle of the catchphrase makes him cringe.

"I am not equal to someone who is negative," Matt contends, "not in the way I am treated and not in the way I feel. These campaigns try to promote our sameness, but testing HIV positive is the same shot to the heart it has always been."

"If I got HIV today, I would be devastated," Matt explains. "It's a very big deal. HIV affects every decision I make. People say I should be grateful to be alive. Well, it doesn't work that way. No wonder people stop taking their meds."

"And," Matt adds pointedly, he feels this way despite being "white and privileged."

Activist Kairo Brown, who founded the organization Meet for a Cause to help impoverished LGBTQ youth in Baltimore, doesn't have time for endless discussions of privilege or racism, as bad as it may be, because he is consumed by the daily struggle for survival among those he serves. "I hear us blame white people," Kairo says, "but what about what we as Black people are doing to other Black people? We must unite as a community."

There is meager social support within the Black community for people living with HIV, Kairo believes. Many young Black men are trying to deal with their own feelings of brokenness, with their search for a crowd that will welcome them, even if for some it means never returning for treatment after testing positive because the price of transparency in their circle of friends is much too high. As in every other community, women are often left to fend almost entirely for themselves.

Community workers across the spectrum told me about impoverished clients who fill out clinic surveys in exchange for financial incentives, checking any box at all, signing anything handed to them, because they need a free bus pass a lot more than they care about the data making sense. They know people who allow themselves to become sick, treating HIV symptoms with an Advil from the gas station, because they believe illness will get them more services.

Case managers told me about clients who tested positive and then scoured the internet, searching for another answer that might explain things away, falling victim to fake potions and frauds, because a bullshit answer is better than the one that says HIV.

HIV providers talk of clients who store their medications under bushes because the shelter doesn't have lockers. They watch the treatment regimens of their patients start and stop at roughly the same rate as their monthly hospitalizations, when drugs are dripped from IV bags in a mad scramble to repair the damage. They draw blood from people addicted to opioids using the arm that hasn't been amputated because of an infected abscess.

And all the people living with HIV in the margins of our society, advocates and sex workers and mothers and addicts and case managers alike, know they are one disconnected cell phone, one bout of depression, one missed bus, one part-time paycheck away from total devastation.

There are even revelers in the grand parade who are privately troubled, who grit their teeth when they smile, who haven't admitted that it has been months since they took their meds because the co-pay got too expensive or the fatigue of it all has become too much to bear, who have chosen to delay treatment until things get bad or until they find a cheaper apartment or until some unseen solution comes along. It might. It might not.

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These AIDS-related complications are real, and they exist in a world far away from happy Facebook status updates. Traveling the distance between them might as well be crossing the galaxy.

And yet, mercifully, even in the midst of all these challenges, success stories and moments of grace exist.

Brent Bible took an HIV test when he was 17 years old as a requirement to enter a teen drug rehab program. "They called me and said to come back in and bring my mom," Brent tells me. "When they said I was positive, my mom broke down. But I was like, Everything is OK. I'm not going to cry about it."

Sometimes, youthful resilience is nothing of the kind. The next day, Brent tried to kill himself.

"It didn't work," Brent says. "So, I just said, Fuck it, I'll party." He escaped his troubles—the absent dad and the addicted mother and the challenges of being a gay Black man—by defiantly choosing hard drugs over HIV medications. He remembers that time with tears in his eyes. "It was hard, for so many years," Brent tells me. He's 29 years old now, but some things still haunt him.

Brent eventually pulled himself from the brink, but getting HIV care required a stability he hadn't yet achieved. "I didn't have a place to stay," he tells me, "and I needed proof of where I lived, proof of this and proof of that. And I wasn't working and didn't have transportation. Some places were no help at all." Today, Brent makes his doctor appointments and takes his meds, and his viral

load is undetectable. He knows he is lucky. He knows people who were broken by the pressure of life with HIV.

“Being around them, they seemed happy,” Brent recalls, remembering several friends in their 20s who are now lost to AIDS, “but behind closed doors, they might just be done with it all. You just don’t know. You never really know.”

We have a collective responsibility to Brent, to help him rise above the stigma, to continue his treatment in the months and years ahead, to ask him uncomfortable questions when he says he is just fine, to teach him survival skills and to assure him that everyone living with HIV doesn’t always feel as happy as they look on the posters.

Because the statistic that 7,000 people will die simply waits, year after year, to be satisfied. Because depression and fatigue can undermine the will to live. Because people deserve the truth about life with HIV and the support to face it. Because we don’t want to be shocked all over again and left wondering why.

Because you never really know.

Mark S. King was diagnosed with HIV in 1985. His blog, My Fabulous Disease, has been nominated for a 2018 GLAAD Media Award.

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https://www.poz.com/article/truth-about-the-7000