2024 Ryan White Planning Council Manual

Houston EMA Ryan White Planning Council

Mission Statement

The Houston EMA Ryan White Planning Council will improve the quality of life and advocate for those living with HIV and /or affected by HIV by taking a leadership role in the planning and assessment of HIV Resources.

Vision Statement

We envision an educated community where the needs of all people 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 until the end of the epidemic.

Goals

1. Collaborate with and utilize information from all constituencies to plan and deliver high quality and cost effective care.
2. Identify and provide services to unserved and underserved populations.
3. Promote the dissemination of information on HIV prevention, treatment and resources.

Ryan White Planning Council
2024 Membership

Josh Mica, Chair

Ardry "Skeet" Boyle, Vice Chair

Ryan Rose, Secretary

Kevin Aloysius

Servando Arellano

Yvonne Arizpe

Jay Bhowmick

Caleb Brown

Titan Capri

Johanna Castillo

Tony Crawford

Johnny Deal

Kathryn Fergus

Kenia Gallardo

Glen Hollis

Kenneth Jones

Denis Kelly

Peta-gay Ledbetter

Cecilia Ligons

Roxane May

Rodney Mills

Norman Mitchell

Diana Morgan

Shital Patel

Bill Patterson

Oscar Perez

Tana Pradia

Paul Richards

Beatriz E.X. Rivera

Pete Rodriguez

Yolanda Ross

Megan Rowe

Evelio Salinas Escamilla

Jose Serpa-Alvarez

Imran Shaikh

Robert Sliepka

Crystal Renee Starr

Carol Suazo

Steven Vargas

Mike Webb

Priscilla Willridge

2024 Ryan White Planning Council

WORKING STANDING COMMITTEE LIST

(Updated 1-16-24)

Red Text = 2024 Committee Mentor Blue Text = New Council member Green = Committee Vice Chair

STEERING	
Josh Mica, RWPC Chair	Cecilia Ligons, Co-Chair, Operations
Skeet Boyle, Vice Chair	Crystal Starr, Co-Chair, Operations
Ryan Rose, Secretary	Peta-gay Ledbetter, Co-Chair, Priority and Allocations
Johnny Deal, Co-Chair, Affected Community	Rodney Mills, Co-Chair, Priority and Allocations
Carol Suazo, Co-Chair, Affected Community	Tana Pradia, Co-Chair, Quality Improvement
Kenia Gallardo, Co-Chair, Comprehensive HIV Planning	Pete Rodriguez, Co-Chair, Quality Improvement
Robert Sliepka, Co-Chair, Comprehensive HIV Planning	

AFFECTED COMMUNITY			
1. Johnny Deal, Co-Chair	7. Kathryn Fergus	*Affiliate Members*	
2. Carol Suazo, Co-Chair	8. Cecilia Ligons		
3. Servando Arellano	9. Tana Pradia		
4. Skeet Boyle	10. Ryan Rose		
5. Caleb Brown	11. Evelio Salinas Escamilla		
6. Tony Crawford			

COMPREHENSIVE HIV PLANNING			
1. Kenia Gallardo, Co-Chair	8. Shital Patel	*Affiliate Members*	
2. Robert Sliepka, Co-Chair	9. Beatriz E.X. Rivera		
3. Jay Bhowmick	10. Evelio Salinas Escamilla		
4. Johanna Castillo	11. Jose Serpa-Alvarez		
5. Titan Capri	12. Imran Shaikh		
6. Glen Hollis	13. Steven Vargas		
7. Kenneth Jones			

OPERATIONS			
1. Cecilia Ligons, Co-Chair	4. Johnny Deal	7. Priscilla Willridge	
2. Crystal Starr, Co-Chair	5. Bill Patterson		
3. Skeet Boyle	6. Ryan Rose		

PRIORITY AND ALLOCATIONS			
1. Peta-Gay Ledbetter, Co-Chair	6. Paul Richards	*Affiliate Members*	
2. Rodney Mills, Co-Chair	7. Megan Rowe		
3. Jay Bhowmick	8. Priscilla Willridge		
4. Roxane May			
5. Bill Patterson			

QUALITY IMPROVEMENT			
1. Tana Pradia, Co-Chair	7. Denis Kelly	*Affiliate Members*	
2. Pete Rodriguez, Co- Chair	8. Diana Morgan		
3. Kevin Aloysius	9. Beatriz E.X. Rivera		
4. Yvonne Arizpe	10. Yolanda Ross		
5. Caleb Brown	11. Evelio Salinas Escamilla		
6. Glen Hollis	12. Mike Webb		

(Over)

2024 Ryan White Planning Council

(not yet updated) PROJECT LEAP ADVISORY COMMITTEE			
1. Kenia Gallardo, Co-Chair	9. Tana Pradia	*External Members:*	
2. Robert Sliepka, Co-Chair	10. Ryan Rose	*1. Ashley Barnes*	
3. Servando Arellano		*2. Johnny Deal*	
4. Skeet Boyle		*3. Herman Finley*	
5. Caleb Brown		*4. Mary L. Guidry*	
6. Ronnie Galley		*5. Deborah Hurd*	
7. Josh Mica			
8. Allen Murray			

Houston Area HIV Services Ryan White Planning Council
Standing Committee Structure

(Reviewed 01-14-20)

1. Affected Community Committee

This committee is designed to acknowledge the collective importance of consumer participation in Planning Council (PC) strategic activities and provide consumer education on HIV-related matters. The committee will serve as a place where consumers can safely and in an environment of trust discuss PC work plans and activities. This committee will verify consumer participation on each of the standing committees of the PC, with the exception of the Steering Committee (the Chair of the Affected Community Committee will represent the committee on the Steering Committee).

When providing consumer education, the committee should not use pharmaceutical representatives to present educational information. Once a year, the committee may host a presentation where all HIV/AIDS-related drug representatives are invited.

The committee will consist of HIV+ individuals, their caregivers (friends or family members) and others. All members of the PC who self-disclose as HIV+ are requested to be a member of the Affected Community Committee; however membership on a committee for HIV+ individuals will not be restricted to the Affected Community Committee.

2. Comprehensive HIV Planning Committee

This committee is responsible for developing the Comprehensive Needs Assessment, Comprehensive Plan (including the Continuum of Care), and making recommendations regarding special topics (such as non-Ryan White Program services related to the Continuum of Care). The committee must benefit from affiliate membership and expertise.

3. Operations Committee

This committee combines four areas where compliance with Planning Council operations is the focus. The committee develops and facilitates the management of Planning Council operating procedures, guidelines, and inquiries into members' compliance with these procedures and guidelines. It also implements the Open Nominations Process, which requires a continuous focus on recruitment and orientation. This committee is also the place where the Planning Council self-evaluations are initiated and conducted.

This committee will not benefit from affiliate member participation except where resolve of grievances are concerned.

4. Priority and Allocations Committee

This committee gives attention to the comprehensive process of establishing priorities and allocations for each Planning Council year. Membership on this committee does include affiliate members and must be guided by skills appropriate to priority setting and allocations, not by interests in priority setting and allocations. All Ryan White Planning Council committees, but especially this committee, regularly review and monitor member participation in upholding the Conflict of Interest standards.

5. Quality Improvement Committee

This committee will be given the responsibility of assessing and ensuring continuous quality improvement within Ryan White funded services. This committee is also the place where definitions and recommendations on "how to best meet the need" are made. Standards of Care and Performance Measures/Outcome Evaluation, which must be looked at within each year and monitored from this committee. Whenever possible, this committee should collaborate with the other Ryan White planning groups, especially within the service categories that are also funded by the other Ryan White Parts, to create shared Standards of Care.

In addition to these responsibilities, this committee is also designed to implement the Planning Council's third legislative requirement, assessing the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, or assessing how well the grantee manages to get funds to providers. This means reviewing how quickly contracts with service providers are signed and how long the grantee takes to pay these providers. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the Planning Council and whether all the funds are spent. This Committee may benefit from the utilization of affiliate members.

BYLAWS of the
HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL
Revised October 14, 2021

ARTICLE I

Establishment, Definitions and Purposes

Section 1.01. Establishment. The Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 USC §300ff et. seq. (West 1991 & Supp. 1997),), later revised as the Ryan White HIV/AIDS Treatment Extension Act of 2009, requires the establishment of an HIV health services planning council by the chief elected official of the eligible area involved, as defined in §300ff 12(a)(1) of the Act. The County Judge (as hereinafter defined) has established the Ryan White Comprehensive AIDS Resources Emergency Act HIV Health Services Planning Council in conformity to Section §300ff 12(a)(1) of the Act. The Council, as established by the County Judge, is not incorporated under the Laws of the State of Texas or any other jurisdiction.

Section 1.02. Definitions. The following definitions shall have the ascribed meaning when used herein, except to the extent the context hereof clearly requires and indicates otherwise:

"Acquired Immune Deficiency Syndrome" (AIDS) is defined by the current criteria established by the Centers for Disease Control (CDC).

"Act" is defined as the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 USC §300ff et.seq.(West 1991 & Supp. 1997), later revised as the Ryan White HIV/AIDS Treatment Extension Act of 2009.

"AIDS" is defined as Acquired Immune Deficiency Syndrome.

"Ryan White Grant Administration" is defined as the section of Harris County Public Health that administers grant funds allocated to the "Eligible Metropolitan Area" under the Act.

"Council" is defined as the Ryan White HIV Health Services Planning Council established by the County Judge.

"County Judge" is defined as the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals living with HIV, as defined in §300ff 12(a)(1) of the Act and herein refers to the duly elected County Judge of Harris County, Texas.

"Eligible Metropolitan Area" is defined as the Houston/Harris County Area which area has been determined by the Centers for Disease Control to consist of Harris County, Waller County, Fort Bend County, Montgomery County, Chambers County and Liberty County.

"Emergency" is defined as an unforeseen combination of circumstances or the resulting state that

calls for immediate action.

"HIV" is defined as the Human Immunodeficiency Virus.

"HIV Infection" is defined as the presence of HIV in the bloodstream as confirmed by the diagnostic tests prescribed by the Centers for Disease Control.

"HRSA" is defined as the Health Resources Services Administration of the Public Health Service of the United States Department of Health and Human Services.

"HSDA" is defined as the Texas Department of Health Services Delivery Area.

"RFPs" is defined as Request for Proposals.

Section 1.03. Purposes. The purposes for which the Council is established are:

(1) To conduct needs assessment activities;

(2) To develop a comprehensive plan for the organization and delivery of health services described in §300ff 14 of the Act that is compatible with any existing State of Texas or local plan regarding the provision of health services to individuals living with HIV;

(3) To establish priorities for the allocation of funds within the Eligible Metropolitan Area;

(4) To allocate funds within the Eligible Metropolitan Area;

(5) To assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the Eligible Metropolitan Area.

ARTICLE II

Appointment of Council, Composition of Council, Term and Compensation

Section 2.01. Appointment of Council. All members of the Council shall be appointed by the County Judge. Vacancies occurring on the Council shall be filled by appointment of the County Judge and serve at the pleasure of the County Judge. All candidates are subject to the established Nominations Screening process, with the exception of persons representing HRSA required governmental bodies, including the State Medicaid Agency, HOPWA and others.

Section 2.02. Composition of Council. The Planning Council will be made up of individuals as specified in Sec.2602(2) PLANNING COUNCIL REPRESENTATION as stated in the most current Ryan White Program, and will be reflective of the local HIV/AIDS epidemic. The Planning Council may also request other positions/representation in order to maintain diversity within the EMA reflecting the pandemic and/or needed expertise within the EMA subject to the approval of the County Judge. These positions are subject to the Nominations Screening Process.

Section 2.03. Term. Each Council position is for a term of two (2) years. The terms of one-half the Council positions shall terminate in even-numbered years and the other half of the positions shall terminate in odd-numbered years. A term shall begin on January 1 and shall terminate on December 31 of the second year following. Council members appointed to vacancies shall complete the unexpired term of office.

Section 2.04. Term Limits. The County Judge shall appoint Council members to no more than three two-year terms. All members serve at the pleasure of the County Judge through an open nominations process.

Section 2.05. Compensation/Reimbursement. Persons serving as members of the Council shall not receive any salary or other compensation for their services as a member of the Council. All Council members may be reimbursed allowable expenses as approved by Harris County Public Health, the Ryan White Planning Council, and the CEO.

ARTICLE III

Duties of the Council

Section 3.01. Duties. The duties of the Council are to see to the establishment and implementation of the purposes of the Council as set out in Section 1.03 of these Bylaws and those duties which are prescribed by the provisions of the Act as within the purview of the Council.

Section 3.02. Orientation. All new members shall be required to attend mandatory orientation within 6 months.

ARTICLE IV

Committees

Section 4.01. Steering Committee. The Steering Committee shall be composed of the following persons: Chair of the Council, Vice Chair of the Council, Secretary of the Council, and the Chair, or Co-Chairs, of each Standing Committee. Actions of the Steering Committee are subject to ratification by the Council. The Steering Committee is responsible for the following:

(1) setting agendas for the Ryan White Planning Council;

(2) making recommendations to the Ryan White Planning Council;

(3) providing leadership;

(4) previewing reports from the Standing Committees;

(5) and functioning in “emergency” situations as they arise.

Section 4.02. Standing Committees. There shall be six Standing Committees. Each member of the Council except the Planning Council Chair is required to serve on at least one of the following standing committees.

1) Affected Community
2) Operations

3) Comprehensive HIV Planning
4) Priority and Allocations
5) Quality Improvement
6) Steering

Section 4.03. Ad hoc groups, work groups, subcommittees. The Chair of the Council or the Council may, from time to time, establish such other ad hoc groups as may be expedient or necessary to carry out the duties and responsibilities of the Council. The scope and responsibilities of such ad hoc groups shall be delineated at the time such groups may be established.

ARTICLE V

Officers, Election of Officers, Election of Committee Chairs
Duties of Officers and Duties of Service Committee Chairs

Section 5.01. Officers. The officers of the Council shall be a Chair, a Vice Chair and a Secretary. Officers cannot serve as Standing Committee Chairs. Ryan White Part A or B or State Services funded providers/employees/subcontractors/Board Members and or employees/ subcontractors of the Grantee shall not be eligible to run for office of Chair of the Ryan White Planning Council. A parliamentarian may be appointed at the pleasure of the Chair. Subsequent to election, if the Chair becomes a contractor, he/she shall be removed and a new election held to elect a new Chair.

Section 5.02. Election of Officers. The officers shall be elected by the majority vote of the members of the Council at the December meeting, which shall be termed the Organizational Meeting. (Per letter from Judge Eckels dated 12-13-00: "As in any political election, the number of candidates is not regulated. Following the first vote in the race, if one candidate has not received the majority, a run-off election is held between the two candidates receiving the most votes. The Council may accept nominations for the slate of officers that exceeds two candidates and may receive nominations from the floor regardless of the number of candidates already nominated.") One of the three officers must be a self-identified HIV positive person. Officers elected at the Organizational Meeting of the Council shall serve from the date of election to the next annual Organizational Meeting. If a vacancy occurs in any office, the Council shall elect a replacement to serve the remainder of the term.

Section 5.03. Appointment of Committee Chairs. Committee Chairs will be appointed by the Planning Council Chair. Committee Chairs must be members of the Planning Council for at least one year. If committee leadership is not available from among Planning Council members with at least one year's service, the Chair may seek leadership among remaining Planning Council members.

Section 5.04. Duties of Officers. The officers of the duly appointed Council shall have the responsibility for the performance of the following duties:

Chair: The Chair of the Council shall serve as the Chief Executive Officer of the Council and shall preside at all meetings of the Council and the Steering Committee. The Chair is the only official spokesperson for the Council and will be responsible for interfacing with the public and with the media. As the only authorized spokesperson, the Chair will have a business card that includes his/her name. He/she will also be responsible for correspondence to members regarding attendance and participation issues. The Chair shall perform such other duties as are normally performed by a chair of an organization or such other duties as the Council may prescribe from time to time. The Chair of the Council is an ex-offico member of all committees (standing, subcommittee, and work groups). Ex-offico means that he/she is welcome to attend and is allowed to be a part of committee discussion. They are not allowed to vote. In the absence of the Chair of the Council, the next officer will assume the ex-offico role with committees.

Vice Chair: The Vice Chair of the Council shall preside at meetings of the Council and Steering Committee in the absence of the Chair. The Vice Chair shall perform such other duties as the Chair may designate or the Council shall prescribe from time to time.

Secretary: Per Texas law, the Secretary may not chair a meeting. The position of Secretary shall include the following duties:

1) The Secretary will ensure that minutes are taken, approved, and filed as mandated by the Ryan White Program.
2) The Secretary will be responsible for keeping an up-to-date roll of Planning Council members.
3) When a roll call vote is taken, the Secretary will call the roll call vote, note the vote and announce the results of the roll call vote. The Secretary will monitor voting for possible conflicts of interest, the Secretary will process inquiries into votes made in conflict of interest.
4) The Secretary will keep a copy of the Planning Council Bylaws and other relevant Policies and Procedures at the Planning Council meetings, and will provide the Council with clarification from the Bylaws and Policies & Procedures, as requested.
5) The Secretary will keep a record of all committees of the Planning Council. When (if) new committees are established, the Secretary will assure or cause to be assured the actual formation and implementation of the new committees.
6) The Secretary will be responsible for notification of specially called Planning Council meetings, corresponding to the members as required by the Bylaws.

Standing Committee Chairs/Co-Chairs: The Standing Committee Chairs, or one of the Standing Committee Co-Chairs, shall preside at all meetings of their respective committees. The Committee Vice Chair shall preside at all committee meetings in the absence of the Chair, or both of the Co-chairs. If none is present, committee members shall use consensus to select another committee member to chair that particular meeting. The Committee Chairs/Co-chairs are responsible for the execution of the duties prescribed herein for the Committees and for such other duties as may be prescribed by the Chair of the Council or the Council from time to time. The Committee Chairs/Co-chairs are responsible for the recording of or cause to be recorded all deliberations

undertaken by each respective Committee. Copies of all approved minutes are available in the Office of Support for the Ryan White Planning Council.

ARTICLE VI

Quorum, Voting, Proxies and Attendance

Section 6.01. Quorum. Thirty percent of the members satisfy in-person requirements at Council meetings.

At least two (2) committee members and a Chair must be present; one of these must be a self-identified HIV positive member, to constitute a Standing Committee quorum.

Section 6.02. Voting. Each member of the Council shall be entitled to one vote on any regular business matter coming before the Council. A simple majority of members present and voting is required to pass any matter coming before the Council except for that of proposed Bylaw changes, which shall be submitted (in written form) for review to the full Council at least fifteen (15) days prior to voting and will require a two-thirds (2/3) majority for passage. The Chair of the Council shall not vote except in the event of a tie. The Chairs of the Standing Committees shall not vote at Committee meetings except in the event of a tie.

Section 6.03. Proxies. There shall be no proxy voting.

Section 6.04. Council Attendance.
Council members are required to attend meetings of the Houston Area HIV Health Services (Ryan White) Planning Council. Any Council member with four (4) absences from Council meetings within a calendar year or who fails to perform the duties of a Council member described herein without just cause, is subject to removal by the CEO. The Secretary shall cause attendance records to be maintained and shall regularly provide such records to the Chair.

Standing Committee Attendance:
Committee members are required to attend regularly scheduled committee meetings. Four (4) absences from committee meetings in a calendar year may be grounds for reassignment or termination of committee membership. The Council Chair will be responsible for determining reassignment or termination of committee membership. Reasons for absences that would be used for determining reassignment or termination include: 1) sickness; 2) work related conflicts (in or out of town and vacations); and 3) unforeseeable circumstances. The Chair of the Operations Committee will notify the Planning Council Chair if a member is absent for four (4) committee meetings and, if warranted, the Planning Council Chair will formally notify the member in writing of removal from committee membership. The member will be given an opportunity to request assignment to another committee. If the member continues to fail to meet committee requirements, it is the sole responsibility of the County Judge to determine if the member will be discharged from membership on the Planning Council.

Any Planning Council member who is unable to attend a Planning Council meeting or standing committee meeting of the committee must notify the Office of Support prior to such meeting. The Office of Support staff will document why a member is absent. The Operations Committee will review attendance records quarterly.

ARTICLE VII

Administration of Funds, Information Regarding Funding
and Council Oversight of Funding

Section 7.01. Administration of Funds. The County Judge shall designate the lead agency which will be charged with the administration and distribution of any funds granted to the Eligible Area under the Act. The Council shall report to the County Judge its findings and recommendations regarding the prioritization and allocation of funds granted under the Act, together with its recommendations as to the use of any such funds in accordance with the provisions of the Act.

Section 7.02. Information Regarding Funding. Ryan White Grant Administration will be responsible for the collection and dissemination of monthly reports to the Council on the administration of the funds granted to the Eligible Metropolitan Area under the Act.

Section 7.03. Council Oversight of Funding. The Council is responsible for an annual assessment of the administrative mechanism and distribution of the funds granted to the Eligible Metropolitan Area under the Act by the lead agency designated by the County Judge. The Council shall perform such other oversight duties as may be required by the Act or any regulation promulgated there under.

ARTICLE VIII

Conflicts of Interest

Section 8.01. Conflict of Interests. A conflict of interest (COI) occurs: 1) when an appointed or voting member of the planning council has a direct or indirect fiduciary or other personal or professional interest in a council decision or the outcome of a vote, 2) when a member uses his/her position for purposes that are motivated by pursuit of private gain for themselves or their families, friends, or business associates. COI is defined to include interests that existed within 12 months preceding the date when the conflict ended. The mere perception of COI is a significant concern.

The Council, acknowledging that perception is as important as reality, has elected to voluntarily adopt the following code of conduct regarding conflict of interest to be followed during all deliberations and decisions.

1) In order to make members aware of any potential positive bias, Council members agree to disclose their associations with any organization seeking to do business with the Ryan White Part A or B Administrative Agencies for which they or their spouse or domestic partner, during the past twelve months:
    a) own, have ownership interest, or have been employed;
    b) are or have been a Board member;
    c) are or have been a consultant; or
    d) are or have been involved in a contractual relationship.

3) In order to make other members aware of any potential negative bias, Council members agree to disclose their associations with any organization seeking to do business with

the Ryan White Part A or B Administrative Agencies with which they or their spouse or domestic partner, during the past twelve months are or were involved in mediation, arbitration or litigation over any employment, contract, service delivery or other matter.

4) Council members agree to abstain from voting on any decision related to any organization for which they or their spouses or domestic partner have association as specified in number 1, above.

4) Council members will not serve on Grantee proposal review panels.

Section 8.02. Disclosure of Conflicts of Interests. Council members who have COI must declare that conflict before the discussion of a motion. This will be recorded in the official minutes. All council members must submit signed affidavits disclosing any COI when joining the Council, and at least annually, and/or more often as needed, thereafter. Members who are closely affiliated with an applicant are excluded from the prioritization process.

ARTICLE IX

Regular Meetings, Special Meetings, Notice and Business to be Considered

Section 9.01. Regular Meetings. Regular Meetings of the Council shall be held no less than quarterly at such times and places as shall be designated by the Council. Written Notice of Regular Meetings shall be given by email no less than five (5) calendar days prior to such Regular Meeting.

Section 9.02. Special Meetings. Special Meetings of the Council shall be held at such times and places as shall be designated by the Chair of the Council or upon the written request of one-half (1/2) of the members of the Council. Notice of Special Meetings shall be given by telephone or email no less than three (3) working days prior to such Special Meeting.

Section 9.03. Notice. It shall be the duty of the Secretary to give or cause to be given such notice to each member of the Council. Notice of Regular Meetings shall be given in writing. Notice of Special Meetings may be given telephonically, by email or by fax. Notice of Council meetings shall be posted in accordance with the Open Meeting Act, TEX. GOV'T CODE ANN. §§ 551.001-551.146, as amended.

Section 9.04. Business to be Considered. Any business coming before the Council shall be considered at a duly constituted and noticed Regular Meeting or Special Meeting. Only items approved by the Steering Committee for presentation to the Council and posted on the agenda may be voted on.

Section 9.05. Public Comment. There is an opportunity for public comment at all meetings. Persons wishing to speak must follow the Policies and Procedures for Public Comment.

ARTICLE X

Grievance

Section 10.01. Grievance. There is a Ryan White Planning Council grievance process and the Grievance Policies & Procedures must be followed.

ARTICLE XI

Amendments, Governing Procedure, Compliance and Invalidity of Provisions

Section 11.01. Amendments. These Bylaws may be amended from time to time by a vote of two-thirds (2/3) of the entire membership of the Council. Proposed amendments shall be submitted (in written form) for review to the full Council at least fifteen (15) days prior to voting.

Section 11.02. Governing Procedure. The meetings of the Council shall be conducted in accordance with Roberts Rules of Order; revised except to the extent the provisions of Roberts Rules of Order conflict with the Bylaws of the Ryan White Planning Council in which event the Bylaws shall prevail.

Section 11.03 Compliance. The Council shall at all times comply with the duties and responsibilities set out in the Act and shall perform all of its deliberations in accordance therewith.

Section 11.04. Invalidity of Provisions. In the event any provision hereof conflicts with the provisions of the Act or other applicable law, such provision shall be deemed stricken and the remainder of these Bylaws shall be in full force and effect without regard to such invalid provision.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

POLICY AND PROCEDURES
TABLE OF CONTENTS

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL (RWPC)

EST. JUL 15, 1998 **REV JANUARY 1, 2020** **POLICY No. 100.01**

PUBLIC COMMENTS

PURPOSE

This policy establishes guidelines by which public comments will be received by the Houston Area HIV Health Services Ryan White Planning Council.

AUTHORITY

The RWPC through adoption of its bylaws ensures that there will be a procedure for receiving public comments.

INTENT

The Houston Eligible Metropolitan Area (EMA) HIV Services Planning Council represents the HIV/AIDS affected six county area (EMA). The RWPC does not act on behalf of individuals from affected communities nor agencies serving these communities. The PC identifies the needs of all affected communities, prioritizes those needs and allocates limited Ryan White Part A (formerly known as Title I) funds to meet a portion of those needs. Per a request from the Texas Department of State Services, the PC also makes recommendations regarding the priorities and allocation of funds for Ryan White Part B and State Services funding. The Planning Council does not allocate funds to individuals or to agencies except as allowed in limited circumstances within the Ryan White Program. While a "Comprehensive Needs Assessment" is completed when required by Health Resources and Services Administration (HRSA), "Needs" are assessed on an ongoing basis through various HIV/AIDS Needs Assessment processes.

PROCESS

All RWPC meetings are open to the public (see Policy No. 200.03) and are announced and conducted in accordance with the Open Meetings Act. There will always be a place on the Agenda for public comments. The RWPC can at any time determine where on the agenda public comments can be made. At the Planning Council meetings, only members of the Planning Council can vote on agenda items. However, official Affiliate Members can vote on items at the committee level on which they serve (Policy No. 400.01). Public comments may be limited to 3 minutes per individual. At the discretion of the Chair, public comments may be limited to a shorter, or expanded to a longer period of time, but the amount of time must be announced at the beginning of the public comment portion of the agenda and a uniform amount of time must apply equally to all who are giving comments at the meeting. Only during the Public Comment portion of the meeting are Council members asked to refrain from engaging in dialogue with or asking questions of individuals who are providing public comment at Council meetings. The Chair of the Council will refer public comments that need additional follow up to the appropriate committee. Council

members will abide by the Public Information Act. See staff policy regarding the distribution of information. (See Staff Personnel notebook.)

SPECIALLY SCHEDULED PUBLIC COMMENTS

During the year, the standing committees will announce requests for Public Comment on key work products before going to the whole PC for final approval. In addition, the PC may also announce requests for Public Comments on key issues.

HOW DECISIONS ARE MADE

The PC will NOT make decisions on information presented to the PC during public comments unless it relates to an item that has followed the appropriate Council process. It will hear comments and then assign follow-up to the appropriate standing committee (see RWPC Policy No. 400.01). All business for decision by members of the full Planning Council will be handled in the following fashion:

- Introduce the business item at a Steering Committee Meeting (unless item has already been assigned to/undertaken by the appropriate committee)
- Steering assigns the task to the appropriate committee
- Chair of the appropriate committee may:
  - Create a sub-committee
  - Create a work group
  - Seek public input
  - Set a time limit as to resolution
- Report the recommended action back to Steering
- Steering includes the Committee's recommended action on the Council Agenda for Council Meeting if Committee's recommended action passes Steering.
- Full Council votes

All items on the agenda for vote by the full Council will become official by majority vote.

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL (RWPC)

EST. JUL 15, 1998 **REV JANUARY 1, 2020** **POLICY No. 200.01**

PLANNING COUNCIL AND AFFILIATE COMMITTEE MEMBER APPLICATION AND SCREENING PROCESSES

PURPOSE

This policy establishes guidelines by which members are nominated for membership on the Houston Area HIV Health Services Ryan White Planning Council (RWPC). It also outlines the process for applying for Affiliate Committee membership. These are two separate processes.

AUTHORITY

The process related to Council membership will comply with the most current Ryan White HIV/AIDS Program Part A Manual. The CARE Act as amended (currently referred to as the Ryan White HIV/AIDS Treatment Extension Act of 2009 or the Ryan White Program), Section 2602(b)(1) states: "Nominations to the planning council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Since there are no HRSA guidelines for Affiliate Committee membership, the process for applying and being screened for Affiliate Committee membership must comply with Houston Ryan White Planning Council (RWPC) bylaws, policies and procedures.

PLANNING COUNCIL APPLICATION PROCESS

The Nominations Screening Process for Planning Council membership will be as follows: The process shall be continuous and/or as needed to fill vacancies in Council membership. The Council shall work with the CEO's office to ensure that Council membership is in compliance with HRSA mandates regarding membership. All terms begin in January. Members may be appointed to fill an unexpired term.

With the exception of persons representing HRSA required government organizations, such as Medicaid, HOPWA and others, Council applicants will be subject to the Nominations Screening Process conducted by the Operations Committee. The process will be an open-ended process available to all interested persons wishing to serve.

PLANNING COUNCIL REPRESENTATION:

See HRSA grant instructions.

The composition of the RWPC will be reflective of the local HIV epidemic and according to HRSA policy. Besides the HRSA required representation categories of Planning Council Membership, the RWPC may also request other positions/representation, subject to the approval of the CEO, in order to maintain diversity within the RWPC reflecting the pandemic and/or needed expertise

within the EMA. These positions are subject to the Nominations Screening Process.

PLANNING COUNCIL RECRUITMENT/ADVERTISEMENT:

The Operations Committee shall announce the Nominations Screening Process by notification to interested and affected groups in the form of press releases, advertisements, flyers/brochures, etc. Announcements should be targeted to the following organizations and communities:

- Local HIV/AIDS organizations
- Veterans, Gay, Lesbian, Bi-sexual, Transgender, African American, Hispanic, Asian, Rural and other communities
- Project LEAP students

Recommendations for vacant positions, which occur during the year, will be selected from this pool of applicants.

PLANNING COUNCIL NOMINEE APPLICATION:

Council Application: Forms for RWPC membership will be reviewed annually by the Operations Committee for revisions/changes to the forms and will be made available in English and Spanish.

With the exception of persons representing HRSA required government organizations, such as Medicaid, HOPWA and others, persons interested in serving on the RWPC must submit a completed nominee application form to the Operations Committee. Staff will contact an applicant if their form is not complete and inform them that the Committee will not interview a candidate with an incomplete application form.

Interviews with the Operations Committee and a potential nominee will be scheduled after an application is received. The interview process will be used to determine the applicants' interest, experience, background and availability of time. Open-ended questions will be used to clarify answers given in response to a specific list of questions. The goal is to obtain as much appropriate information as possible about the applicant. During the process, the potential applicant will be able to ask questions of the Operations Committee.

CONSIDERATION OF APPLICANTS:

The Operations Committee will consider all applications in order to ensure that the PC is balanced in terms of expertise, racial and ethnic composition, geography, and other criteria developed by HRSA and the RWPC.

LIST OF CANDIDATES:

The Operations Committee will submit all applications with a committee recommendation to the CEO. The CEO will also be notified of the candidates who are not being recommended. The CEO will appoint all members to the Council.

AFFILIATE COMMITTEE APPLICATION PROCESS

Forms for Affiliate Committee membership will be reviewed annually by the Operations

Committee for revisions/changes to the forms and will be made available in English and Spanish. Affiliate members will be appointed for a one year term by the Chair of the Council to each of the Standing Committees with the exception of Operations and Steering (ref. RWPC Policy 1000.01). Individuals wishing to become Affiliate members must submit to the Office of Support an Affiliate Membership application, which will include contact information for two references. Before making an appointment, the Chair must contact references for candidates unless the person has already served as an Affiliate Committee or Council member. The Council Chair can ask the Director of the Office of Support to assist with contacting references. Both must use the approved form to document the results of all calls.

When committees have membership openings, the Office of Support will notify the Council Chair of all pending applications and references will be contacted at that time and before an appointment is made. The Chair of the Council will make committee appointments in consultation with the Director of the Office of Support.

PLANNING COUNCIL AND AFFILIATE COMMITTEE APPLICATION PROCESSES

For both Planning Council and Affiliate Committee applicants, the following items will be addressed through correspondence or during the interview, and on the application:

TIME COMMITMENT:

Each applicant shall be informed of the time commitment necessary to participate as a member. Minimum time requirements for a Council member are at least four (4) hours per month. Two (2) hours for monthly RWPC meetings and two (2) hours for monthly Service Committee meetings. Minimum time requirements for an Affiliate Committee member are at least two (2) hours per month for committee meetings. This information is to be included on both Council and Affiliate Committee application forms.

CONFLICT OF INTEREST:

As part of the application process, all candidates will be informed in writing that individuals who are members of or who have a financial interest in an organization receiving and/or seeking Ryan White Part A or B or State Services funding are considered to have a conflict of interest. **(OPTIONAL TEXT)** If appointed, the individual will be required to complete a Conflict of Interest Disclosure Form annually and/or as needed, describing the relationship of the person to each organization that can benefit from an action by the RWPC. Additionally all Council and Affiliate Committee members will be required to identify conflicts of interest during a discussion and/or vote and abstain from voting on issues pertaining to that conflict.

HIV DISCLOSURE:

Persons who are self-identified as living with HIV or having AIDS may choose whether or not to reveal their HIV/AIDS status. All laws regarding HIV/AIDS confidentiality are adhered to. This information is included on the application forms.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 15, 1998 **REV JANUARY 1, 2018** **POLICY No.200.02**

APPOINTMENT OF COUNCIL, COMPOSITION OF COUNCIL AND COMPENSATION

PURPOSE

This policy establishes guidelines set forth in RWPC Bylaws Rev.11/01, Article II, Sections 2.01 through Section 2.05 and current HRSA guidelines. This policy will ensure representation of the communities living with HIV on the Planning Council.

AUTHORITY

Adopted and amended Bylaws of the Houston Area HIV Health Ryan White Planning Council as Revised 01/18; Ryan White HIV/AIDS Treatment Extension Act of 2009 or the Ryan White Program.

APPOINTMENT OF COUNCIL

All members of the above mentioned Council will be appointed by the Chief Elected Official (CEO) of Harris County. Vacancies will be filled by appointment of the CEO and serve at the pleasure of the CEO. All candidates are subject to the established Nominations Screening Process (see RWPC Policy No. 200.01).

COMPOSITION OF COUNCIL

The Planning Council will be made up of individuals as specified in Sec.2602(2) PLANNING COUNCIL REPRESENTATION as stated in the current Ryan White Program, and will be reflective of the local HIV/AIDS Epidemic according to HRSA policy. The Planning Council may also request other positions/representation in order to maintain diversity within the EMA reflecting the pandemic and/or needed expertise within the EMA subject to approval of the CEO. These positions are subject to the Nominations Screening Process.

A minimum of 33% of the membership of the Planning Council will be persons living with HIV who do not have a conflict of interest (or according to current HRSA policy) and are willing to represent the community.

Recruitment will comply with the Health Resources Services Administration (HRSA) Program Guidance to ensure Planning Council membership reflects and is representative of those affected by HIV/AIDS throughout the EMA. Therefore, special recruitment efforts will be made among those least represented on the PC.

TERM

Council position terms are two (2) years. The terms of one-half of the Council positions shall terminate in even-numbered years. The other half of the positions shall terminate in odd-numbered years. A term shall begin on January 1 and shall terminate on December 31 of the second year following. Council members appointed to vacancies shall complete the unexpired term of office.

The CEO shall appoint Council members to no more than three consecutive two-year terms. All members serve at the pleasure of the CEO through an open nominations process.

COMPENSATION/REIMBURSEMENT

Persons serving as members of the Houston Area HIV Health Services Ryan White Planning Council shall not receive any salary or other compensation for their services as a member of the Council. All Council members may be reimbursed allowable expenses as approved by Harris County Public Health, the Ryan White Planning Council and the CEO.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. May 5, 1998	REV MARCH 12, 2020	POLICY No. 200.03

MEETINGS

TELECONFERENCING AT MEETINGS

Due to unusual circumstances, such as illness or travel, Council and committee members are allowed to participate in a Ryan White committee meeting via telephone as long as the Office of Support has access to the technology needed to accommodate such a request. Regarding Council meetings, members may not use teleconferencing to participate in a full Council meeting except under unusual circumstances, such as severe weather or a public health emergency (for example an outbreak of the flu). In this situation, the Office of Support, in consultation with the Chair of the Council (or the Vice Chair and then Chair of the Operations Committee if the Chair or Vice Chair is unavailable), will decide if members can participate in a full Council meeting via conference call, again depending upon the availability of the technology needed to accommodate the call. Due to the limited technological capability of conference calling, Council members will be included in the call on a first come, first serve basis. In this unusual situation, the general public will be encouraged to submit public comment through fax or email, they may listen to the conference call at the location where the staff will be in attendance, and/or they may request a digital copy of the recorded proceedings (if available) or a paper copy of the meeting minutes after the meeting has taken place.

Under a declared health emergency, quorum will be determined by the number of Council members present and/or on the conference call at the official start time for the meeting.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 7, 2001 **REV JANUARY 1, 2018** **POLICY No. 300.01**

LETTERS OF SUPPORT, BUSINESS CARDS AND EVENT CO-SPONSORSHIP

PURPOSE

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

AUTHORITY

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

BUSINESS CARDS

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

LETTERS OF SUPPORT

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

PROCESS

EVENT CO-SPONSORSHIP

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

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

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

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

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JULY 15, 1998 REV JANUARY 1, 2020 POLICY No.400.01

STANDING AND OTHER COMMITTEES AND AFFILIATE MEMBERSHIP

PURPOSE

This policy establishes the roles and responsibilities of each Standing Committee of the Ryan White Planning Council (RWPC) and defines other committees.

AUTHORITY

The RWPC through adoption of its bylaws ensures that there will be six (6) Standing Committees (including Steering) and establishes that there will be "other" committees as may be necessary to carry out the duties and responsibilities of the RWPC.

Ryan White HIV/AIDS Treatment Extension Act of 2009 or the Ryan White Program and by establishment of Houston Area HIV Health Services Ryan White Planning Council as established by the CEO ensures that the actions and decisions of the RWPC as represented through its committees are within the scope and intent of the Act.

REQUIREMENTS FOR STANDING COMMITTEE MEMBERSHIP

Planning Council members will be asked to complete a Skills Inventory checklist to document experiences and skills appropriate to committee charges and work plans.

STANDING AND OTHER COMMITTEES

STEERING COMMITTEE:

Members of this committee will consist of the PC officers and chairs, or co-chairs, of the standing committees. In a case where standing committees have co-chairs, only one of them may vote at Steering Committee meetings. The Steering Committee will be responsible for the following:

- Setting the agendas for Ryan White Planning Council
- Making recommendations to the Ryan White Planning Council
- Providing leadership
- Previewing reports from the Standing Committees
- Functioning in "emergency" situations as they arise.

The Steering Committee will meet once a month for a projected two-hour meeting. This committee will not have Affiliate members.

QUALITY IMPROVEMENT COMMITTEE:

This committee will be given the responsibility of assessing and ensuring continuous quality improvement within Ryan White Part A funded services. This committee is also the place where definitions and recommendations on "how to best meet the need" are made. Standards of Care and Outcome Evaluation, which must be looked at within each year, will also be monitored from this committee. Whenever possible, this committee should collaborate with other Ryan White planning groups, especially within the service categories that are also funded by other Ryan White monies, to create shared Standards of Care.

This committee is also designed to implement the PC's third legislative requirement assessing the rapid disbursement of Ryan White Part A funds. It will receive reports on the HIV services procurement process and aggregate service reports to assure compliance with PC service priorities, allocations and compliance with the EMA's HIV/AIDS epidemiology. This committee will initiate, manage and evaluate, as needed, services for outcomes and cost effectiveness. This Committee may benefit from the utilization of Affiliate members skilled in service evaluation when professional evaluators are absent among Council members.

COMPREHENSIVE HIV PLANNING COMMITTEE:

This committee will be responsible for implementing, evaluating, monitoring and overseeing the Comprehensive Plan that is approved by the Council. They will act as a liaison to other Planning Groups, and will receive recommendations that are made to the Council regarding the Comprehensive Plan.

This committee will also be in charge of the comprehensive needs assessment activities that are performed periodically by the Council. In as much as these tasks call for community involvement, using this committee to promote community involvement will be a top priority. Matters that relate to the Continuum of Care will be addressed in this committee since it is part of the Comprehensive Plan.

Timeline: This committee will be responsible for presenting to the Council on at least a yearly basis, an evaluation of the progress of the Comprehensive HIV Services Plan and any revisions/updates for strengthening the plan. They will also be responsible for presenting to the Council a revised Comprehensive HIV Services plan every 3-5 years (or according to HRSA expectations).

PRIORITY AND ALLOCATIONS COMMITTEE:

This committee is designed to give attention to the comprehensive process of establishing priorities and allocations for each PC year. Per a request from the Texas Department of State Health Services, this committee will also provide recommendations on priorities and allocations for Ryan White Part B and State Service funding (see the Letter of Agreement between the Planning Council, Department of State Health Services and other stakeholders dated 07/07). This committee will be appointed by the PC Chair and its membership must be guided by skills appropriate to prioritizing and allocating, not by self-interests in the outcomes from prioritizing and allocating. The committee will be subject to Conflict of Interest standards (see RWPC Policy No.800.01). This committee will meet regularly for a projected two to three hour meeting, and will benefit from the use of Affiliate resource persons.

COMMITTEE MEMBERSHIP

To function well, the Priority and Allocations Committee must have access to individuals who represent:

- Skills in epidemiology, health care finance, and financial systems planning
- Individuals living with HIV
- Expertise/experience in the Houston EMA Continuum of Care and from health and support services, both private and public. Health services are broadly defined to include the full array of health related services, and are not limited to biomedical services.

In addition, the Priority and Allocations Committee will require cooperation from individuals who will serve as resource persons to the Priority and Allocations process. Information will be required from individuals knowledgeable in all aspects of the Ryan White Program, State-funded services, HUD, HOPWA, Medicaid and more. Information will be required from the Administrative Agency on service needs met through Part A funds.

Resource persons may or may not be requested to attend all Priority and Allocations Meetings. The goal will be to balance committee membership according to race and ethnicity, sex and sexual orientation and gender, HIV serostatus, skills and experience, and according to Conflict of Interests policies and procedures.

COMMITTEE LEADERSHIP

The Committee Chair and Vice Chair must be members of the Houston Area HIV Services (Ryan White) Planning Council.

COMMITTEE PARTICIPATION

Each committee member and each committee chair/vice chair will be required to complete a signed assurance of Committee Member Expectations.

CONFLICTS OF INTEREST

No more than two individuals employed by Ryan White Part A, Part B or State Services funded agencies may serve on the Priority and Allocations Committee.

AFFECTED COMMUNITY COMMITTEE:

This committee is designed to acknowledge the collective importance of consumer participation in PC strategic activities and provide consumer education on HIV-related matters. The committee will serve as a place where consumers can safely and in an environment of trust discuss PC work plans and activities. This committee will verify consumer participation on each of the standing committees of the PC, with the exception of the Steering Committee (the Chair of the Affected Community Committee will represent the committee on the Steering Committee). The committee will consist of individuals living with HIV, caregivers (friends or family members) and others. All members of the PC who self-disclose as living with HIV should be invited to be a member of the Affected Community Committee; however membership on a committee for individuals living with HIV will not be restricted to the Affected Community Committee.

When providing consumer education, the committee should not use pharmaceutical representatives to present educational information. Once a year, the committee may host a

presentation where all HIV/AIDS-related drug representatives are invited. It is acceptable for a pharmaceutical company to provide refreshments at such an educational meeting as long as the refreshments are valued at less than $25 per person.

OPERATIONS COMMITTEE:

This committee will be responsible for four (4) areas of compliance with the Houston Area HIV Health Services Ryan White Planning Councils operations as outlined in the Ryan White Program. The committee will (1) develop and facilitate the management of PC operating procedures, guidelines, and inquiries into member compliance with these procedures and guidelines. (2) Implement the Open Nominations Process (RWPC Policy No.200.01), which will require a continuous focus on recruitment and orientation. (3) Initiate and conduct the PC self-evaluations and where the PC staffing pattern design and staff recruitment-selection-evaluation is initiated and conducted. (4) Grievances related to the PC processes will be handled by this committee (RWPC Policy No.1000.01). This committee will meet regularly for a projected two hour meeting and will not benefit from Affiliate members, except where resolve of grievances are concerned. Affiliate members knowledgeable about the area of grievance may sometimes be utilized to promote objectivity in decision-making.

Because members of the Operations Committee are asked to protect the information of a personal and confidential nature of a Council applicant, and because the Chair of the Planning Council is allowed to participate in interviews with Council applicants as an ex-officio member of the Committee, all members of the Operations Committee and the Chair of the Planning Council are required to sign the Houston Ryan White Planning Council Statement of Confidentiality form. If a Committee member, or the Chair of the Planning Council, does not wish to sign the Statement of Confidentiality form then they are allowed to serve as a member of the Operations Committee, but they are not allowed to participate in interviews with Council applicants.

AD HOC COMMITTEES, WORK GROUPS, SUBCOMMITTEES:

These committees are to be utilized when necessary to conduct meetings outside of regular RWPC, and Standing Committee meetings. Their task is to make decisions, and relay suggestions back to the Standing Committee or the RWPC. These committees are short term in nature and task oriented. The formation of these committees can be suggested by officers and members of the RWPC as necessary to carry out the aims, goals, and objectives of the RWPC as it relates to the intent of the Ryan White Program. The Conflict of Interest Policy applies to all members. Only one voting member per agency will be allowed.

AFFILIATE COMMITTEE MEMBERS:

Affiliate members will be appointed by the Chair of the Council to each of the Standing Committees with the exception of Operations and Steering. The Operations Committee will not benefit from affiliate membership except where noted (ref. RWPC Policy 1000.01). Individuals wishing to become Affiliate members must submit to the Office of Support an Affiliate Membership Application which will include contact information for two references. Before making an appointment, the Chair must contact references for candidates unless the person has already served as an affiliate committee member, Council member or Project LEAP student. The Council Chair can ask the Manager of the Office of Support to assist with contacting references. Both must use the approved form to document the results of all calls.

When committees have membership openings, the Office of Support will notify the Council Chair of all pending applications and references will be contacted at that time and before an appointment is made.

VOTING PRIVILEGES AND CONFLICT OF INTEREST FOR AFFILIATE COMMITTEE MEMBERS:

Affiliate members can only vote at committee, sub-committee, and workgroup meetings. They may not vote at Council meetings.

Affiliate members must declare a conflict of interest, abiding by the same rules as full council members. On the committee level, only one voting member per agency (full or affiliate) will be permitted to vote. The number of affiliate members on a standing committee should not equal or exceed the number of council members on that committee.

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL (RWPC)

EST. MAY 5, 1999 **REV JANUARY 1, 2018** **POLICY No. 400.02**

ROLES AND RESPONSIBILITIES OF PLANNING COUNCIL MEMBERS AND COUNCIL SUPPORT STAFF

PURPOSE

This policy is to establish the roles and responsibilities of 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 adoption and approval of the most current By-laws 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.

INTENT

Create an atmosphere of respect and mutual understanding as to the tasks involved in processes vital to HRSA mandates for Eligible Metropolitan Area Planning Councils, and their responsibilities.

PLANNING COUNCIL

The Planning Council is charged with the following:

- Setting Priorities
- Resource Allocation
- Comprehensive Planning
- Assessing Needs
- Assessing the Efficiency of the Administrative Mechanism.

OFFICE OF SUPPORT

The Director shall report to the Houston Area HIV Health Services Ryan White Planning Council (RWPC) and will be responsible for the following:

- Providing direction to both the RWPC and its support staff
- Completing the legal fulfillment of all Ryan White Part A Council responsibilities within the revised Ryan White Program.
- Managing the budget for the Office of Support in accordance with HRSA and Harris County regulations.
- All expenditures over $5,000 must be approved in writing by the Planning Council Chair unless already specifically identified in a Council approved budget (Note: the Director may not be directed to incur any expense that is: 1. Not justifiable as an expense under Ryan White Part A; 2. Not available or unobligated within the budget).

- Providing day-to-day management of Planning Council activities.
- Providing day-to-day management of the support staff operations and be responsible for hiring and terminating staff, in consultation with the Personnel Committee.

In addition the Director shall have overall management responsibility for:

- Devising and presenting to the Council, on an annual basis, a time line for the work of the RWPC.
- Acting as the Council's point of request for public information and as a liaison with and between the Council, its Standing Committee, Ad Hoc Committees, official caucuses, and the Administrative Agent.
- Facilitating and enhancing regional cooperation among other planning councils, service providers, consumers, and constituent communities.
- Assisting the RWPC and/or its committees in responding to HRSA recommendations, including assisting with interpretations; acting upon these interpretations by developing and facilitating a process to adopt these changes, as approved by the RWPC mandates and initiatives and in accordance with HRSA and local county regulations.

COMMITTEES

Only the designated Chair or Co-Chair of a committee may make a budgetary request from the Director. The Chair must submit the request in writing outlining the purpose for which the funds are to be used. If the request is for items not previously approved by the Council, the Director will determine whether the request can be justified as a Ryan White Part A expense and whether there is money available to pay for the request. Upon estimation of the expense, if the amount is to exceed $5,000 signed approval must be given by the Chair of the Planning Council before the Director can act unless the expense has been previously approved by Council.

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 Director of the Office of Support prepares a proposed budget.

2. The Director 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 Grant Administration Section (the "grantee").
3. The grantee reviews the budget in terms of Ryan White Program guidelines and discusses any concerns with both the Director of the Office of Support and the assigned liaison to the CEO.
4. The Director 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 Director provides the grantee with the Council approved budget.
8. The grantee reviews the budget and provides written confirmation to the Director 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 Director of the Office of Support who revises the budget and begins the process at Step 1 as described above.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 15, 1998 **REV NOVEMBER 14, 2019** **POLICY No. 500.01**

ELECTION OF OFFICERS, ELECTION OF COMMITTEE CHAIRS, DUTIES OF OFFICERS & CHAIRS

PURPOSE

This policy establishes the guidelines by which the officers of the Houston Area HIV Health Services Ryan White Planning Council will be elected. In addition, this outlines and defines the duties of RWPC Officers and duties of the Chairs of each of the Standing Committees. (See RWPC Policy No.400.01)

AUTHORITY

Bylaws (01/18) Article V, Sec5.01 - Sec5.06 ensures that the nomination and selection of officers and committee chairs will be in accordance with those principles.

DEFINITIONS

Ryan White Planning Council Officers refers to the positions of Chair, Vice Chair, and Secretary.

PROCESS

Nominations for officers may be submitted to the Planning Council Support Staff up until the end of the November Steering Committee meeting. After this time, nominations are added from the floor the day of the election. Nominations for officers will be announced at least one month prior to the December Houston Area HIV Health Ryan White Planning Council meeting. Any member may submit a nomination for himself/herself or another member for a specific office. Before the December Steering Committee meeting, each candidate must submit to the Office of Support a brief written description of their qualifications for the office they are seeking and prepare a short presentation describing their qualifications.

The annual election will be held at the December RWPC meeting. Before the election takes place, members will be reminded that any member can ask for a call vote if that is their preference. If paper ballots are used, voters must print their name on their ballot before submitting. If voter does not print their name on the ballot, the ballot will be disqualified and not included in the election results. Paper ballots are to be stored in a fire proof safe in the Office of Support for twelve months after the election so that they can be accessed by anyone who wishes to review them. During the election, the Operations Committee will announce the slate of nominees, which will include but not be limited to, each candidate verbally expressing his or her interest in and qualifications for the office they are seeking. Typically, election to office will be by written ballot unless there is only one candidate running for a specific office. A simple majority vote will be required for election. (Per letter from Judge Eckels dated 12-13-00: “As in any political election, the number

of candidates is not regulated. Following the first vote in the race, if one candidate has not received the majority, a run-off election is held between the two candidates receiving the most votes. The Council may accept nominations for the slate of officers that exceeds two candidates and may receive nominations from the floor regardless of the number of candidates already nominated.") Each member of the Council shall be entitled to one vote on any regular business matter coming before the Council. A simple majority of members present and voting is required to pass any matter coming before the Council except for that of proposed Bylaw changes, which shall be submitted (in written form) for review to the full Council at least fifteen (15) days prior to voting and will require a two-thirds (2/3) majority for passage. The Chair of the Council shall not vote except in the event of a tie. The election of the officers will be done one at a time in the following order: Chair, Vice-Chair, and Secretary.

QUALIFICATIONS FOR RWPC OFFICERS:

Ryan White Part A or B or State Services funded providers/employees/subcontractors/Board Members and or employees/subcontractors of the Grantee(s) shall not be eligible to run for office of Chair of the Ryan White Planning Council. Except as otherwise required by the Ryan White Program, staff representing the Office of Support and Part A and B administrative agencies cannot serve as members of the Ryan White Planning Council. Staff representing these entities is requested to attend Council, committee and other meetings when work products are being developed and approved.

Candidates will have served as an appointed member of the RWPC for the preceding twelve (12) months and, if needed, have been reappointed by the CEO. If subsequent to the election the Chair of the RWPC becomes a provider/employee of a subcontractor/Board member of a subcontractor/of the Grantee he/she shall be immediately removed from office. A new election will be held to fill any open positions. In the event of a mid-year election, once an officer has vacated a position, a call to accept nominations will be announced at the Steering Committee meeting immediately following the resignation. Nominations for the vacated position may be submitted to the Planning Council Support Staff up until the end of the following Steering Committee meeting (approximately 30 days after the call for nominations). At this time, Office of Support staff will distribute the slate of nominees to all members of the Planning Council. After the close of the Steering Committee meeting, nominations can only be added from the floor the day of the election, which will take place at the Council meeting approximately seven days after the slate of nominees is closed at the Steering Committee meeting. At all times, any one of the three officers must be a self-identified person living with HIV.

ATTENDANCE REQUIREMENTS FOR RWPC OFFICERS:

If an officer of the Ryan White Planning Council misses three, unexcused consecutive meetings of the Steering Committee and Planning Council, they must step down as an officer and an election will be held to fill the position. (Example: an officer must step down if he/she does not contact the Office of Support and request an excused absence and if they miss the October Steering Committee, October Planning Council and the November Steering Committee meetings.) Staff is asked to remind nominees for officer positions of this new requirement. And, when presenting their qualifications to the Council before an election, nominees must state that, to the best of their knowledge, they will not have difficulty meeting 3this additional attendance requirement.

DUTIES OF OFFICERS:

The officers of the RWPC will be responsible for the following:

Chair: Chief Executive Officer of the Council; preside at all meetings of the Council; appoint Standing Committee Chairs; represent (or designate a representative to serve) on behalf of the Council at meetings, conferences, etc. where "Council representation" is requested. Chair assigns committee participation of Council members, and performs such other duties as are normally performed by a chair of an organization or such other duties as the Council may prescribe from time to time. The Chair will be responsible for correspondence to members regarding attendance and participation issues. The Chair will also sign and date the final version of the minutes as indication of PC approval. The Chair of the Council is an ex-offico member of all committees (standing, subcommittee, and work groups). Ex-officio means that he/she is welcome to attend and is allowed to be a part of committee discussion. He/she is not allowed to vote. In the absence of the Chair of the Council, the next officer will assume the ex-offico role with committees.

Vice Chair: Preside at meetings of the Council in the absence of the Chair. Perform such other duties as the Chair may designate or the Council shall prescribe from time to time. Performs the above duties in the absence of the Chair.

Secretary: The position of Secretary will oversee the following tasks:

1. The Secretary will ensure that minutes are taken, approved, and filed as mandated by the Ryan White Program.
2. Keep an up-to-date roll of PC members. The PC Operations Committee (RWPC Policy 400.01) will file membership management reports with the Secretary for presentation to the PC.
3. Call the roll call vote, noting voting and will announce the results of the roll call vote. The Secretary will monitor voting for possible conflicts of interest (COI), the Secretary will process inquiries into votes made in COI.
4. Keep a copy of the RWPC Bylaws and other relevant Policies and Procedures at the PC meetings, and will provide the Council with clarification from the Bylaws and Policies & Procedures, as requested.
5. Keep a record of all committees of the PC. When (if) new committees are established, the Secretary will assure or cause to be assured the actual formation and implementation of the new committees.
6. Be responsible for notification of specially called PC meeting, corresponding to the members as required by the Bylaws.

COMMITTEE CHAIRS:

Committee Chairs will be appointed by the Planning Council Chair. Committee Chairs must be members of the PC for at least one year. If committee leadership is not available from among PC members with at least one year's service, the Chair may seek leadership among remaining PC members. The Standing Committee Chairs will preside at all meetings of their respective committees. The Committee Vice Chair shall preside at all committee meetings in the absence of

the Chair. If neither are present, committee members shall use consensus to select another committee member to chair that particular meeting. The Committee Chairs are responsible for the execution of the duties prescribed herein (see RWPC Policy 400.01) for the Committees and for such other duties as may be prescribed by the Chair of the Council or the Council from time to time. The Committee Chairs are responsible for the recording of or cause to be recorded all deliberations undertaken by each respective Committee. Copies of all approved minutes are available from the Office of Support (832-927-7926). Minutes from full Council meetings are available on the PC website (www.rwpcHouston.org) once the draft copy has been approved by the Chair of the Council.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 15, 1998 **REV JANUARY 1, 2020** **POLICY No. 600.01**

QUORUM, VOTING, PROXIES, ATTENDANCE

PURPOSE

This policy establishes the guidelines as to what legally constitutes a Houston Area HIV Health Services (Ryan White) Planning Council meeting. In addition, the policy will define and establish how voting is done, what constitutes a roll call vote and who monitors that process. This policy will define attendance, and the process by which a member can be removed from the council.

AUTHORITY

The adoption of the Houston Area HIV Health Services (Ryan White) Planning Council Bylaws Rev. 01/18 Article VI; (Sections 6.01-6.04).

PROCESS

QUORUM:

A majority of the members of the Council are required to constitute a quorum. A minimum of one (1) self-identified member living with HIV must also be present to constitute a quorum. If quorum is not met, the Council Chair, in consultation with the Office of Support staff, will determine when to dismiss those present. To constitute a Standing Committee quorum, at least two (2) committee members and a Chair must be present; one of these must be a self-identified member living with .HIV.

VOTING:

Each council member will have only one vote on any regular business matter coming before the Council. A simple majority of members present and voting will be required to pass any matter coming before the Council except for that of proposed Bylaws changes. Proposed changes to the Bylaws will be submitted in written form for review to the full Council at least fifteen (15) days prior to voting and will require a two-thirds (2/3) majority for passage. The Chair of the Council will not vote except in the event of a tie. The Chairs of the Standing Committees shall not vote at Committee meetings except in the event of a tie. In a case where standing committees have co-chairs, only one of them may vote at Steering. The Chair of the Council is an ex-offico member of all committees (standing, subcommittee, and work groups). Ex-offico means that he/she is welcome to attend and is allowed to be a part of committee discussion. He/she is not allowed to vote. In the absence of the Chair of the Council, the next officer may assume the ex-officio role with committees. In an effort to manage agency influence over a single committee or workgroup, only one voting member (Council or Affiliate) per agency will be permitted to vote on Ryan White Planning Council committees and workgroups. If there is an unresolved tie vote and the Chair of the Committee works for the same agency as another committee member, then the information will be forwarded to the Steering Committee for resolution.

ALTERNATE PARTICIPATION:

During committee meetings any full council member living with HIV may serve as an alternate on a committee for any absent committee member living with HIV. The Chair of the Committee will communicate to the rest of the committee that the alternate person living with HIV is there to conduct business. Alternates have full voting privileges. This rule is not applicable in full Council meetings.

CONFLICT OF INTEREST AND VOTING AMONG AFFILIATE MEMBERS:

Affiliate members must declare a conflict of interest.

The number of Affiliate members on a committee (not a subcommittee or work group) should not equal or exceed the number of Council members on that committee.

ROLL CALL VOTE:

When a roll call vote is taken, the Secretary will call the roll call vote, noting voting, and will announce the results of the roll call vote. The Secretary will monitor voting for possible conflicts of interest (RWPC Policy No. 800.01). The Secretary will process inquiries into votes made in conflict of interest.

ATTENDANCE:

Council members are required to attend meetings of the Houston Area HIV Health Services (Ryan White) Planning Council. Affiliate Committee members are required to attend meetings of the committee to which they are assigned. The Secretary shall cause attendance records to be maintained and shall regularly provide such records to the Chair of the Operations Committee. The Operations Committee will review attendance records quarterly.

If a Council or Affiliate committee member has 4 absences (excused or unexcused) from Council meetings or 4 absences from committee meetings within a calendar year or fails to perform the duties of a Council member described herein without just cause, that member will be subject to removal. In order to avoid such action, the following will occur: Step 1: Office of Support staff will contact the member by telephone to check on their status. Step 2: If the member continues to miss meetings, the Chair of the Planning Council will formally notify the member in writing to remind them of Council policies regarding attendance and to give the member an opportunity to request assignment to another committee. If assignment to another committee is requested, the Chair of the newly selected committee and the Planning Council Chair must approve the change. Step 3: If the Council member continues to miss meetings, the CEO will be informed of the situation and the steps taken by the Council to address the situation. If an Affiliate committee member continues to miss meetings, the Chair of the Council will be informed of the situation and the steps taken by the Council to address the situation. Step 4: The CEO has the sole authority to terminate a Council member and will notify said member in writing, if that is their decision. The CEO or the Chair of the Planning Council has the authority to terminate an Affiliate committee member and will notify said member in writing, if that is their decision.

If for two consecutive months the Office of Support is unable to make contact with a Council or an Affiliate committee member by telephone and receives returned email and/or mail sent to that member, staff will send a certified letter requesting the member to contact the Office of Support

by telephone or in writing to update their contact information. If the member does not respond to the certified letter within 30 days, or if the certified letter is returned to the Office of Support, the Operations Committee will be notified at their next regularly scheduled meeting. At the request of the Operations Committee, the Chair of the Planning Council and the CEO will be informed of the situation and the steps taken by the Council to address the situation. As stated above, the CEO has the sole authority to terminate a Council member and will notify said member in writing, if that is his/her decision. The CEO or the Chair of the Planning Council has the authority to terminate an affiliate committee member and will notify said member in writing, if that is his/her decision.

Reasons for absences that would be used to determine reassignment or dismissal include: 1) sickness; 2) work related conflicts (in or out of town and vacations), and 3) unforeseeable circumstances. Any Planning Council member who is unable to attend a Planning Council meeting or standing committee meeting must notify the Office of Support prior to such meeting. The Office of Support staff will document why a member is absent.

PROXIES:

There will be no voting by proxy.

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL

EST. JUL. 15, 1998 **REV JANUARY 1, 2020** **POLICY No. 800.01**

CONFLICT OF INTEREST

PURPOSE

To define the policy in which the Houston Area HIV Health Services (RW) Planning Council identifies and addresses conflict of interest within the planning council (PC).

- Inherent in the system - The Ryan White Program states: The HIV health services planning council shall include representatives of...community-based organizations serving affected populations and HIV service organizations; local public health agencies...

- Must be managed - The Ryan White Program states: The PC may not be directly involved in the administration of a grant. The PC may not designate (or otherwise be involved in the selection of) particular entities as recipients of any amount provided in the grant.

AUTHORITY

The Ryan White HIV/AIDS Treatment Extension Act of 2009, Sec.2602(b)(1); Sec.2602(b)(5)(A); Sec.2602(b)(5)(B); Article VIII, Sec8.01 of the Bylaws (01/18) of the Houston Area HIV Health Services (RW) Planning Council.

DEFINITION(S)

"Conflict of Interest" (COI) is defined as an actual or perceived interest by a RWPC member in an action which results or has the appearance of resulting in personal, organizational, or professional gain. COI does not refer to persons living with HIV (PLWH) whose sole relationship to a Ryan White Part A or B or State Services funded provider is as a client receiving services. The potential for conflict of interest is present in all Ryan White processes: needs assessment, priority setting, comprehensive planning, allocation of funds and evaluation.

PROCESS

The rules contained in this policy apply to all RWPC members, council support, contractors and consultants to the Houston Area HIV Health Services (RW) Planning Council, all of whom shall be referred to as RWPC members in this policy.

RWPC members who have a financial interest in, are employed by, sit on Boards of Directors, or have been employed by such an entity at any time during the previous twelve months, or are members of a public or private entity seeking Ryan White Part A or B or State Services funding will not participate directly or in an advisory capacity, in the Administrative Agency's processes of selecting entities to receive Ryan White Part A or B or State Services funding within that particular service category. RWPC members shall be provided with copies of, and shall abide by local state regulations governing COI.

RWPC members must complete a COI Disclosure Form annually and/or as needed, describing the relationship of the person to each organization that can benefit from an action by the RWPC. This information, in the form of a matrix of members and their conflicts of interest, will be provided to all members of the RWPC. Additionally all RWPC members will identify conflicts of interest during a discussion and/or vote and abstain from voting on issues pertaining to that conflict. All RWPC members are encouraged to request a review of potential COI of another member during a RWPC meeting.

The Secretary of the RWPC has responsibility for addressing actions to resolve COI when they occur (see RWPC Policy 500.01). When the Secretary has a COI, monitoring voting for COI and processing inquiries related to COI will fall to the role of the Council Vice Chair, if the Council Vice Chair has a COI the responsibility will fall to the Council Chair. If still unresolved then the responsibility will fall to the Chair of the Operation Committee.

In the event of a COI and/or during the period of review of said COI, members with a COI may participate in the discussion of the COI or questions, but shall abstain from voting on the matter.

The Operations Committee of the RWPC shall recommend to the CEO the termination of a member from the RWPC if the member refuses to complete a COI disclosure form, refuses to declare a COI, or refuses to cooperate in a COI review, or if it is determined that the member took action intended to influence the conduct of the Administrative Agency in selecting entities to receive Ryan White Part A or B or State Services funding within a particular service category or an action which resulted in or had the appearance of resulting in personal, organizational, or professional gain.

COI INQUIRY/INTRODUCTION/PROCEDURE:

A COI matrix from the information provided on the COI questionnaire will indicate the service category(ies) in which a conflict(s) occurs.

An inquiry as to whether or not an individual has a conflict of interest that has not been disclosed is handled as a privileged motion: raising a question of privilege.

Questions of privilege relate to the conduct of officers, members, and employees. In this specific case, the conduct being addressed would be not having disclosed a COI. A question of privilege (COI Inquiry) will usually take place during or after a discussion or vote. If necessary, raising a question of privilege may interrupt a member's speech.

A member of the RWPC, who feels that another member has violated the COI policy by failing to disclose a COI or by voting on an issue regarding a service category in which a conflict has been disclosed, should raise a question of privilege in order to inquire about a possible conflict. The following steps will take place:

Step 1: A member rises, addresses the chair, and then, without waiting, says, "I rise to a question of privilege."

Step 2: The Chair will at this time request the Secretary to take control of the meeting. The Secretary will direct him/her to state his/her question.

Step 3: The member will briefly express his/her complaint and propose, as a motion, a solution.

The motion is the actual question of privilege or a request to inquire about a COI.
Step 4: The Secretary will attempt to process the motions to inquire as to whether a member has a COI by general consent. (General consent requires no objections). If the general consent is obtained, the motion will be discussed.

If general consent fails, the Secretary will ascertain if there is a second to the motion and then process it as a main motion (even if a main motion was interrupted).

As soon as the interrupting question of privilege is disposed of, the assembly resumes consideration of the question that was interrupted.

METHOD OF DISCLOSURE:

Annually and on an as needed basis, PC and affiliate committee members are required to submit a Proposed Conflict of Interest Disclosure Questionnaire (RWPC Form 2, COI) to PC Support Staff.

PROCEDURE FOR COUNCIL MEMBERS WHO BECOME VENDORS AFTER JOINING THE COUNCIL:

Vendors must abide by the same conflict of interest policies that everyone else does.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL. 15, 1997 **REV JANUARY 1, 2020** **POLICY No. 900.01**

PETTY CASH

PURPOSE

This policy establishes the guidelines by which petty cash reimbursements of expenses to attend Houston Area HIV Health Services (Ryan White) Planning Council meetings are made. The purpose of these funds is to encourage a wide range of community participation. While all members of the RWPC are eligible for reimbursement, all members are encouraged to pay for their own expenses out of their own funds if possible. This policy includes both internal as well as Affiliate members.

AUTHORITY

"Guidelines for Reimbursement of People on a Ryan White Title I Planning" dated January 21, 1997, and the Ryan White HIV/AIDS program Part A Manual - Revised 2013. The RWPC voted on February 10, 1996 to set as a priority the reimbursement of expenses to attend RWPC meetings (including subcommittee and related meetings). Those eligible to receive reimbursement of expenses to attend committee, subcommittee and related meetings include Council and Affiliate committee members.

DEFINITIONS

Meetings - are defined as outlined in the RWPC adoption of its Bylaws, Article IX. Rev. 01/18.

Meals - are those that are related to and occur as the result of attending any scheduled Houston area HIV/AIDS Health Services (Ryan White) Planning Council meeting, including Ryan White committee and workgroup meetings, and outreach events.

PROCESS

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

Transportation - Expenses will be reimbursed as a result of a Planning Council or Affiliate committee member attending a scheduled meeting. If travel is conveyed through the use of the members own vehicle the rate will be the same as the county rate per mile. Council and Affiliate committee members are reimbursed for mileage to and from a consistent, designated starting point (either home or work). The start point will be documented in the member's file and mileage will be determined by an Internet site selected annually by the Office of Support. Members are encouraged to carpool. When members carpool, only the member who is the driver of the automobile can request mileage reimbursement from his or her designated starting point.

If a member is employed, and work hours are any time on a Monday through Friday during regular

business hours (approximately 8 a.m. until 5 p.m.), the member must provide the requested employment-related information on the Petty Cash Transportation Form. If work hours typically overlap with Ryan White meetings, then the member must use their primary work address as their designated starting point for determining mileage reimbursement. Harris County may contact an employer to confirm employment information provided on the Petty Cash Transportation Form. When an individual uses their work address as the point of origin for their travel reimbursement, then they are not eligible for childcare reimbursement.

If the member travels by cab, then an official cab company receipt must accompany the request for reimbursement. Traveling by cab should be the option of last resort, with the following exceptions. Council and Affiliate committee members who are accompanied by children are allowed to take a cab to and from work, home and/or the child care provider. Members are also allowed to use a cab if no other means of transportation is available or there are barriers to existing transportation. Bus expenses will be reimbursed at the prevailing METRO rate (round trip).

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

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

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

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

REIMBURSEMENT

Reimbursement requests are to be submitted to the Office of Support for payment. Receipts must be submitted any time within 45 days of the date of the event or they will not be approved. End of year reimbursements must be submitted within 30 days after the end of the Ryan White Part A fiscal year. Reimbursement requests presented 30 days after the end of the fiscal year will not be approved. Any request that does not fall within the time frames outlined above needs to be submitted in writing to the RWPC Director for approval. All reimbursements are available from the Ryan White Office of Support Staff.

If a check is lost or stolen, as long as the check has not been cashed, the Office of Support will replace one check per year as a courtesy to the member and Ryan White will pay the administrative fee. If more than one check is lost or stolen within a calendar year, the lost or stolen check will not be replaced.

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

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

Members are allowed to ask the Operations Committee for exemptions from any portion of the above policy by submitting a letter to the Director of the Ryan White Office of Support stating why personal circumstances should allow them to be exempt. The Director will share the letter with the Operations Committee at their next scheduled meeting. The Operations Committee will respond to the request in writing.

MAXIMUM REIMBURSEMENT RATES

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

The allowable amount for all members is:

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

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

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

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

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

Written requests for exceptions can be submitted to the Operations Committee for review and approval.

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

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

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

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

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

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 15, 1998 REV JANUARY 1, 2018 POLICY No. 1000.01

GRIEVANCE

PURPOSE

This policy establishes which types of grievances will be covered by the procedures and who may bring a grievance. This process will address priority setting and allocating funds to those priorities and any subsequent process to change the priorities or allocations. Any changes as a result of a hearing, mediation or arbitration process will be perspective in nature (i.e. any changes as a result of this process will effect future decisions and not impact former or current funding decisions).

This policy will permit individuals or entities directly affected by the outcome of a decision related to funding as being eligible. At a minimum; providers eligible to receive Ryan White funding; consumer groups/PLWH coalitions and caucuses.

This policy will allow for non-binding procedures for resolving conflicts, including but not limited to Mediation for the parties in reaching a solution. In addition, Binding Arbitration will be the final resolve in this process.

AUTHORITY

Section 2602(b)(6) requires Planning Councils to develop procedures for addressing grievances with respect to funding; Section 2602(c)(1)(A), refers to non-binding and binding arbitration and under subsection (b)(1) allows for local discretion and describes the elements that must be addressed in establishing local grievance procedures and provides grantees with flexibility in the design of such local procedures. Section 2602(c)(1)(B) requires that once grievance policies are established they are determined adequate. This will assess whether such procedures permit legitimate grievances to be filed, evaluated, and resolved at the local level. Section 2602(c)(2) states that "to be eligible to receive funds under this part a grantee shall develop grievance procedures that are determined by the Secretary to be consistent with the model procedures developed under paragraph (1)(A) of HRSA regs. By adoption of the BYLAWS of the Houston Area HIV Health Services (Ryan White) Planning Council; Rev 12/17.

DEFINITIONS

Arbitration - A private informal process by which all parties agree, in writing, to submit their disputes to one or more impartial persons authorized to resolve a controversy by rendering a final and binding award.
Arbitrator - An impartial third party who has completed a minimum of 40 hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution system or organization. Decisions awarded by arbitrators are binding unless otherwise stipulated in advance of the arbitration proceeding.
Business Day - Reference to a business day will be understood to mean Monday through Friday,

8:00am to 5:00pm.
Court - Includes an appellate court, district court, constitutional county court, statutory county court, family law court, probate court, municipal court, or justice of the peace court.
Grievance - Any unresolved controversy, claim or dispute relating to the Planning Council process involving establishing priorities; allocating funds to those priorities and any subsequent process to change the priorities or allocations.
The Operations Committee - The Operations Committee will convene as needed to address a grievance. All final resolutions by that committee will be presented at the next full Planning Council meeting and presented by the Chair of the Operations Committee.
Grievant - An individual or group of individuals with standing and who file a grievance with the Director of the Office of Support for the Planning Council.
Hearing - Meeting held with the Houston Area HIV Health Services (Ryan White) Planning Council Operations Committee at which an individual or group of individuals provides specific testimony relating to an unresolved controversy, claim or dispute.
Mediation - A private, informal process in which an impartial third person facilitates communication among parties to encourage reconciliation, settlement or agreement of a particular dispute, controversy, or claim.
Mediator - An impartial third person who facilitates the communication between parties in dispute and encourages reconciliation, settlement or agreement of a particular dispute, controversy of claim. Qualifications of a mediator must include a minimum of 40 classroom hours of training in dispute resolution techniques provided by an alternative dispute resolution system or organization. A mediator may not impose his own judgment on the issues for that of the parties.

TIMELINE:

Written notification of grievance, using the Grievance Intake Form, must be given to the Director of the Office of Support for the Planning Council within five (5) business days after the incident or results of the process being grieved are announced. When written notification of grievance is received, the Director of the Office of Support will establish a file which briefly describes the grievance issue and the remedy being requested.

The Director , within three (3) business days, will notify the Chair of the Operations Committee and the Chair of the Planning Council of the grievance notification. The Director will also acknowledge receipt of grievance to grievant by certified mail, return receipt requested, within three (3) business days of notification.

A grievance hearing will be held within fourteen (14) business days after receipt of notification of the grievance. At that time, the Operations Committee will determine whether the grievance is within the scope of the procedures, and whether or not a grievant is eligible to initiate a non-binding process. Once a grievance has been filed, if not resolved at the initial hearing, the conversation from here forward must be limited to the items discussed in the grievance hearing. Amendments to the form are acceptable only before the hearing. The person who filed the grievance and the party(s) involved will be interviewed by the Operations Committee.

The grieving party will be notified by certified mail, return receipt requested, of the date, time and place of hearing at least five (5) business days before the hearing is held.

The Operations Committee will render a decision within ten (10) business days after the scheduled Grievance hearing, and Grievant will be notified of said decision by certified mail, return receipt requested, within three (3) business days after rendered decision.

If, after being notified of the Operations Committee's decision, any party to the grievance is not satisfied with said decision, that party may request mediation of the dispute. That party must notify in writing the Director of the Office of Support of the request for mediation no later than three (3) business days after receiving the Operations Committee's decision. Mediation will be provided by the Harris County Alternative Dispute Resolution Service, or any other such service that is mutual agreed upon by all parties involved, who will provide impartial third parties to mediate the filed grievance. Mediation costs will be shared equally among both parties involved.

The initial mediation will be scheduled within fourteen (14) business days after the Planning Council Director (subject to the schedule of the mediation service) receives the request. The mediation process will be held at a location designated by the mediation service provider, and all business conducted during the mediation process will be considered confidential. Documents provided during mediation will be subject to the Public Information Act. Maximum amount of time to complete any non-binding process will be eight (8) hours. Additional time may be granted on an "as needed" basis to promote resolution of the grievance.

Any unresolved controversies, claims or disputes that cannot successfully be resolved through the Operations Committee process or through good faith negotiations in mediation shall be settled by arbitration. Results of the arbitration will be binding upon all parties involved. The grievant must notify in writing the Director of the Office of Support of the intent to pursue arbitration within three (3) business days after the mediation process ends.

A panel of three (3) qualified neutral arbitrators will conduct the arbitration process. An independent, impartial third party organization designated in advance will provide each party with a list of proposed arbitrators who may be familiar with the subject matter involved in the grievance. Each side will have ten (10) business days to strike the names of those individuals on the list that are deemed unacceptable, prioritize the remaining names in order of preference and return the list to the designated organization. The designated organization will contact the arbitrators remaining on the list in order of preference to serve on the panel.

The Arbitration Committee will hear the dispute within thirty (30) business days after the appointment of the arbitrators. Fees associated with the arbitration process will be borne by the parties equally. However, each party shall be responsible for expenses related to its own counsel, experts, witnesses, and preparation and presentation of documents. Cost and fees may include, but are not limited to, all reasonable pre-award expenses of the arbitrators' fees, administrative fees, travel expense, out-of-pocket expenses for copying and telephone, court cost, witness fees, and attorney's fees.

Policy 002.

Date of Issue	_____	Date of Grievance Recommendation	_____
Date Filed	_____	Date of Appeal	_____
Date Received	_____	Date of Appeal Decision	_____
Date of Hearing	_____	Date Grievance Concluded	_____

Please do not write in this space

The Grievance Process will be as follows:

1) Grievant must notify the Director of the Office of Support for the Planning Council in writing of a grievance.
2) The Director will immediately notify Chair of the Operations Committee of request for hearing.
3) The Grievance hearing will be scheduled within fourteen (14) business days after the request for hearing is received by the chair of the Operations Committee.
4) Amendments to the form are acceptable only before the hearing.
5) If a mutual agreeable solution is not reached in this process, the grievant may request mediation.
6) Mediation will be provided by a mutually agreed upon service to all parties involved.
7) Mediation costs will be shared equally among all parties involved.

GRIEVANCE FORM

Instructions: Please type or print the information requested in the space provided below. If additional space is needed, please attach additional pages.

Name: _____ Title: _____

Agency: _____ Phone: _____

Address: _____ Zip code: _____

Briefly provide a description of expectations from the grievance process:

Will you have a representative at the hearing? _____
If yes, please provide the representative's name: _____
List the names of witnesses and a brief overview of the witnesses' testimony:

_____	_____	_____
Grievant Signature	Title	Date

Operations Committee's Recommendations

_____	_____	_____
Signature	Title	Date

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL (RWPC)

EST. JAN 2002 **REVISED JANUARY 1, 2020** **POLICY NO. 1100.00**

COMPUTER POLICY

PURPOSE

This policy establishes the guidelines by which petty cash reimbursements of expenses for personal computer ISP lines on which they do business related to the Houston Area HIV Health Services (Ryan White) Planning Council. While all members of the RWPC are eligible for reimbursement this policy notes that members who are not living with HIV are encouraged to pay for their own expenses out of their own funds. This policy includes both internal as well as affiliate members.

PROCESS

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

REIMBURSEMENT FOR ISP LINES

The Council will pay for 50%, with a maximum cap of $11 per month, for the cost of a Council member's home ISP service. The Council member must submit a copy of the bill and a copy of their check or credit card receipt indicating payment of the total bill in order to be reimbursed from petty cash.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL (RWPC)

EST. OCT. 2002 **REVISED JANUARY 1, 2018** **POLICY NO. 1200.00**

HONORARIUMS

PURPOSE

The purpose of this policy is to establish guidelines by which honorariums or other forms of gratuity are received by Ryan White Planning Council members.

PROCESS

No member of the Ryan White Planning Council, or any other Council-related volunteer, may accept an honorarium or other form of gratuity for services performed in connection to his or her service to the Council. This does not pertain to reimbursements for travel, meals, hotel or other expenses incurred in performance of these services. If an honorarium is sent, the recipient is to turn it in to the Office of Support who will return the check with a letter declining the check and a suggestion that the money be distributed to an HIV organization, such as those listed in the Blue Book.

Activity 6

MEETINGS BY THE "RULES": A GUIDE TO PARLIAMENTARY PROCEDURE

Formal meetings, such as the Ryan White CARE Act planning body meetings, are usually organized by a set of procedures called Robert's Rules of Order. These "rules" establish the ways that things get accomplished at meetings. They ensure that meetings are conducted in an organized way.

Robert's Rules of Order are based on three important principles, or "rights":

- the right of the majority to rule
- the right of the minority to be heard, and
- the right of the individual to have a voice in the decision-making process

Robert's Rules of Order are sometimes referred to as *parliamentary procedure*.[3] Under this system, business is conducted by acting on **motions**—ideas or actions that committee members suggest.

IN THEIR OWN WORDS...

"The structure of the meeting can make it hard to keep consumers involved."

[3] In this section we explain the process by which planning groups make decisions using Roberts Rules of Order. We decided to use a light-hearted example – serving ice cream and cake at meetings – because we wanted to emphasize the **process** of making motions and amendments, rather than the content of the subject under discussion.

This is what happens:

A member of the planning group introduces a main **motion.**

- *"I move that we have ice cream and cake at all meetings."*

Another member then **seconds the motion** (supports it).

- *"I second the motion."*

The person in charge of the meeting then **restates the motion.**

- *"It has been moved that ice cream and cake be served at meetings."*

And opens the meeting to **discussion** about the motion.

- *"Is there any discussion?"*

Discussion takes place.

- *"I think it is a really good idea. I'm always hungry when I come to these meetings, and it would be great to have ice cream and cake to look forward to."*
- *"I'm not so sure about this. Ice cream and cake are not healthy foods. I think we should have carrot sticks instead."*
- *"I'm in favor of the motion. These meetings are so long. It would be great to have a break and have ice cream and cake at each one."*

After a while, when discussion is finished, or when it is time to stop the discussion, the person in charge of the meeting asks if participants are ready to **vote** on the motion. If there is general agreement (consensus), the person in charge restates the motion and takes a vote.

- *"All those in favor of the motion?"* (People can vote with their voices or by raising their hands.)
- *"All those opposed?"* (Again, people can vote verbally or by raising their hands.)

In the case of the ice cream and cake motion, all the members of the committee voted "Aye!" They were in favor of the motion and it passed unanimously! In the future, ice cream and cake will be served at meetings.

Sometimes, though, the process is not so simple. For example:

During discussion one committee member was concerned about the expense of having refreshments served at meetings.

- *"I don't think our committee can afford to have ice cream and cake at every meeting. I would like to **amend** the motion to have ice cream and cake at every other meeting."*

There are various rules about whether the original motion can be **amended** (changed).

- ❖ Sometimes the person who made the original motion is asked to accept a **friendly amendment.** In this case, to change the wording of the original motion to have ice cream and cake at every other meeting.
- ❖ In more formal meetings, the person in charge may ask that the original motion be withdrawn, and then restated to include the proposed changes.
- ❖ Or the person in charge may require that the original motion be voted on. If it is defeated, a new motion, which includes the proposed changes, can then be introduced.

In our example, the **friendly amendment** was not accepted. The original motion was put to a vote, and it passed. Ice cream and cake will be served at all meetings!

Here's another example:

There were many concerns about the cost of ice cream and cake at committee meetings. Discussion continued. Finally, someone suggested that the matter be **referred to a sub-committee.**

- *"We have so many questions about this issue. I propose that we **refer** the motion to a sub-committee to find out exactly what it will cost."*

If there is general agreement, the person in charge of the meeting refers the motion to a subcommittee.

- *"Please gather the necessary information and report back to the full committee at next month's meeting."*

And one more example:

Discussion about ice cream and cake dragged on and on and on. Some people were concerned about the cost; others worried about the nutritional value. Many, however, thought it was a splendid idea. No one could agree. After quite a long time, someone acts to end the discussion and require the members to vote on the **motion** to have ice cream and cake at all meetings.

- *"I move the previous question."* (make a motion to end discussion and take a vote)

Someone else supports the idea to end discussion.

- *"I second the motion."*

The person in charge then asks for a vote. Two-thirds of the people vote to end the discussion. They then take a vote on the original motion. And, finally, it is agreed that ice cream and cake will be served at all meetings!

Remember, Robert's Rules of Order are intended to provide a fair decision-making structure. They are not meant to stop important discussions or to take up lots of valuable time. They are meant to help groups work toward consensus in the fairest and most efficient way possible. **Table 7** presents the terms you are most likely to hear during meetings. Keep it as a handy reference on parliamentary procedure.

Table 7
Robert's Rules of Order: A Glossary of Terms

Motion — an idea or action that a planning body member suggests or recommends

Second the motion — support a suggestion or recommendation that has been made

Amend the motion — offer a change or addition to a motion

Amendment — a proposed change to a motion

Refer the motion — ask a subcommittee to gather additional information about a motion

Postpone the motion — delay a motion until a stated future time

Move the question — bring an end to discussion and take a vote on the motion

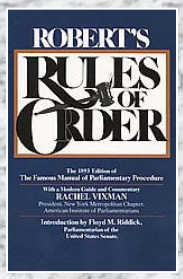
Point of order — suggest that a "rule" of parliamentary procedure has been broken

WHO IS ROBERT?

Henry Martyn Robert was an officer in the United States Army. One day, without any warning, he was asked to run a meeting at his church. It was a disaster! People wouldn't listen to each other; they wouldn't take turns speaking. He was very embarrassed, and he vowed never to attend another meeting until he understood proper meeting procedures. He studied many books on British parliamentary procedure and in 1876 published the first edition of *Robert's Rules of Order*.

Adapted in part from *10 Minutes to Better Board Meetings* by Norah Holmgren (1997), Planned Parenthood Federation of America

ROBERT'S RULES OF ORDER



Parliamentary Procedures for more Productive Meetings

Formal meetings, such as the Ryan White Planning Council and committee meetings, are usually organized by a set of procedures called Robert's Rules of Order.

These "rules" establish the ways that things get accomplished at meetings and ensure that meetings are conducted in an organized way.

Robert's Rules of Order are sometimes referred to as parliamentary procedure. Under this system, business is conducted by acting on motions - ideas or actions that committee members suggest.

Robert's Rules of Order are based on three important principles, or "rights":

- ❖ the right of the majority to rule,
- ❖ the right of the minority to be heard, and
- ❖ the right of the individual to have a voice in the decision-making process.

When a motion is made, the Chair will say "So moved" and call for someone to SECOND the motion.
The chair will ask for discussion of the motion.
Once discussion is complete, the motion is voted on.

If the motion passes, the chair will say "Motion Carried"; if it does not, "Motion Failed".

Going Through the Motions…

To <u>Introduce a Motion</u> you should say:

"I move that… "

EXAMPLE:

To adopt the Agenda for a meeting you would say:

"I move to adopt the agenda".

To <u>Introduce a Motion From a Committee</u> say:

"The (name of committee) moves that… "

EXAMPLE:

To present a committee work product such as the Needs Assessment for endorsement by the full Council you would say:

"The Comprehensive HIV Planning Committee moves to endorse the 2023 Needs Assessment".

To <u>Amend a Motion</u> you would say:

"I move to amend the motion by… "

EXAMPLE:

To add a caveat to a motion you would say:

"I move to amend the motion by adding 'with the understanding that it will go directly to Council for approval'.".

When a motion is made, the Chair will say "So moved" and call for someone to SECOND the motion.
The chair will ask for discussion of the motion.
Once discussion is complete, the motion is voted on.

If the motion passes, the chair will say "Motion Carried"; if it does not, "Motion Failed".

Get Additional Information…

To <u>Request Information</u> (or clarification) before voting on a motion you would say:

"Point of Information"

EXAMPLE:

To better understand the rationale behind a motion you would say:

"Point of information" The chair will then recognize you and call on you to ask your question.

To ask to <u>Have Something Studied Further</u>:

"I move to refer the motion to (name of committee)… "

EXAMPLE:

If you want the Quality Improvement Committee to present documentation regarding changes made to a service category during How To Best Meet the Need you would say:

"I move to refer the motion to the Quality Improvement Committee for further study"

Slow the Process or Stop it…

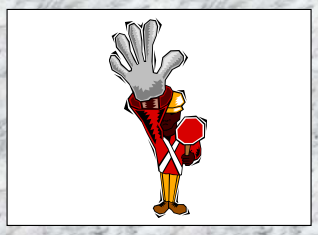
To <u>Postpone Consideration</u> of something you would say:

"I move to postpone the motion to… "

EXAMPLE:

To postpone the vote on a motion you would say:

"I move to postpone the motion to give the committee time to gather additional information on this issue".



To <u>Suspend Further Consideration</u> of something you would say:

"I move we table this matter"

EXAMPLE:

To suspend further consideration of an issue you would say:

"I move we table this matter due to lack of sound information on this issue".

To <u>End Debate</u> on an item you would say:

"I move to call for the question"

EXAMPLE:

To end a lengthy discussion and vote on an issue you would say:

"I move to call for the question".

To <u>Consider Something out of the Scheduled Order</u> you would say:

"I move to suspend the rules and consider… "

EXAMPLE:

To discuss an item earlier in the meeting than it is listed on the agenda you would say:

"I move to suspend the rules and consider the report from the Quality Improvement Committee before the one from the Steering Committee".

Hey, you can't do that…

To <u>Object to Considering Something that is Undiplomatic or Improper</u> you would say:

"I object to the consideration of the question… "

EXAMPLE:

A Priority & Allocations committee member is asking questions about Appletop Agency's use of Ryan White funds, you would say:

"I object to the consideration of the question; the Council is not allowed to discuss agency business".

To <u>Object to a Procedure</u> you would say:

"Point of Order"

EXAMPLE:

A motion was made and seconded but a rather heated debate ensues regarding an earlier motion that failed, you would say:

"Point of Order". The chair will then recognize and call on you to state what you are objecting to.

Not necessarily the final word…

To <u>Vote on a Ruling by the Chair</u> you would say:

"I appeal the Chair's decision"

EXAMPLE:

In the interest of time the chair of the Operations Committee decides to cancel public comment for today's meeting, you would say:

"I appeal the Chair's decision" and the committee will vote on whether or not to let the decision stand.

To <u>Adjourn the Meeting</u> you would say:

"I move we adjourn"

EXAMPLE:

Committee business is done, announcements have been made and there is nothing left to discuss:

"I move we adjourn."

Just like the motions discussed earlier, someone will second and the Chair will call for a vote on whether or not to end the meeting. ☺

Robert's Rules of Order – Parliamentary Procedures

To Do This:	You Say This:	May you interrupt the Speaker?	Must you be Seconded?	Is the Motion Debatable?	Can the Motion be Amended?	What Vote is Needed?
Introduce a motion	I move that …	No	Yes	Yes	Yes	Majority
Introduce a motion from a committee	The (name of committee) moves that…	No	No	Yes	Yes	Majority
Amend a motion	I move to amend the motion by ...	No	Yes	Yes	Yes	Majority
Request information	Point of information.	Yes	No	No	No	None
Have something studied further	I move to refer the motion to (name of committee) ...	No	Yes	Yes	Yes	Majority
Suspend further consideration of something	I move we table this matter.	Yes	Yes	No	No	Majority
Postpone consideration of something	I move to postpone the motion to ...	No	Yes	Yes	Yes	Majority
End debate (call for the question)	I move the previous question.	No	Yes	No	No	2/3
Consider something out of the scheduled order	I move to suspend the rules and consider…	No	Yes	No	No	2/3
Object to considering something undiplomatic or improper	I object to the consideration of the question.	Yes	No	No	No	2/3
Object to a procedure	Point of Order.	Yes	No	No	No	None
Ask for a vote by actual count to verify a voice vote	I call for a division of the house.	No	No	No	No	No
Vote on a ruling by the Chair	I appeal the chair's decision.	Yes	Yes	Varies	No	Majority
Complain about noise, room temperature, etc.	Point of privilege.	Yes	No	No	No	None
Recess the meeting	I move that we recess until…	No	Yes	No	Yes	Majority
Adjourn the meeting	I move we adjourn.	No	Yes	No	No	Majority

Who Was Ryan White?

The Ryan White HIV/AIDS Program was named for a courageous young man named Ryan White who was diagnosed with AIDS following a blood transfusion in December 1984. Ryan White was diagnosed at age 13 while living in Kokomo, Indiana and was given six months to live. When Ryan White tried to return to school, he fought AIDS-related discrimination in his Indiana community. Along with his mother Jeanne White Ginder, Ryan White rallied for his right to attend school - gaining national attention - and became the face of public education about his disease. Surprising his doctors, Ryan White lived five years longer than predicted. He died in April 1990, one month before his high school graduation and only months before Congress passed the legislation bearing his name in August 1990 - the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Listen to Jeanne White Ginder recount those early years of struggle, pain, and triumph. Scroll down to listen to all five dialogs:

- How Could He Have AIDS?
- Mom, I Want to Go to School
- Mom, You Don't Get It
- He Was My Son
- His Legacy Would Be

How Could He Have AIDS?

Ryan was one of the first children with hemophilia to be diagnosed with AIDS. Play audio (MP3 - 545 KB)

Ryan White was diagnosed with AIDS on December 17, 1984. He was one of the first children, one of the first hemophiliacs to come down with AIDS, and it was definitely a time where there was no education and there was hardly any information on AIDS at the time. So I was living in Kokomo, Indiana, and Ryan was attending Western Middle School, and it was something that I really didn't even believe he had. I felt like, "How could he have AIDS?" He was a hemophiliac since birth, and I just felt like "How could he be one of the first ones?" I felt like somehow, in some way, it was going to be something else. I really never really believed he had AIDS for quite a while. At that time, of course, he had no precautions, or anything. There were no precautions at the hospital. And all of a sudden the CDC shows up and the CDC started putting in all kind of precautions, you know: the gloves, the gowns, the masks and so forth, and started talking to the nurses and so forth. It became apparent just like overnight that all of a sudden things were different.

Mom, I Want to Go to School

Ryan really became famous because of his fight to go to school.
Play audio (MP3 - 639 KB)

When Ryan was diagnosed, they only gave him 3-6 months to live. So at that time, I thought every cough, every fever, I worried that it was going to be his last. And I really never thought he'd be healthy enough to go to school. But as he started getting healthy, as he started gaining weight, he started to ask, "Mom," he said, "I want to go to school, I want to go visit my friends. I want to see my friends." So I really kind of put him off for awhile and finally he just said, "Mom, I want to go to school, I want to go visit." So It was a long process, we had to go through almost a year and a half, he didn't go to school for about a year and a half. He was worried about taking the 7th grade over again, and he didn't want people to think he was dumb,

because he was a very smart and intelligent kid. So it was a long process. Through court hearings, we thought it would take one court hearing, and we'd have all these medical experts in so to speak, and then everybody would be educated, but it didn't happen that way.

It was really bad. People were really cruel, people said that he had to be gay, that he had to have done something bad or wrong, or he wouldn't have had it. It was God's punishment, we heard the God's punishment a lot. That somehow, some way he had done something he shouldn't have done or he wouldn't have gotten AIDS.

Mom, You Don't Get It

Mrs. White Ginder recounts Ryan's excitement over getting a summer job. Play audio (MP3 - 541 KB)

Then we moved to Cicero, Indiana, and there, the community welcomed us. And it was all because a young girl, named Jill Stuart, who was president of the student body, who decided to bring in the medical experts and talk to the kids, and then the kids went home then and educated their parents. So Ryan was welcome, he got to go to school, he got to go proms and dances. He even got a job. It was kind of funny, he came home once after he turned 16 and told me he had a job for the summer. I thought, "Oh my gosh. Who is going to hire you, knowing who you are?" I said, "What are you going be doing," and he said, "I'm working at Maui's Skateboard shop." I said, "Really? What are you going to be doing?" and he said, "I'm going to be putting together skateboards." And I said, "How much are they going to pay you?" and he said "$3.50 an hour." I said, "Ryan, that won't even buy your gas to Indianapolis and back." He said, "Mom, you don't get it. I got a job just like everyone else does." So it was really important to Ryan, to just be one of the kids, and to just fit in. He never bragged or anything about who he was, or what he got to do, he just wanted to be around his friends.

He Was My Son

Play audio (MP3 - 196 KB)

Well a lot of people will say, "Your son was such a hero" and all that, but to me, he was my son. And you know, sometimes it's so confusing, because he was my little boy, and to share him with everybody, because he wasn't perfect, but at the same time, he was my son.

His Legacy Would Be

People are receiving better quality HIV care and living longer HIV. Play audio (MP3 -329 KB)

At the time when Ryan was diagnosed with AIDS, I mean, we heard of so many drugs coming out, and none of them was worth nothing. By the time you heard of one, there would be another one out, and you would never get the research for one. And none of them worked. And so even in the early 90s, when I was hearing there was hope, I kind of thought, "You know, we had that hope, too, but they didn't pan out." But they did pan out! The biggest contribution I think that Ryan made is, and I didn't know it at that time, that his legacy would be that people are getting their drugs and their treatment and that people are living with AIDS.

Date Last Reviewed: October 2016

Houston's Ryan White Planning Council

ABOUT THE COUNCIL…

MISSION STATEMENT

The Houston Area HIV Services Ryan White Planning Council will improve the quality of life and advocate for those living with and/or affected with HIV by taking a leadership role in the planning and assessment of HIV resources.

VISION STATEMENT

We envision an educated community where the needs of all people 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 Ryan White HIV/AIDS Treatment Extension Act of 2009 is divided into five major sections: Part A, B, C, D and F. The Houston Area Ryan White Planning Council is responsible for activities under Part A and makes recommendations regarding Part B and State Services funding. In 2021, these funds totaled approximately 30 million dollars.

Houston's Council is a 35-40 member volunteer planning group comprised of community members who have been appointed by the Chief Elected Official (CEO), Harris County Judge Ed Emmett, to serve a two-year term. The CEO is the person who officially receives the Ryan White Program Part A funds and the appointment of the Planning Council is a requirement in order to receive that funding.

Council members, in collaboration with consumers, service providers and other experts, determine what services are most needed by people living with HIV in the Houston Eligible Metropolitan Area (EMA). The Council then prioritizes those services and decides the best way to allocate Houston's grant award to fund the service categories.

The Council is also responsible for making recommendations regarding Standards of Care for each of the funded service categories and for working with other local stakeholders to develop a Comprehensive Plan for all HIV services in the community.

The Council does not directly fund or contract with agencies to provide client services. The Administrative Agent, Ryan White Grant Administration, a department of Harris County Public Health, is responsible for contracting with agencies according to the service descriptions, priorities, and allocations determined by the Council in order to acquire services for people living with HIV in Harris and the nine surrounding Counties.

KFF

The Ryan White HIV/AIDS Program: The Basics

Published: Nov 03, 2022

Key Facts

- The Ryan White HIV/AIDS Program, first enacted in 1990, is the largest federal program (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/) designed specifically for people with HIV, serving over half of all those diagnosed (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf). It is a discretionary, grant program dependent on annual appropriations from Congress.
- It is the nation's safety net program for people with HIV, providing outpatient HIV care, treatment, and support services to those without health insurance and filling in gaps in coverage and cost for those with insurance limitations.
- Most Ryan White clients are low-income, male, people of color, and half are gay and bisexual men and other men who have sex with men.
- The program is the third largest source (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/) of federal funding for HIV care in the U.S., following Medicare and Medicaid and is the largest source of HIV discretionary funding. Funding is distributed to states/territories, cities, and HIV organizations in the form of grants. In FY 2022, (https://www.kff.org/hivaids/slide/ryan-white-hiv-aids-program-federal-funding-fy1991-fy2022/) the Ryan White HIV/AIDS Program was funded at $2.5 billion which includes continued funding for the federal "Ending the HIV Epidemic" initiative.

Overview

The Ryan White HIV/AIDS Program (Ryan White), the largest federal program designed specifically for people with HIV in the United States, serves over half (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf) of those in the country diagnosed with HIV. First enacted in 1990, Ryan White has played an increasingly significant role as the number of people living with HIV has grown over time and people with

HIV are living longer. It provides outpatient care and support services to individuals and families affected by the disease, functioning as the "payer of last resort," by filling the gaps for those who have no other source of coverage or face coverage limits or cost barriers. Many "parts" of the program (described below) can purchase health insurance (https://www.kff.org/hivaids/issue-brief/the-ryan-white-program-and-insurance-purchasing-in-the-aca-era/) on behalf of clients which is often less expensive than paying for drugs alone and offers broader health coverage.

The program has been reauthorized by Congress four times since it was first created (1996, 2000, 2006, and 2009) and each reauthorization has made adjustments to the program. The current authorization lapsed in FY 2013, but the program has continued to be funded through the annual appropriations process as there is no "sunset" provision or end date attached to the legislation. The program is administered by the HIV/AIDS Bureau (HAB) at the Health Resources and Services Administration (HRSA) of the Department for Health and Human Services (HHS), and programs and services are delivered by grantees and sub-grantees at the state and local levels.

HRSA is one of the lead agencies in the federal government's Ending the HIV Epidemic (EHE): A Plan for America initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/), launched in 2019, and the Ryan White Program is set to play a key role in efforts to reach the goal of reducing new HIV infections by 75% in five years and by 90% in ten years. The initiative includes new federal funding, some of which has been channeled to Ryan White.

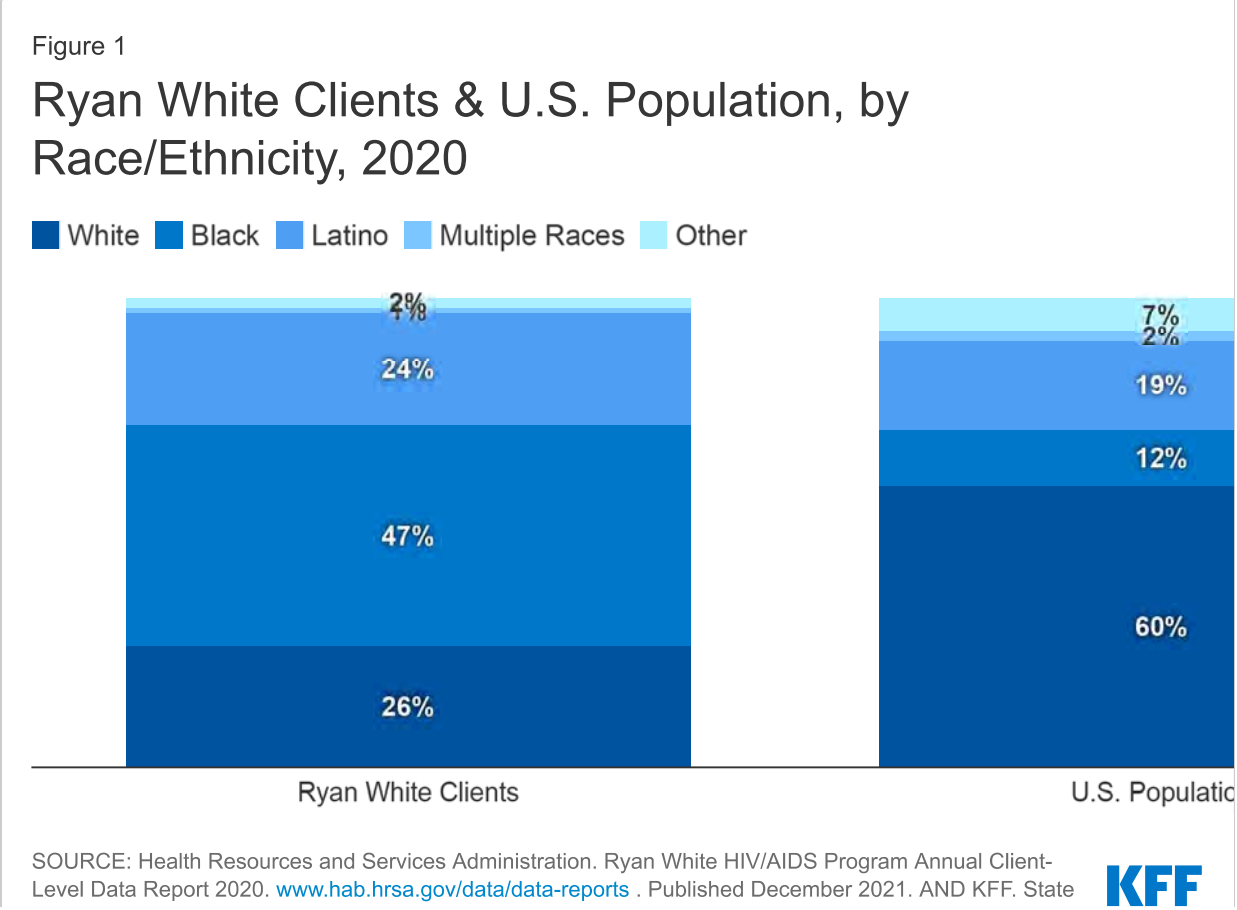
Clients

More than half a million people (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf) receive at least one medical, health, or related support service through the program in 2020, with many clients receiving multiple types of services:

- Nearly two-thirds (61%) had incomes at or below the federal poverty level (FPL) (which in 2020 (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2020-poverty-guidelines) was $12,760 for a single person or $26,200 for a family of four); 29% had incomes between 101% and 250% FPL.
- One-fifth (19%) were uninsured, a decrease from 28% in 2013, prior to enactment of the major coverage provisions under the Affordable Care Act (ACA). Most clients (80%) have some form of insurance coverage: Medicaid is the primary payer for Ryan White clients, covering 38%, including those dually eligible for Medicare. Other coverage includes: private insurance (20%), Medicare only (11%), and other or multiple sources of insurance (12%).
- Clients are largely male (72%), 26% are female and 2% are transgender. Approximately half (49%) are between the ages 45 and 64, up from 22% in 2016. More than one-third (38%) are between 25-44. Smaller shares are under 25 (4%) or over 64 (10%). Most clients are people of color (74%), including 47% who are Black and 24% who are Hispanic. Just over one-quarter of clients (26%) are White. Half (50%) are gay, bisexual men, or men who

have sex with men.

Figure 1



Role of Ryan White in the COVID-19 Response and Other Emerging Health Threats

In early 2020, the U.S. was hit by the COVID-19 pandemic which dramatically impacted health, health coverage, and health access for all people. The Ryan White Program pivoted (https://www.kff.org/hivaids/issue-brief/delivering-hiv-care-prevention-in-the-covid-era-a-national-survey-of-ryan-white-providers/) to find new ways of providing care, seeking to ensure that people with HIV were retained in care, even when the programs that serve them were strained. Recognizing the new stresses the pandemic might mean for Ryan White, Congress appropriated emergency supplemental funding for the program through the Coronavirus AID, Relief and Economic Security (CARES) Act (https://www.kff.org/coronavirus-covid-19/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/#:~:text=The%20CARES%20Act%20contains%20a,support%20for%20the%20global%20response.) in March of 2020 (Discussed further below, see also Table 1). The one-time allocation of $90 million supported 581 existing Ryan White grantees to aid them in preventing, preparing, and responding to the coronavirus. Funding was also provided to Ryan White Part F AIDS Education and Training Center Program (AETC) for the development of educational resources, expansion of telehealth capacity and incorporation of distance-based learning.

Alongside COVID-19, Ryan White has played a role in responding to other emerging health

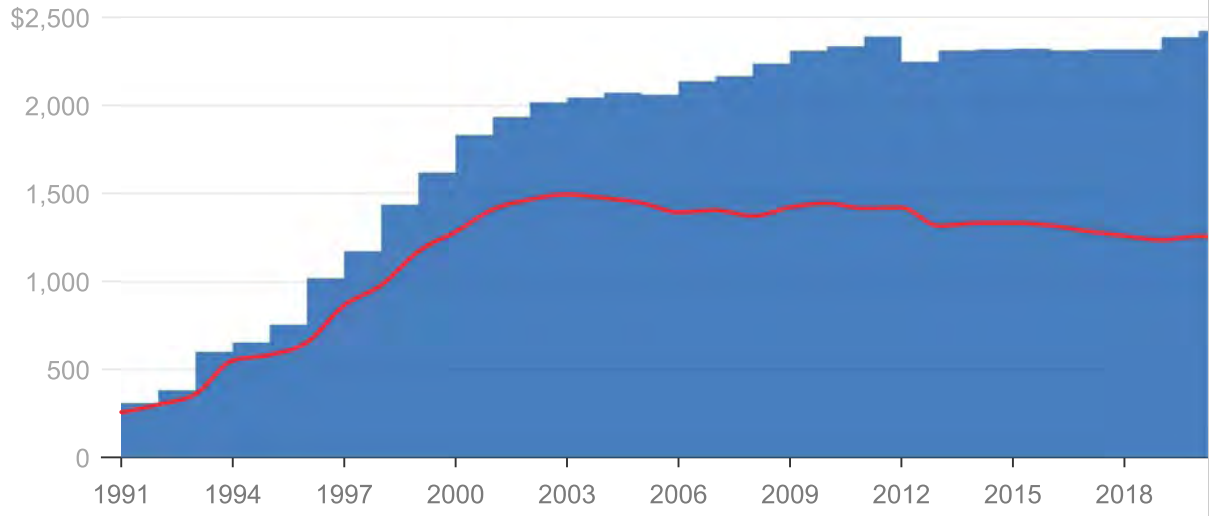
threats such as monkeypox (MPX). On August 4, 2022, the MPX outbreak (https://www.kff.org/other/issue-brief/key-questions-about-the-current-u-s-monkeypox-outbreak/) was declared a public health emergency (https://aspr.hhs.gov/legal/PHE/Pages/monkeypox-4Aug22.aspx?ACSTrackingID=DM87270-USCDC_2146&ACSTrackingLabel=Lab%20Advisory%3A%20HHS%20Declares%20Monkeypox%20a%20Public%20Health%20Emergency%20&deliveryName=DM87270-USCDC_2146) in the U.S.. Early on Ryan White provided flexibility (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/monkeypox-guidance-dear-colleague.pdf) for grantees to use program funds to respond to the outbreak by supporting monkeypox testing, treatment and vaccination for eligible clients.

Structure and Funding

The Ryan White Program is the third largest source (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/) of federal funding for HIV care in the U.S., after Medicare and Medicaid, totaling $2.5 billion in FY 2022. Federal funding for the program, which is appropriated by Congress annually, began in FY1991 and increased significantly in the mid-1990s (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/), primarily after the introduction of highly active antiretroviral therapy (HAART). For many years thereafter, funding continued to increase, but at slower rates, eventually . New funding as part of the EHE Initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/) ($70 million in FY 2020) marked the first significant increase to the program in many years. When adjusted for inflation, however, funding has been flat since 2001 and even on a slight decline as of 2013 despite having more clients enrolled in the program (Figure 2).

Figure 2

Federal Ryan White Funding FY1991-FY2022



NOTE: Funding adjusted using CPI-U www.bls.gov
SOURCE: KFF analysis of data from OMB, congressional budget justifications, and appropriations bills • PNG

The Ryan White HIV/AIDS Program is composed of "Parts," each with a different purpose and funded as a separate line item through annual appropriations. Funding is provided to states and territories (Part B) cities (Part A), and to providers, community-based organizations (CBOs), and other institutions (Parts C, D, and F), in the form of grants. In recognition of the varying nature of the HIV epidemic, grantees are given broad discretion to design key aspects of their programs, such as specifying client eligibility levels and service priorities. However, there are requirements, (https://www.congress.gov/bill/109th-congress/house-bill/6143) including that, unless granted a waiver, grantees must spend 75% or more of funds on "core medical services" under Parts A through C and that all state AIDS Drug Assistance Programs (ADAPs) must have a minimum formulary for medications.

Table 1: Description of the Ryan White Program, by Part, FY22		
Part	**FY22 (Funding in Millions)**	**Part Description**
Part A	$670.5	Funds provided to "eligible metropolitan areas" (EMAs), areas with 2,000+ reported AIDS cases over the past 5 years & "transitional grant areas" (TGAs), areas with 1,000-1,999 reported AIDS cases in the past 5 years. TGAs and EMAs must have a population of at least 50,000. Two-thirds of funds are distributed by formula based on area's share of living HIV (non-AIDS and AIDS) cases and the remainder is distributed via competitive supplemental grants based on "demonstrated need." EMAs must establish Planning Councils, local bodies tasked with assessing needs, developing HIV care delivery plans, and setting priorities for funding. Most TGAs are not required to have Planning Councils. *Number of Grantees: 24 EMAs; 28 TGAs.*
Part B	$1,344.2	Funds provided to states, Washington, D.C., and territories/associated jurisdictions. Grantees provide services directly, through sub-grantees and/or through Part B "Consortia" (associations set up to plan and deliver HIV care). Part B components include: • **Base & Supplemental:** Funds distributed by formula to states based on state's share of living HIV (non-AIDS and AIDS) cases, weighted to reflect the presence of EMAs/TGAs. Additional "supplemental" grants are available for states with "demonstrated need." • **Emerging Communities (ECs):** A portion of Part B base funds is set aside for grants to metropolitan areas with 500-999 cumulative reported AIDS cases over the most recent 5 years. Funding distributed via formula. *Number of grantees: 50 States, D.C., and 8 Territories/Associated Jurisdictions.*
ADAP (non-add)	*$900.3*	***ADAP & ADAP Supplemental:*** *Congress "earmarks" funds under Part B for ADAPs which provide medications and assists with costs related to insurance for people with HIV. ADAP supplemental grants (5% of earmark) available to states with "severe need".*
Part C	$205.5	Funds public and private organizations directly for: • **Early Intervention Services (EIS):** To provide comprehensive primary health care to people with HIV, including services to those newly diagnosed,

		such as HIV testing, case management, and risk reduction counseling. • **Capacity Development & Planning Grants:** To support organizations in planning for service delivery and building capacity to provide services. *Number of grantees: 348 EIS; 59 Capacity Development.*
Part D	$76.8	Funds public and private organizations to provide family-centered and community-based services to children, youth, and women living with HIV and their families, including outreach, prevention, primary and specialty medical care, and psychosocial services. Supports activities to improve access to clinical trials and research for these populations. *Number of grantees: 115.*
Part F	$34.4 (AETCs)/$13.4 (Dental)/$25 (SPRNS)	Includes the following components: • **AIDS Education and Training Centers (AETCs):** National and regional centers proving education and training for health care providers who treat people with HIV. *Number of grantees: 14.* • **Dental Programs:** The "Dental Reimbursement Program," reimburses dental schools/providers for unreimbursed oral health services; the "Community-Based Dental Partnership Program" funds dental provider education and increases access to dental care for people with HIV. *Number of grantees: 51 Reimbursement, 12 Community Partnership.* • **Minority AIDS Initiative (MAI):** MAI, created in 1998, aims to address impact of HIV on racial/ethnic minorities. Provides funding across DHHS agencies/programs, including the Ryan White HIV/AIDS Program, to strengthen organizational capacity and expand HIV services in minority communities. The Ryan White HIV/AIDS Program's (https://sgp.fas.org/crs/misc/RL33279.pdf) component of the MAI was codified (https://www.cdc.gov/niosh/topics/ryanwhite/pdfs/RyanWhiteActof2009.pdf) in the 2006 reauthorization. • **Special Projects of Regional and National Significance (SPRNS):** Funded through "set-asides" of general federal Public Health Service evaluation funding, separately from the amount appropriated by Congress for the Ryan White HIV/AIDS Program, SPNS projects address emerging needs of clients and

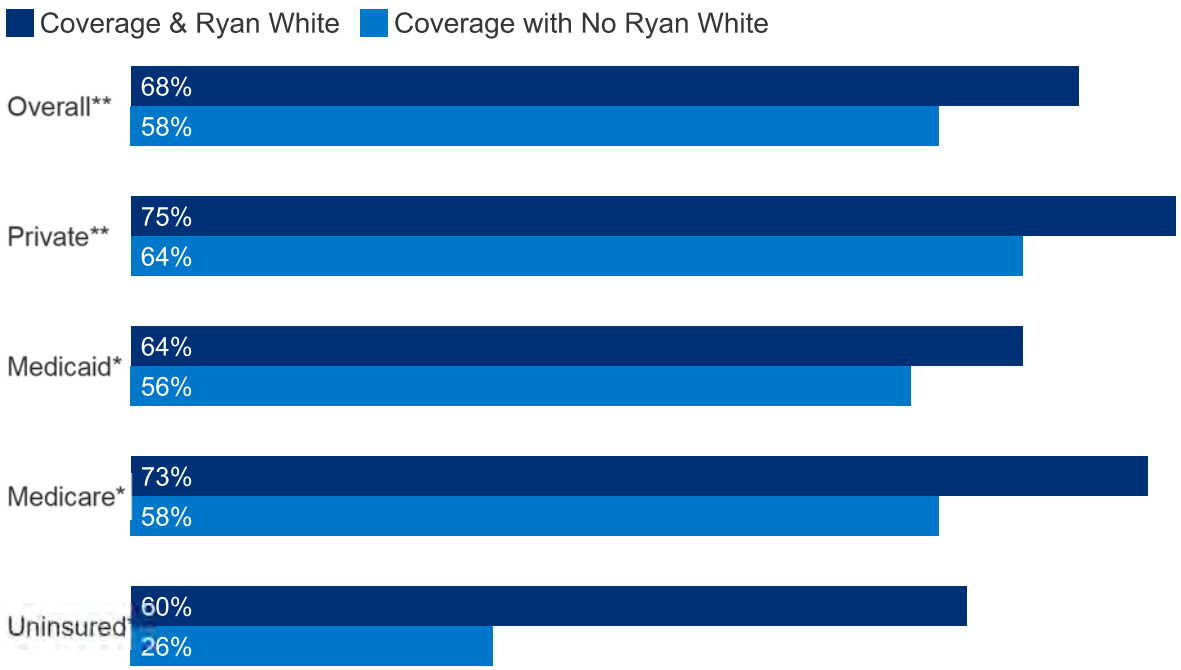
		assist in developing a standard electronic client information data system.
Ending the HIV Epidemic Initiative	$125	Dedicated funding to support the "Ending the HIV Epidemic (EHE)" initiative which aims to reduce HIV infections by 90% in ten years. Ryan White plays a key role in delivering care to people with HIV in the initiative and seen as the agency lead for the initiative's "care pillar."
Total	**$2,494.8**	

Ryan White HIV/AIDS Program and Care Outcomes

While many clients have gained coverage under the ACA, Ryan White continues to play a critical role as a safety net provider for those who remain uninsured or underinsured, helping to fill the gaps for clients with insurance, including assisting with insurance affordability and access to support services. Importantly, Ryan White clients are significantly more likely to have sustained viral suppression (https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/) compared to those without (68% v. 58%) and this pattern was observed across all coverage types (see Figure 3). Viral suppression (https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines) affords optimal health outcomes at the individual level and, because when an individual is virally suppressed they cannot transmit HIV, significant public health benefit.

Figure 3

Ryan White Support and Sustained Viral Suppression Among Adults with HIV, by Insurance Coverage



NOTE: *Rate of viral suppression significantly different between those with coverage source & Ryan White vs. those with coverage source and no Ryan White, (p<.05). **Rate of viral suppression significantly different between those with coverage source & Ryan White vs. those with coverage source and no Ryan White, (p<.001). Sustained viral suppression is defined as having an undetectable viral load over all tests in the preceding 12 months.

SOURCE: KFF/CDC Analysis of Medical Monitoring Project data, 2018 • PNG

Key Issues

First enacted as an emergency measure, the Ryan White program has grown to become a central component of HIV care in the U.S., playing a critical role in the lives of many low and moderate-income people with HIV. Looking ahead, there are several key issues facing the program that will be important to monitor, including:

- **Future funding**. As a federal grant program, funding is dependent on annual appropriations by Congress, and funding levels do not necessarily correspond to actual need (i.e. the number of people seeking services or the costs of services). As a result, not all states and communities have been able to meet the needs of people in their jurisdictions.
- **The future of the EHE initiative**, including subsequent Congressional appropriations for EHE and program flexibilities afforded through this funding stream not possible in traditional program parts.
- **Possible future program reauthorization** could impact program structure and future financing.
- **Major changes to the health policy landscape,** including the continued evolution

around state Medicaid expansion decisions; the Biden administration's approach to and enforcement of the ACA's nondiscrimination protections; the impact of a recent court decision that may impact access to preventive services including PrEP (an HIV prevention medication) and HIV testing; among other changes could affect the ability of Ryan White to meet client need.

- **The challenge of emerging health threats, including COVID-19 and Monkeypox**. Emerging health threats pose a strain on the providers and systems that serve people with HIV, including the Ryan White Program. In addition, because people with HIV need access to ongoing care and treatment and may themselves face additional challenges that could affect their health and care, these other emergencies can have significant impacts on the HIV response. With two such threats having emerged in the last few years alone, Ryan White has been required to both respond to and recover from these events while simultaneously meeting the care and support needs of people with HIV.

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Memorandum of Understanding

(Approved by the Council on12-08-22)

Parties to the Memorandum of Understanding:

1. Harris County Judge – The "Chief Elected Official" (CEO)
2. Houston Eligible Metropolitan Area (EMA) Ryan White CARE Act (as amended) Part A Planning Council – The "Planning Council" (RWPC)
3. Houston EMA Ryan White CARE Act Part A Planning Council Office of Support – The "Office of Support" (RWPC/OS)
4. Harris County Public Health , Ryan White Grant Administration – The **"Recipient"** (HCPH/RWGA)

PURPOSE

This Memorandum of Understanding is created to facilitate cooperative and collaborative working relationships between and among the Houston Ryan White Planning Council, the Council's Office of Support and the Houston Administrative Agency. The Health Resources and Services Administration (HRSA), the federal agency that administers the Ryan White program, encourages stakeholders to draft a Memorandum of Understanding (MOU) to better define responsibilities. This document is not intended to restate all HRSA rules but to clarify entity roles and outline procedures that will foster productive interaction and efficient communication between and among the three stakeholders.

This MOU is a dynamic tool to help the aforementioned stakeholders avert misunderstanding. The underlying foundation of the memorandum is the principle of mutual respect. Mutual respect is created through open communication, active listening, seeking understanding, and acknowledging our mutual goals. This document is built upon the understanding that the three entities are equal stakeholders in the Ryan White process with the mutual goal of helping eligible individuals and families living with HIV/AIDS obtain the highest quality and most appropriate Ryan White Program services.

HRSA DEFINED ROLES AND DUTIES

The following is taken from the **2013** HRSA Part A manual and the Part A Planning Council Primer and describes the role and duties of the:

Chief Elected Official (CEO or G): Harris County Judge

The CEO is the person who officially receives the Ryan White Part A funds. In Houston the CEO is the County Judge, making the Judge ultimately responsible for administering all aspects of the Part A program funds (Part A includes Minority AIDS Initiative, or "MAI" funds). Duties include: ensuring that all legal requirements are met, appointing all members of the Planning Council and selecting the Harris County Public Health and Environmental Services Department to be the Administrative Agency for the Part A grant.

Planning Council: Houston Area HIV Services Ryan White Planning Council

The Houston Ryan White Planning Council is a group of volunteers appointed by the CEO whose purpose is to plan for and oversee the delivery of services to persons living with HIV in the Houston EMA. Duties include: setting up planning body operations; setting service priorities; allocating resources to those priorities; and assessing the administrative mechanism, which means reviewing how long the Recipient takes to pay providers, reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether all the funds are spent". The Council also works in partnership with the Administrative Agency to assess need, develop a comprehensive plan, coordinate with other Ryan White programs and services, and reallocate funds. The Council reports to the CEO.

Planning Council Support: Office of Support
This entity provides administrative support to the Council. Duties include: coordinating and staffing all Council processes; interfacing with HRSA, the CEO's Office and other County Offices regarding Council business; and assisting Council members to stay in compliance with federal and county rules and regulations as well as Council bylaws, policies & procedures. The Manager of the Office of Support reports to the Planning Council and the CEO.

Administrative Agency (the CEO 's Agent, also called the Recipient): Harris County PH/Ryan White Grant Administration
This entity carries out the day-to-day administrative activities required to implement and administer services in the Houston EMA according to the plan set forth by the Planning Council. Duties include: procuring services for PLWH consistent with Planning Council priorities and allocations, including all aspects of the RFP, review, award and contracting process with service providers; establishing intergovernmental agreements; ensuring services to women, infants, children and youth living with HIV ; ensuring that Ryan White Part A funds are used to fill gaps; ensuring delivery of quality services; preparing and submitting Part A applications; assuring all services are in compliance with the HRSA Ryan White National Part A and Universal Monitoring Standards; limiting Recipient administrative costs; limiting contractor administrative costs; monitoring contracts; implementing Quality Management activities, advising the Council on HRSA mandates; and working with the Council to assess need, develop a Comprehensive Plan, coordinate with other Ryan White programs and services, and reallocate funds. According to HRSA, an employee of the Recipient may serve as a co-chair to the Planning Council, provided the bylaws of the planning council permit or specify that arrangement. At the current time, Council bylaws do not permit such an arrangement. The Manager of RWGA reports to the Executive Director of the Harris County Public Health Services Department (HCPHS) or his/her designee.

LOCALLY DEFINED RESPONSIBILITIES

HRSA clearly assigns responsibility for certain work products to specific entities. For example: the Planning Council is the only entity allowed to set service priorities and determine annual allocations. Similarly, the Administrative Agency is the only entity allowed to monitor contracts and collect agency-specific information. In areas where there is shared responsibility, it is agreed that, in the Houston EMA, the entity named below will have primary responsibility for initiating and completing the following:

Planning Council:

- Through the Needs Assessment process, determine the size and demographics of the population of individuals with HIV disease (Section VI, page 2).
- Determine the needs of such population.
- Adapt the HRSA defined service definitions to meet the local needs.
- Indicate to the Recipient, through the service definitions and standards of care, how the services are to be purchased.
- Determine the annual Part A service priorities.
- Determine the annual Part A allocations.
- Collaborate with the Administrative Agency in determining the Part A Standards of Care.
- Collaborate with the Administrative Agency in determining the Part A Performance Measures.
- Reallocate unspent or carryover funds in a timely manner (see below under Administrative Agency for an explanation of the 10% rule).

- Through Council membership and joint activities, such as the Needs Assessment process, coordinate with other Ryan White programs and services.
- According to HRSA mandates, produce the Comprehensive Needs Assessment that is currently required at least every three (3) years.
- According to HRSA mandates, produce and update the Integrated HIV Prevention and Care Services Plan that is currently required at least every five (5) years.
- Produce the Blue Book so long as it is a Council-approved priority. Work with the Harris County Purchasing Department to procure a printer for the final product.
- Procure vendors for specific work products where the contract is under $25,000 and no formal RFP process is needed. Provide system-wide guidance regarding the Continuum of Care, client eligibility and preferred treatment strategies, at a minimum meeting HHS treatment guidelines, in order that HCPHS/RWGA can implement the Centralized Patient Care Data Management System (CPCDMS) in a manner supportive of the Council's annual implementation plan and approved Integrated Plan. Examples of such guidance include the Council's approved stance on de-identified client-level data collection (i.e., no names or other identifying information stored in the CPCDMS) and applicable goals and objectives listed in the Integrated Plan.

RWPC Office of Support Staff:

- Provide guidance to the Council on HRSA and County policy that relates to Council processes and work products.
- Provide guidance and leadership to the Council in order to ensure the Council accomplishes all required and necessary goals and objectives.
- At the beginning of each grant year (i.e., January and February) meet with all stakeholders in the Ryan White Part A process to provide guidance and leadership in the Council's development and implementation of a timeline for all required Council work products that is consistent with published deadlines. Inform and advise the Council on multi-year and/or recurring processes such as needs assessment and integrated planning in order that the Council is appropriately informed of its deadlines and expected work products.
- Coordinate and staff all Council processes except the workgroups for Standards of Care and Performance Measures.
- If an outside vendor is utilized, supervise the vendor contract for the Comprehensive Needs Assessment.
- If an outside vendor is utilized, supervise the vendor contract for the Integrated Plan.
- Work with the Council to develop the Blue Book. The Office of Support will work with the Purchasing Department to secure and supervise the printer and other vendors needed to produce the document.
- Provide RWPC-related information required for the submission of the annual HRSA grant application in a timely manner in order that HCPH/RWGA can prepare the grant application and non-competing renewable funding request for review and submission by the CEO.

Administrative Agency:

- Provide the Council with accurate, timely, aggregate service category and other information needed for the different Council processes such as the *How to Best Meet the Need*, priority setting, annual allocations and other processes.
- Collaborate with the Planning Council in determining the Part A Standards of Care.
- Collaborate with the Planning Council in determining the Part A Performance Measures.
- Coordinate and staff the Part A Standard of Care and Outcome Measures workgroups in order to ensure

appropriate interface with the Quality Management Program and because Standards of Care must also reflect the HRSA Ryan White Part A National Programmatic, Fiscal and Universal Monitoring Standards, the current Part A grant guidance, conditions of award and more.

- Reallocate funds per Council-approved decisions. Inform the Council no later than the next scheduled Planning Council Steering Committee meeting of any allocation changes made under the Houston RWPC-approved "10% rule". The 10% rule allows the administrative agency to shift funds between Service Categories without prior Council approval so long as the funds shifted are no more than 10% of the current approved Council allocation for either service category affected by the change.
- Prepare the Houston EMA HRSA grant application and non-competing renewal funding request for review and submission to HRSA by the CEO.
- Implement and maintain the de-identified client-level data system used in the Houston EMA. The data system used by HCPH/RWGA is the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is the property of HCPH/RWGA and is used to securely collect and store HRSA- and RWPC- required data on client utilization, client demographics, medical and co-morbidity information, health outcomes and to enable the Recipient to implement the HRSA-mandated Quality Management program.
- Inform the Council in an ongoing and timely manner of issues surrounding automated client-level data collection, changing data requirements from HRSA and other stakeholders, future technology changes and potential future issues of concern to Houston EMA stakeholders (e.g. interface with the State's Take Charge Texas data system for RW Part B data collection by TDSHS).

PROCEDURES

Meetings: Please refer to Council bylaws, policies and procedures for details regarding protocol for Council members. This section is devoted to outlining staff functions in relationship to Council protocol. Regarding the Administrative Agent and Office of Support:

- Staff representation from the Office of Support will be provided at all regular Council meetings including standing committees, ad-hoc and workgroup meetings. Staff representation from RWGA will be provided as appropriate.
- In an effort to help chairs and other attendees delineate between members of the voting body, staff and the general public, neither staff nor members of the general public will sit at the table with Council or committee members while business is being conducted. Because of the more informal nature of the Affected Community Committee and most workgroups, the chair of the committee or workgroup may choose to make an exception to this rule by allowing the general public to sit at the table and participate in discussion throughout the meeting. Only members of the committee may vote at a committee meeting See the Council policy regarding voting at workgroup meetings.
- Staff will provide data and give periodic reports to the Planning Council during time allotted on the meeting agenda.
- Additional insights and suggestions from staff will be given to the Planning Council during meetings in the following manner:
    - Staff and Planning Council members will request permission from the Chairperson before providing input or requesting information from other members of the group.

Requesting Information: Council committees and workgroups will follow Council-approved policy and procedures to request information from the Office of Support or RWGA. This may be done via a standardized form or, in more informal situations, by request of the Council Chair or Vice Chair, Committee Chair or Co-Chair, or workgroup Chair as applicable. Individual Council members should make requests for information

through the Committee or workgroup chair as described above.

Distributing Information to the Council, its Committees and Work Groups: Information will be delivered to the Manager of the Office of Support for distribution to the Council, its Committees and workgroups. The Manager will determine the appropriate process to be used to disseminate the information. When providing information, please keep the following in mind:

1) Requests requiring Council or committee approval must be submitted in writing eight days before the date of the meeting.
2) If the information does not require approval, submission of the information eight days before the date of the meeting is preferred.
3) Once a workgroup or committee has created a recommendation in response to the request, the chair of the Committee, workgroup or designee will be responsible for moving the request forward and speaking on behalf of the request.

Verifying Information. Any member of this MOU can question accuracy and request sources to support or verify reports and other information. When accuracy is questioned within the context of a Council or Committee meeting, the chair can ask the entity that submitted the document or report to verify the information at the next meeting. It is incumbent on the one who submitted the document or report to verify the source and attest to its accuracy. While the information is being verified, it is important that decision-making continue and that the information be treated as valid to the extent possible.

However, it is the responsibility of HCPH/RWGA and RWPC Office of Support staff to provide guidance to the Council regarding HRSA policy, County rules and procedures and other relevant information necessary for the Council to perform its responsibilities in an appropriate and timely manner. Therefore, information provided to the Council or its committees by staff is expected to be accurate and relevant to the issue or question being discussed and Stakeholders should respect such information. When necessary, more detail regarding the accuracy or applicability of such information may be requested, however such requests must not infringe upon established roles and responsibilities under the Ryan White Program (e.g., Council members may not, in their role as Council members, request agency or contract-specific information). Office of Support and HCPH/RWGA staff are responsible for ensuring the overall Ryan White Part A grant process complies with all applicable HRSA guidelines and other Federal, State and local laws, rules and guidelines.

Proof Reading the Ryan White Part A Grant Application: The Administrative Agency will provide the Office of Support with a draft copy of the application for review by the Council. Notwithstanding HRSA giving Recipients less than the customary 60 days to prepare and submit the annual Part A grant application, the Council will nominally have one week (7 calendar days) to review the application and suggest corrections, edits or improvements. The Office of Support will be responsible for collecting and collating the comments and sending these to the Administrative Agency in a timely manner.

Contracting with outside vendors: Any contracting process that requires issuing an RFP or Interlocal Agreement shall be the responsibility of the Administrative Agency.

Reviewing and Updating the MOU: Annually in October of each year the Operations Committee of the Ryan White Planning Council will contact the principal Stakeholders (i.e., RWPC, RWPC Office of Support, CEO and Administrative Agency) in this MOU to see if any of the Stakeholders wish to review and/or revise the document. This annual process will provide an opportunity for Stakeholders to ensure the MOU will continue to be responsive to the needs and responsibilities of all concerned.

THE DO'S AND DON'TS OF COUNCIL PARTICIPATION: As members of a planning body, there are a number of areas where HRSA and/or county legislation mandates Council participation. The following is not a complete list, but strives to address areas where there are more likely to be questions.

DO's	DON'T's
✓ **Do use Robert's Rules of Order in Meetings**	✓ **Don't ignore the Chairperson and interrupt others who have been called upon to speak.**
✓ **When giving reports, do present key information your committee used to make a decision.**	✓ **Don't offer your personal opinion.**
✓ **Do ask for questions and think beyond your own situation.**	✓ **Don't force your point of view on others.**
✓ **Do make a motion for action.**	✓ **Don't repeat what everyone else has just stated.**
✓ **Do attend meetings in order to listen and learn.**	✓ **Don't feel intimidated and stop participating.**
✓ **Do share your concerns and ask questions.**	✓ **Don't vote for something you don't understand.**
✓ **Do come to meetings prepared.**	✓ **Don't ignore your meeting packets.**
✓ **Do work with other committee members to determine the information needs of the committee and have the committee chair ask the staff to prepare the information.**	✓ **As a Council member, don't ask the staff to prepare reports for your agency or personal use.**
✓ **Do assess how well services that are funded by the Recipient address the planning council's priorities, allocations and instructions for addressing these priorities.**	✓ **Don't evaluate how well services are being delivered and the cost effectiveness of such services which are to be undertaken separately under the leadership of the Recipient.**
✓ **Do assess the administrative mechanism in the following ways: 1.) evaluate how well the Recipient manages to get funds to providers by reviewing how quickly contracts with service providers are signed and how long the Recipient takes to pay providers. 2.) Review whether the funds are used to pay only for services that were identified as priorities by the planning council and whether all the funds were spent. 3.) Evaluate how well services funded by Ryan White Part A are meeting community needs.**	✓ **Don't evaluate the Recipient or individual service providers, which is a Recipient responsibility.**
✓ **Do review and discuss aggregate data about service categories.**	✓ **Don't get directly involved in the administration of the grant or be involved in the selection of particular entities as recipients of Part A funds.**

Signed By:

County Judge Lina Hidalgo	Date
Crystal Renee Starr, Chair Houston Ryan White Planning Council	Date
Heather Keizman, Interim Manager HCPH/Ryan White Grant Administration	Date
Victoria “Tori” Williams, Director, Office of Support, Houston Ryan White Planning Council	Date

Ryan White Planning Council Committee
INFORMATION REQUEST FORM

Signature of Committee Chair: _____ Date: _____

Name of Committee Chair: _____ Telephone:_____

Email Address:_____ Due date:_____(Min. of 30 Days From Date of Request)

Question you want answered. (ex. How many youth are in primary care?)

In what form/s would you like the information (please check all that apply):

___Word Table ___Word Chart ___Word Text ___PowerPoint presentation

___Excel Table ___Excel Chart ___SPSS Table ___SPSS Chart

___Other: (Please describe):

_____

In order that we might present the information in the most useful format for you, please indicate how you plan to use the data

Thank you. Email this form to: Victoria.williams@cjo.hctx.net.

Date request filled: _____

Received by_____ Date Received: _____

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

LETTER OF AGREEMENT

Parties to the Letter of Agreement:

1. Harris County Judge – The "Chief Elected Official" (CEO)
2. Houston Eligible Metropolitan Area (EMA) Ryan White Part A Planning Council – The "Planning Council" (RWPC)
3. Houston EMA Office of Support for the Ryan White Part A Planning Council
4. Texas Department of State Health Services (TDSHS) - Part B Grantee
5. Houston Regional HIV/AIDS Resource Group, Inc. - Houston HIV Service Delivery Area (HSDA) Part B Administrative Agency
6. Harris County Public Health, Ryan White Grant Administration Section (HCPH/RWGA) - Houston EMA Part A Administrative Agency

PURPOSE

This Letter of Agreement is created to facilitate cooperative and collaborative working relationships between and among the Ryan White Part B Administrative Agency (AA) and the Ryan White Part A Planning Council. The Health Resources and Services Administration (HRSA), a division of the United States Department of Health and Human Services, encourages stakeholders to document via a Letter of Agreement (LOA) to better define responsibilities for the Houston Eligible Metropolitan Area (EMA) and the Houston Health Services Delivery Area (HSDA) designated by the Texas Department of State Health Services (TDSHS). The Houston EMA is designated by HRSA to receive Ryan White Program Part A funds to provide services to People Living with HIV/AIDS (PLWH/A). The Houston EMA is a six-county area in southeast Texas that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller counties. The Houston HSDA consists of these same six counties and four others – Austin, Colorado, Walker and Wharton.

This document is not intended to restate all HRSA and TDSHS rules, but rather to clarify entity roles and outline procedures that will foster productive interaction and efficient communication between and among the six stakeholders.

This LOA is a dynamic tool to help the principal stakeholders avert conflict and foster collaborative relationships and decision-making processes. The underlying foundation of the agreement is the principle of mutual respect. Mutual respect is created through open communication, active listening, seeking understanding, and acknowledging our mutual goals. This document is built upon the understanding that the six entities, parties to the LOA, are equal stakeholders in the Ryan White process with the shared goal of helping individuals and families living with HIV/AIDS obtain the highest quality and most appropriate Ryan White Program eligible services.

HRSA DEFINED ROLES AND DUTIES

The following is taken from the 2002 HRSA Title I (Part A) manual and the Title I (Part A) Planning Council Primer and describes the role and duties of the:

Chief Elected Official (CEO):
The CEO is the person who officially receives the Part A Ryan White Program funds, also referred to as the Grantee for Part A. In the Houston EMA, the CEO is the County Judge., The County Judge is ultimately responsible for administering all aspects of the Part A funds. Duties include: ensuring that all legal requirements are met; appointing all members of the Planning Council; and selecting the HCPH to be the AA (or recipient) for the Part A funding.

Houston Ryan White Part A Planning Council (Planning Council)
This entity is a group of volunteers appointed by the CEO whose purpose is to plan for and oversee the delivery of services to persons with HIV in the defined EMA/HSDA. Duties include: setting up planning body operations; setting priorities; allocating resources to those priorities; assessing the administrative mechanism which means reviewing how long the grantee takes to pay providers, reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council; and whether all the funds are spent. The Council also works with the AAs to assess need, develop a comprehensive plan, coordinate with other Ryan White programs and services, and reallocate funds as necessary. The Planning Council reports to the CEO.

Planning Council Office of Support:
This entity provides administrative support to the Council. Duties include, but not limited to: coordinating and staffing all Council processes; interfacing with HRSA, the CEO's Office and other County Offices regarding Council business; and assisting Council members stay in compliance with federal and county rules and regulations, as well as Council bylaws, policies and procedures. The Manager of the Office of Support reports to the Planning Council and the CEO.

Ryan White Part A Administrative Agency (CEO's Agent, also called the Part A recipient):
This entity carries out the day-to-day administrative activities required to implement and administer services in the defined EMA according to the plan set forth by the Planning Council. Duties include: procuring services for PLWH/A consistent with Planning Council priorities and allocations, including all aspects of the Request for Proposals (RFP), review, award and contracting process with service providers: establishing intergovernmental agreements; ensuring services to women, infants, children, and youth with HIV/AIDS; ensuring that Ryan White Program Part A funds address funding gaps; ensuring delivery of quality services; preparing and submitting Part A applications; assuring all services are in compliance with HRSA rules and regulations; limiting recipient administrative costs; limiting contractor administrative costs; monitoring contracts; advising the Council on HRSA mandates; and working with the Council to assess need, develop a comprehensive plan, coordinate with other Ryan White Program recipients and service providers programs, and reallocate funds.

Texas Department of State Health Services (TDSHS)

This entity is the Ryan White Program Part B and State Services (SS) Recipient for the state of Texas. The Part B recipient is the entity that officially receives the Part B funds. Locally,

TDSHS is ultimately responsible for administering all aspects of Part B and SS funds. Duties include: ensuring that all legal requirements are met; selecting and contracting with Part B/SS AAs; and providing oversight, monitoring and technical assistance to AAs in the planning and implementation of Part B/SS funds.

Houston Regional HIV/AIDS Resource Group, Inc.

This entity is contracted by TDSHS to carry out the day-to-day administrative activities required to implement and administer services in the Part B and SS HIV/AIDS Administrative Service Area (HASA) according to the comprehensive plan. Duties include: procuring services for PLWH/A consistent with the local priorities and allocation as approved by TDSHS; including all aspects of the RFP, review, award and contracting process with service providers; establishing intergovernmental agreements; ensuring services to women, infants, children, and youth living with HIV/AIDS; **(ADD): ensuring service deliver to rural residents living with HIV/AIDS residing in the HSDA**; ensuring that Ryan White Program funds are used to address gaps; ensuring delivery of quality services; preparing and submitting Part B applications to the State; assuring all services are in compliance with HRSA rules and regulations; limiting recipient administrative costs; limiting contractor administrative costs; monitoring contracts; and assessing need, developing a comprehensive plan, coordinating with other Ryan White Program recipients and services; and reallocating funds.

DEFINED RESPONSIBILITIES IN THE HOUSTON EMA/HSDA

In areas where there is shared responsibility between the Part A Planning Council, Part A & B/SS AAs, and the Office of Support, it is agreed that, in the Houston EMA/HSDA, the entities named above will have primary responsibility for initiating and completing the following:

Houston Ryan White Planning Council and Part A and B/SS Administrative Agents agree to:

- Collaborate in developing the Part A and B/SS Standards of Care;
- Collaborate in determining the Part A/Part B/SS Outcome Measures; and
- The Part B/SS AA, TDSHS, and Part A AA will develop procedures to ensure that Part A, Part B & State Services client level data is entered into the ARIES system whether through direct input or import.

Houston Ryan White Planning Council and Part B/SS Administrative Agency (The Resource Group) agree to:

- Collaborate to provide guidance and leadership in the development and implementation of a timeline for all required Part B/SS AA and Council work products that is consistent with published deadlines;
- Collaborate on planning and completion of multi-year and/or recurring processes, such as needs assessment and comprehensive planning in order that the Council is appropriately informed of its deadlines and expected work products;
- Collaborate on a Needs Assessment process to determine the size and demographics of the population of individuals living with or affected by HIV/AIDS in the Houston EMA/HSDA, and through this process jointly determine the needs of such populations in the defined geographic area;
- Collaborate on the production of, and updates to, the Comprehensive Needs Assessment for the defined EMA/HSDA; and

- The Part B/SS AA and the Planning Council will collaborate to develop a single list of service priorities for the Houston HSDA.

Houston Ryan White Planning Council agrees to:

- Indicate to the Part A and Part B/SS AAs, through the service definitions and the standards of care, how the services are to be configured;
- Develop recommendations for Part B and State Services allocations for the EMA/HSDA; (Recommended priorities and allocations and reallocations for the EMA/HSDA may not be changed by the Part B/SS Administrative Agency and must be presented to TDSHS for approval.)
- Develop recommendations for the reallocation of Part B and SS funds;
- Assess the Part B/SS AA administrative mechanism, which could include reviewing how long the AA takes to pay providers, reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether all the funds are spent. (Per the County Judge's Office: Distribute copies of the final assessment to DSHS, the Part B/SS AA and the Chair of the Board of Directors for the Houston AA for RW Part B and State Services.) This will be done annually in January; and
- Solicit input from the Part B/SS AA in the development of the Houston EMA/HSDA HIV/AIDS Resource Guide, commonly known as The Blue Book.

Part B/State Services Administrative Agency agrees to:

- Provide accurate, timely, aggregate service category and other information needed or requested for the different Council processes such as the *How to Best Meet the Need*, priority setting, annual allocations, reallocations and other processes;
- Coordinate and staff the Part B/SS Standard of Care and Outcome Measures Work Groups to ensure appropriate interface with the Quality Management Program and because Standards of Care must also reflect all HRSA Ryan White and TDSHS programmatic and fiscal guidelines and more;
- Within thirty-days of receiving a notice of grant award for Part B or State Services funding, inform the Office of Support in writing of the award amount and date of notice;
- Inform the Office of Support after the initial grant awards are distributed and within 45-days after the end of the second quarter of any unobligated funds available for reallocation;
- Notify all Part B/SS agencies when the Planning Council's Priority and Allocations Committee is preparing to allocate or reallocate funds;
- Within 30-days of announcing the availability of funds, provide the Council with de-identified service category funding requests increase so that the Council can review and make recommendations for reallocating these funds;
- Inform the Office of Support within thirty-days of any allocation changes made under the Houston RWPC-approved "10% rule". The 10% rule allows the AA to shift funds between Service Categories without prior Council recommendation as long as funds shift no more than 10% of the current approved TDSHS allocation for either service category affected by the change;
- In the final quarter of the Ryan White Part B and SS grant years, after implementing the year end Planning Council-approved reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, the Part B/SS AA may reallocate any remaining unspent funds as necessary to ensure no funds are returned to the TDSHS. If

funds are to be moved from the Houston HSDA, the Part B/SS AA will notify the Office of Support when the information is submitted to the TDSHS. The Office of Support will notify the members of the Priority and Allocations Committee upon receipt and the Steering Committee and Council at their next scheduled meetings; and

- Annually in November of each year, contact the principal Stakeholders, listed at the beginning of this document, to determine if any wish to review and/or revise the LOA. This annual process will provide an opportunity for Stakeholders to ensure the LOA will continue to be responsive to the needs and responsibilities of all concerned.

Distributing Information to the Council, its Committees and Work Groups

Information will be delivered to the Office of Support for distribution to the Council, its Committees and workgroups. The Office of Support will determine the appropriate process to be used to disseminate the information. When providing information, please keep the following in mind:

1.) Requests requiring Council or committee approval must be submitted in writing eight-days prior to the date of the meeting;

2.) When information does not require approval, submission of the information eight-days before the date of the meeting is preferred; and

3.) Once a workgroup or committee has created a recommendation in response to the request, the chair of the Committee, workgroup or designee will be responsible for moving the request forward and speaking on behalf of the request.

Signed By:

_____ _____

Harris County Judge Date

_____ _____

Chair, Houston Ryan White Planning Council Date

_____ _____

Office of Support for the Houston Ryan White Planning Council Date

_____ _____

TDSHS, Texas Part B and State Services Grantee Date

_____ _____

Houston Regional HIV/AIDS Resource Group, Inc. Date

_____ _____

Harris County Public Health, RWGA Section Date

Part B: AIDS Drug Assistance Program

HRSA's Ryan White HIV/AIDS Program

Program Fact Sheet | September 2023

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. Over half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. First authorized in 1990, RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. In 2021, 89.7 percent of RWHAP clients receiving HIV medical care were virally suppressed, which means they cannot sexually transmit HIV to their partners and can live longer and healthier lives. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

HRSA
Ryan White HIV/AIDS Program

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part B provides grants to all states and U.S. territories to improve the quality, availability, and organization of HIV health care and support services. Under RWHAP Part B, the AIDS Drug Assistance Program (ADAP) provides U.S. Food and Drug Administration (FDA)–approved medications to low-income people with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare.

Grant recipients may also use ADAP funds to—

- Obtain health care coverage for eligible clients
- Provide services that improve access to, adherence to, and monitoring of drug treatments

In 2021, ADAP provided nearly 290,000 clients with HIV-related medications and/or access to medications through health care coverage assistance.

Recipients and Eligibility

Recipients are the chief elected officials of a state or territory who designate the state department of health or another state entity to implement and manage the RWHAP Part B grant. All 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, Republic of the Marshall Islands, Commonwealth of the Northern Mariana Islands, Republic of Palau, and Federated States of Micronesia receive ADAP funding as a component of their Part B grant.

Client Eligibility

The state or territory decides client eligibility for ADAP based on the following criteria:

- **Residency:** State or territory determines how it defines residency, including for transient populations
- **Medical eligibility:** HIV diagnosis
- **Financial eligibility:** Usually determined as a percentage of the federal poverty level

ADAP Implementation

The RWHAP statute requires that each ADAP must cover at least one drug from each class of HIV antiretroviral medications on its ADAP formulary. ADAP funds may be used only to purchase FDA-approved medications. Within these requirements, each ADAP decides which medications to include on its formulary and how those medications will be distributed.

HRSA requires that ADAP eligibility criteria be applied consistently across the state or territory and expects that all formulary medications and ADAP-funded services are equitably and consistently available to all eligible enrolled people throughout the state or territory.

Funding Considerations

Part B base grants and ADAP base grants are determined using a formula based on reported living cases of HIV in the state or territory in the most recent calendar year for which data are available. Congress appropriated approximately $464.6 million for RWHAP Part B base in fiscal year (FY) 2023.

The ADAP base grants provide access to HIV-related medication through the purchase of medication and health care coverage. Congress appropriated approximately $900.3 million for Part B ADAP in FY 2023.

Five percent of ADAP appropriations is reserved for additional funding to states and territories that have a severe need for medication assistance. The states and territories that meet the eligibility criteria can choose to apply for this through ADAP supplemental funding.

ADAP Emergency Relief Funding is a competitive supplemental grant program intended for states and territories that can demonstrate the need for additional resources to prevent, reduce, or eliminate ADAP waiting lists, including through cost-containment measures.

THE HENRY J. KAISER FAMILY FOUNDATION

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August 2017| Fact Sheet

AIDS Drug Assistance Programs (ADAPs)

What are ADAPs?[1]

AIDS Drug Assistance Programs (ADAPs) provide HIV-related prescription drugs to low-income people with HIV/AIDS who have limited or no prescription drug coverage. With more than 250,000 enrollees in calendar year (CY) 2015, ADAPs reached approximately one third of people with HIV receiving care nationally, and provided HIV medications to half of all people with HIV on treatment in the U.S.[2,3]

ADAPs began serving clients in 1987, when Congress first appropriated funds to help states purchase the only approved antiretroviral (ARV) drug at that time, AZT.[4] In 1990, they were incorporated into the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now known as the Ryan White Program.[5,6] Since Fiscal Year (FY) 1996, Congress has specifically earmarked funding for ADAPs through Part B of Ryan White, which is allocated by formula to states.[7] Ryan White has been reauthorized by Congress four times since first created and changes have been made to ADAPs over time. While the current authorization has lapsed, there is no sunset provision in the law. Therefore, ADAP, and the Ryan White Program more broadly, can continue to be funded through annual Congressional appropriations.

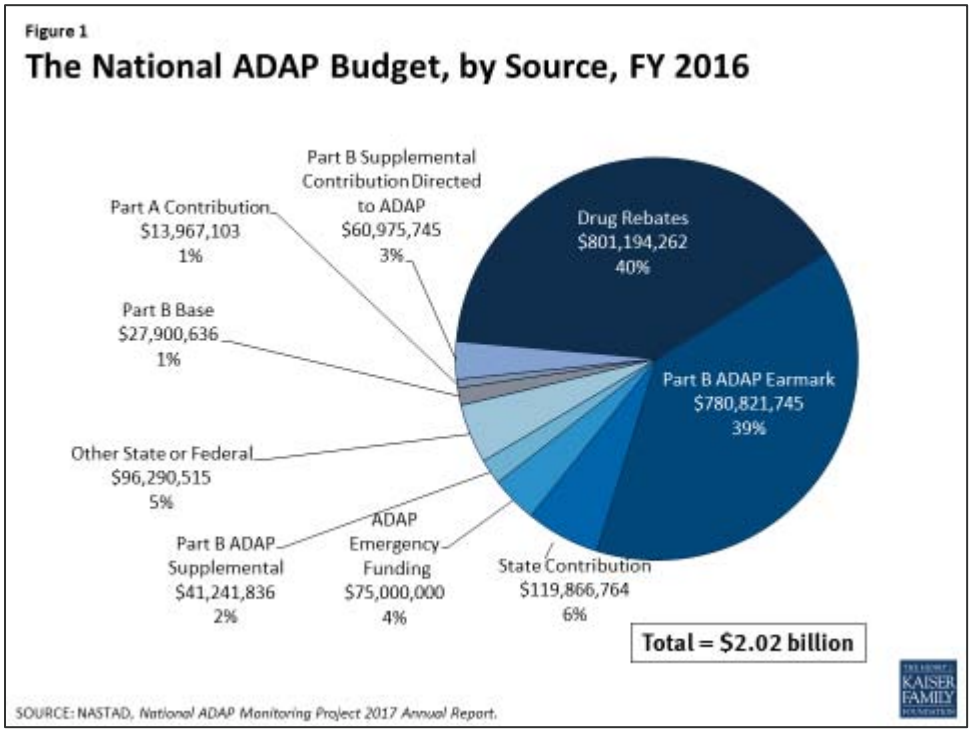
All states, Washington, D.C., and other U.S. territories receive federal ADAP earmark funding through Part B of Ryan White. In addition to the ADAP earmark, ADAPs receive state funding and contributions from additional sources, including other parts of Ryan White, but this support is highly variable and largely dependent on local decisions and resources. ADAPs are not entitlement programs – annual federal appropriations and, where available, other funding, determine how many clients ADAPs can serve and the level of services they can provide. Each state operates its own ADAP, including determining eligibility criteria and other program elements, such as formularies, resulting in significant variation across the country.

ADAP Budget

ADAP funding and budget composition is highly variable from year to year, and influenced by a broad range of factors. In recent years, the budget has also included transfers from other parts of Ryan White, as well as emergency funding to help alleviate ADAP waiting lists and unmet program needs.

- The national ADAP budget (including all funding sources) was $2.02 billion in FY 2016, lower than it was in FY 2015 ($2.24 billion).
- Through FY 2012, the federal ADAP earmark was the largest component of the budget.[8] It has declined as a share of the budget in recent years, and accounted for 39% of the FY 2016 budget, behind drug rebates.
- Drug rebates accounted for 40% of the overall ADAP budget in FY 2016, a drop from the previous year.
- State funding accounted for 6% of the budget.

- Other funding, including ADAP emergency funding; Part B ADAP supplemental awards; Part B supplemental contributions directed to ADAPs; transfers to ADAPs from state Part B base awards and from Part A; and other state/federal funding accounted for 16% of the overall ADAP budget.



- In FY 2016, 59 jurisdictions – all U.S. states, Washington, D.C., and other U.S. territories – received federal ADAP earmark funding. In addition: 38 ADAPs received drug rebates; 28 received state funds; 20 received other state/federal funding; 17 ADAPs received Part B base contributions; 15 states received Part B supplemental awards (not specific to ADAP) and, of those, 10 directed some of that supplemental funding to ADAP; 14 received emergency funds; 13 received direct Part B supplemental treatment funds;; and 6 received transfers of Part A funds.
- Among the states reporting data in both FY 2015 and FY 2016, 30 experienced net decreases in their budgets.

ADAP Formularies

ADAP formularies (the list of drugs covered) vary significantly across the country. In 2016:

- 6 states had an open formulary
- All offered all of the drugs identified in the "recommended regimens" in the nation's HIV treatment guidelines.[9]
- Of the 45 ARVs currently available (including multi-class combination products and generics), ADAP formularies covered between a low of 37 drugs in Arkansas to all 45 in 27 states.
- In addition to ARVs, many ADAPs provide access to drugs to treat opportunistic infections and HIV co-infection (e.g. treatment for hepatitis).

ADAP Expenditures and Prescriptions

In FY 2015:

- Drug expenditures totaled $1.315 billion, with an additional $310 million spent on insurance assistance (premiums and cost sharing).
- Annual per capita drug spending was $8,663 for drug purchases and co-payments and $2,720 for insurance purchasing and continuation.

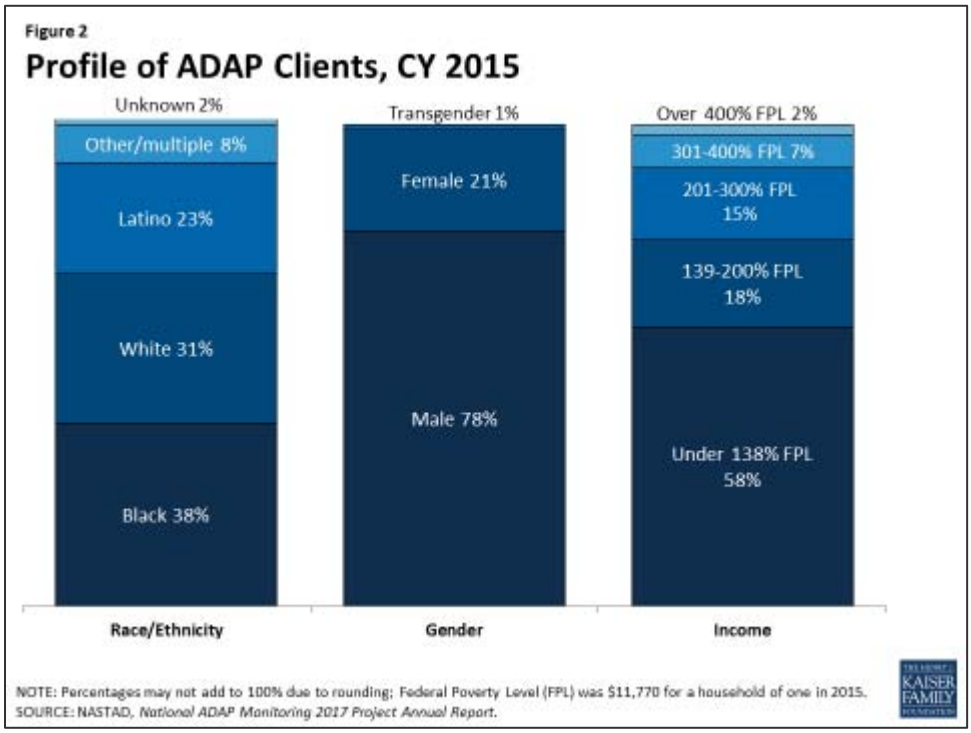
ADAP Eligibility Criteria

The Ryan White Program requires all ADAP clients to be HIV-positive, low-income, and under- or uninsured, but no income level is specified under current law. Each ADAP determines its own eligibility criteria. As of January 1, 2015:

- All ADAPs have state residency requirements and many require proof of residency.
- Financial eligibility ranges from 200% FPL in 4 states to 500% FPL in 10 states.[10] In some cases, eligibility differs for the various program components within individual ADAPs (e.g., the insurance purchasing program vs. the direct medication program).

ADAP Clients

ADAP client enrollment and utilization have grown over time and are now at their highest levels to date. Client demographics vary by state and region, but nationally have remained fairly constant over time.



- 257,396 people were enrolled in ADAPs in CY 2015, ranging from 140 in Wyoming to more than 35,000 in California.
- Of CY 2015 clients enrolled, ADAPs provided medications only to 101,418 clients and insurance coverage (or insurance coverage and medications) to 124,099 clients.
- A majority of clients were people of color (69%) and most were male (78%).
- Three quarters (76%) had incomes at or below 200% of the Federal Poverty Level, (FPL), including over half (58%) with incomes at or below 138% FPL.
- Half of clients were between 45-64 years of age (50%), followed by those ages 25-44 (40%).
- Three quarters (77%) of all ADAP clients were virally suppressed (having a viral load of below 200 copies/ml), which is a higher share than for people with HIV nationwide (57% of those in care).[11] Viral suppression is higher among clients receiving insurance assistance (88% of whom are virally suppressed) compared to those receiving only medications from ADAPs (73% of whom are virally suppressed). Viral suppression is critical to achieving optimal individual health outcomes and research has shown there are also preventive benefits – when an individual with HIV is virally suppressed, the risk of sexual transmission is negligible.[12,13]

Cost-Containment Measures and Waiting Lists

ADAPs must balance client demand with available resources on an ongoing basis. Because of recent economic conditions, instituting cost-containment measures or management practices is common. In the past, waitlists were used as a primary cost-containment measure. Waitlists peaked in September 2011 when 9,298 individuals in 11 states were eligible for ADAPs yet unable to access medications. Currently, waitlists have been eliminated as a result of an influx of reprogrammed Ryan White funding and separate emergency funding between 2010 and 2013. In some cases, ADAPs received higher rebates from drug companies and individual ADAPs implemented stricter cost-containment measures such as capped enrollment and reduced eligibility and formularies. Few states currently have cost-containment measures (e.g., enrollment caps and waiting lists) in place, although as they were more common in the past when ADAPs faced budget crises, their use will be important to monitor their use moving forward.

Drug Purchasing Models

All ADAPs participate in the 340B program, enabling them to purchase drugs at or below the statutorily defined 340B ceiling price. ADAPs conduct drug purchasing through different mechanisms:

- 7 ADAPs centrally purchase and dispense medications through their own pharmacy or contract pharmacy (known as "direct purchase").
- 21 ADAPs pay retail pharmacies for drugs and subsequently bill manufacturers for the 340B rebate amount.
- 7 purchase through a "hybrid model," using an existing entity to purchase drugs and submitting rebate claims for any additional discount amount.
- 14 use a "dual model," purchasing medications through their own pharmacy or contract pharmacy and paying retail pharmacies for drugs, later filing for rebates.

Insurance Purchasing & Coordination

Clients have gained access to new coverage opportunities under the Affordable Care Act (ACA). In adjusting to the new health coverage landscape and in complying with Ryan White's payer of last resort requirement, ADAPs have intensified their efforts to coordinate with other health coverage entities, including private insurance marketplaces and Medicaid.[14] In many cases, providing insurance assistance is more cost effective for ADAPs (the average per capita cost of a client enrolled in insurance coverage is about one third of that of clients enrolled in direct drug programs) and doing so provides clients with robust coverage. ADAPs assisted with insurance coverage for 124,099 clients in 2015, at a cost of $310 million.

Only 3 ADAPs (ID, MS, SD) did not use funds for purchasing health insurance in 2015. The remaining states offer varying forms of insurance purchasing/coordination, including assisting with Medicare, employer-based coverage, and individual market coverage. While most ADAPs seek to leverage the opportunities provided by the ACA, not all ADAPs with insurance purchasing infrastructures use them to purchase qualified health plans in the health insurance marketplaces created by the law.

Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added an outpatient prescription drug benefit, Part D, to the Medicare program. As the payer of last resort, ADAPs must ensure that any Medicare Part D-eligible client is enrolled in Part D and that ADAP is not paying directly for prescription drug expenses. However, ADAPs can help with clients' out-of-pocket costs associated with Part D coverage. In CY2015, 13% of clients were served by Part D.

Under the ACA, as of January 1, 2011, payments made by ADAPs on behalf of a Medicare Part D beneficiary count toward "TrOOP" (a beneficiary's true out-of-pocket costs), allowing the client to pass through the "doughnut hole" (or, coverage gap) into catastrophic coverage.[15]

Looking Ahead

ADAPs continue to play a critical role in providing prescription drugs and a pathway to insurance coverage for low- and moderate-income people with HIV who would otherwise have limited access. In addition, ADAPs often serve as a bridge to other care and support services. As the number of people living with HIV has increased in the U.S., so too has the need for ADAPs. While ADAPs have faced challenging national and state fiscal conditions in the past, leading to the creation of waiting lists, emergency funding, increased rebates from manufacturers, and the implementation of the ACA have relieved much of this pressure. Looking ahead, as lawmakers continue to debate the future of the ACA, as well as federal spending more generally, it will be important to monitor the impacts of any policy changes on ADAPs and the clients they serve.

[1] Except where noted, data included in this fact sheet are from the National Alliance of State and Territorial AIDS Directors (NASTAD), *National ADAP Monitoring Project 2017 Annual Report*. Not all states and U.S. jurisdictions reported data for each indicator. See the original report for a list of areas that did not report. See select state-level data at: http://www.kff.org/state-category/hivaids.

[2] Based on KFF analysis of data from CDC.

[3] KFF analysis of CDC and NASTAD ADAP Reporting Data. See ADAP Monitoring Report and https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a5.htm?s_cid=mm6347a5_w

[4] The term "state" includes states, the District of Columbia, and U.S. territories.

[5] Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Pub. L. No. 101-381; Ryan White CARE Act Amendments of 1995, Pub. L. No. 104-146, SEC. 2616. [300ff-26].

[6] HRSA, HIV/AIDS Bureau.

[7] Five percent of the ADAP earmark is set-aside for the ADAP Supplemental Drug Treatment Grant.

[8] Not including the ADAP Supplemental Drug Treatment Grant set-aside.

[9] Department of Health and Human Services, Panel on Antiretroviral Guidelines for Adults and Adolescents (2013). Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents, July 14, 2016. Available at: http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/.

[10] The 2015 Federal Poverty Level (FPL) was $11,770 annually (slightly higher in Alaska and Hawaii) for a household of one.

[11] CDC. *Selected National HIV Prevention and Care Outcomes in the United States*. July 2016. https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-national-hiv-care-outcomes.pdf

[12] CDC. *Prevention Benefits of HIV Treatment*; updated January 2017.

[13] NIH. NIH Statement on World AIDS Day 2016; December 2016.

[14] The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148.

[15] The Medicare program includes a "coverage gap" or "doughnut hole" which, as mandated by the ACA, will gradually be phased out by 2020, when beneficiaries will pay 25% of the cost of their drugs in the gap. Until then, recipients not receiving low-income subsidies (LIS) are liable for all prescription drug costs in the coverage gap. ADAP can assist with these expenses and ADAP spending can count towards the client's TrOOP until they reach catastrophic coverage.

Application for
Fiscal Year 2022-2024 Ryan White Part A
Formula and Supplemental Funds
C.F.D.A. 93.914

Submitted by
Lina Hidalgo, Harris County Judge
For
The Houston Eligible Metropolitan Area

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Project Title: *Ryan White HIV/AIDS Program Part A, HIV Emergency Relief Grant Program*
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i. PROJECT ABSTRACT

The Houston EMA's Ryan White HIV/AIDS Part A Program provides comprehensive health care and support services to people living with HIV (**PLWH**) who reside in the six-county area in southeast Texas that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller counties. Approximately 75% of the general population and 91% of PLWH in the EMA reside within Harris County, the most populous county in Texas and the third most populous county in the nation. The City of Houston, where an estimated 79% of PLWH in the EMA reside, is the most populous city in Texas and the fourth most populous city in the nation. The table below presents the most currently available surveillance data for PLWH in the EMA, as provided by Texas Department of State Health Services (**TDSHS**).

2019	PLWH			PLWH	
	#	%		#	%
Total	**30,198**	**100%**	<13 years	**49**	**0%**
Male	**22,736**	**75%**	13-24 years	**1,211**	**4%**
Female	**7,462**	**25%**	25-34 years	**6,202**	**21%**
White	**5,176**	**17%**	35-44 years	**6,956**	**23%**
African American	**14,398**	**48%**	45-54 years	**7,522**	**25%**
Hispanic/Latinx	**9,065**	**30%**	55-64 years	**6,040**	**20%**
Other	**1,559**	**5%**	65+ years	**2,218**	**7%**

The Houston area represents one of the largest metropolitan areas in the U.S., and the EMA is responsible for providing primary medical care services throughout the region, especially in areas of high HIV prevalence (Montrose - southwest of downtown Houston, far southwest Houston, northeast Houston, and south Houston). The EMA has an advanced system of care that addresses HIV service needs from diagnosis to end-stage disease. Central to this system is primary medical care. The Harris Health System operates the Northwest Health Center, focused on HIV services for women and adolescents, and Thomas Street Health Center, a comprehensive primary and specialty care HIV clinic, which is in central Houston. Federally Qualified Health Centers (**FQHC**) offer community-based options for primary care, including Legacy Community Health in the Montrose area, which has historically served the gay/MSM community; Avenue 360 in Houston's northwest side, targeting Hispanic/Latinx and African American PLWH; and St. Hope Foundation (**SHF**) in southwest Houston that focuses on African American PLWH. Rural PLWH are served by three FQHCs: two in Fort Bend County and one in Montgomery County operated by SHF and Access Health. An HIV clinic at the UT Houston Health Science Center provides primary care services to HIV-positive children. Complementing these providers is a long-standing coordinated case management system including medical case management services embedded in all primary care programs, clinical case management co-located at behavioral treatment sites, and service linkage located at HIV testing and primary care sites to ensure clients are accessing and retained in care.

The overall 2019 viral load suppression rate for the Houston EMA is 59% among diagnosed PLWH, based on data provided by TDSHS. Data reveal possible disparities in viral suppression rates in various subpopulations. Using the population-based rate of 59% as the benchmark, data indicate that youth aged 13-24 had lower rates of viral suppression at 54%. Among racial/ethnic groups, African American PLWH had the lowest proportion of individuals with viral suppression (55%). For reported exposure category, people with injection drug use as a primary transmission risk exhibited the lowest proportion of viral suppression (54%) in 2019 compared to other risk groups.

The EMA has received RW Part A funding for 31 years and MAI funding for 22 years.

TABLE OF CONTENTS FOR PROJECT NARRATIVE

Sept 14, 2021

Dear Colleagues:

Every year, staff in the TB/HIV/STD Section of the Texas Department of State Health Services (DSHS) provide Ryan White HIV/AIDS Program (RWHAP) Part A grantees and administrators with information on HIV trends, participation in HIV treatment, and HIV health outcomes for use in their grant applications. As staff began preparing data for the 2021 applications, the latest HIV surveillance data available was from the calendar year 2019. The latest STD data, used in estimating co-morbidities, was from calendar year 2018. The 2020 HIV and STD data were delayed due to statewide COVID-19 activities. This is consistent with the national trends. The Centers for Disease Control and Prevention (CDC) extended the deadline for all final 2020 STD and HIV case data. STD 2020 data is due September 2021, and HIV 2020 data is due December 2021.

DSHS staff are working to get caught up with the 2021 HIV/STD data so that there are no delays. Additionally, DSHS is working to improve the overall quality and timeliness of data submissions at all levels, such as providers, labs, and public health entities, on DSHS systems.

Please let us know if you have questions or concerns. We appreciate your understanding.

Felipe Rocha, Director
TB/HIV/STD Section

INTRODUCTION

The Houston EMA region has been severely affected by the HIV epidemic and has received Ryan White HIV/AIDS Program Part A (**RW/A**) funding for the past 31 years. The funding, awarded to Harris County (the Recipient) and administered by Harris County Public Health's Ryan White Grant Administration unit, is essential to sustain and enhance a comprehensive system of high quality, community-based care and treatment for low-income individuals with HIV, and includes Core Medical Services such as Primary Medical Care, Medical Case Management, Local Pharmaceutical Assistance, Oral Health Care, Health Insurance Assistance, Medical Nutritional Therapy, and Substance Abuse Services. In addition, the funding is essential to develop strategies to reach high-risk HIV populations, emerging populations, individuals unaware of their HIV status, and diagnosed individuals with unmet need. The purpose of this grant proposal is to provide the narrative description with supporting data on the need for RW/A funding and describe the planning and evaluation process in the Houston EMA. *Due to the COVID-19 response by the Texas Department of State Health Services* (**TDSHS**)*, the most currently available statewide HIV/AIDS surveillance data is from 2019. For more details, please reference the TDSHS letter on page i. The Houston EMA's 2019 surveillance data and other supporting data will be presented throughout the project narrative.*

NEEDS ASSESSMENT

A. DEMONSTRATED NEED

- **A.1) Epidemiologic Overview**

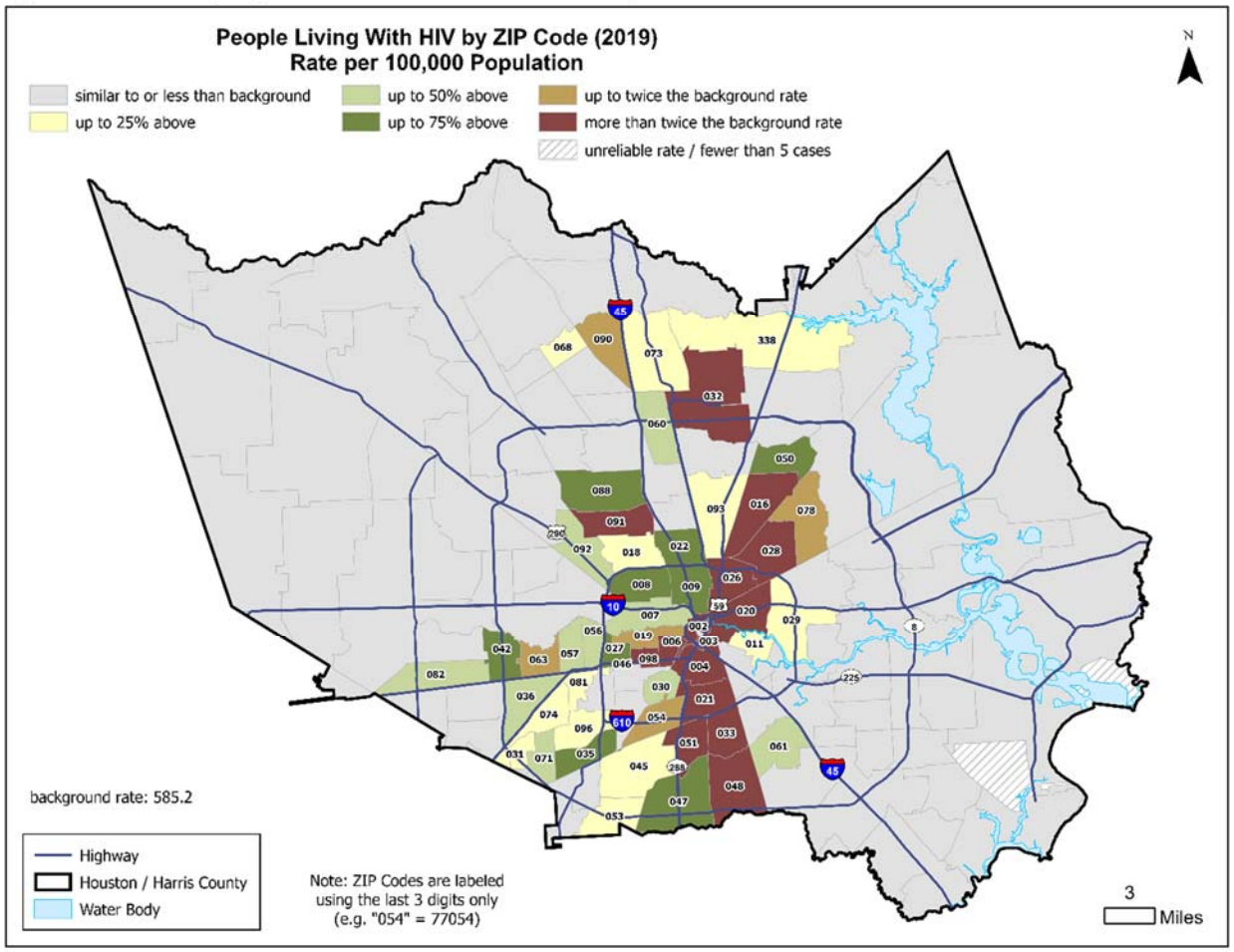
Attachment 3 displays the numbers, percentages, and rates of living HIV/AIDS cases and newly diagnosed HIV cases by demographics in the Houston EMA. Since socioeconomic data is not captured as part of HIV surveillance, this data is not readily available. Instead, socioeconomic indicators collected as part of the RW eligibility and registration process (homelessness, poverty, and insurance status) are presented in ***Attachment 3***.

A.1.a) Summary of the HIV epidemic in the Houston EMA

In 2019, 30,198 people were living with HIV (**PLWH**) in the Houston EMA. The prevalence rate in the EMA was 478 per 100,000, which was higher than the rate of 337 in Texas and the rate of 411 in the U.S.[1] The prevalence rates for males and females in Houston were 726 and 234, respectively. Both rates were higher than the rates in Texas (537 for males and 140 for females). The prevalence rate for African Americans was 1,274, which was higher than the rate for African Americans in Texas, at 993. The prevalence rates for Whites and Hispanics/Latinx were also higher than corresponding rates in Texas. The rates of PLWH by each age group in the Houston EMA, as shown in ***Attachment 3,*** were approaching 1.5 times the average rates in Texas. For further discussion on PLWH, please refer to page 3.

The burden of HIV disease in Houston/Harris County, where more than 90% of PLWH in the EMA reside, is illustrated in **Figure 1**, showing rates of PLWH by zip codes in Houston/Harris County for 2019. HIV cases were unevenly distributed across the area. Zip codes where the highest rates occurred, up to double the background prevalence rate, were concentrated in central Houston/Harris County, including some northeastern and southern parts of central Houston/Harris County.

Figure 1. **PLWH by Zip Code in Houston/Harris County, 2019**



Data Source: Texas Enhanced HIV/AIDS Reporting System – data analyzed by the Houston Health Department; population data from the American Community Survey 5-year estimates (2015-2019), the American Community Survey 1-year estimates (2019), and the 2010 US Census; zip codes were labeled using the last three digits only (e.g., 77002 was labeled as "002"). Zip codes with fewer than five cases have been suppressed.

A.1.b) Description of 1) persons newly diagnosed, 2) PLWH, 3) persons at higher risk for HIV, and 4) socioeconomic characteristics of PLWH

1) Persons newly diagnosed with HIV in the Houston EMA

Attachment 3 shows new HIV (not AIDS) diagnoses in the Houston EMA by demographic groups. In 2019, there were 1,313 new HIV diagnoses in the Houston EMA. The new diagnoses occurred predominately among males (80%), African Americans (42%), Hispanics/Latinx (39%), and individuals who reported the exposure category of **MSM** (71%), or Men who have Sex with Men. When compared to the overall 2019 HIV diagnosis rate for the EMA (21 per 100,000), a disproportionate impact was observed among males (rate of 34), African Americans (rate of 49), youth aged 13-24 (rate of 33), and adults aged 25-34 (rate of 48). Overall, the trend of new HIV diagnoses appears to be stable, from the rate of 20 in 2017 to 21 in 2019. Among racial/ethnic groups, the rate of new HIV diagnoses in African Americans decreased from 52 to 49 from 2017 to 2019, while the rate in Other populations increased from 10 to 14. New HIV diagnosis rates

remained relatively similar among age groups, except for youth aged 13-24, whose rate increased from 27 to 33 from 2017 to 2019.

Data from the TDSHS show that among 1,344 new diagnoses in 2018, 275 or 21% received an HIV Stage 3 AIDS diagnosis within three months of their initial HIV diagnosis. Late diagnosis data for 2019 are not yet available. Populations disproportionately affected by late/concurrent diagnoses in the Houston EMA included Hispanics/Latinx at 25% and MSM/people who inject drugs (**MSM/PWID**) at 32% among their respective demographic/exposure groups.

2) PLWH in the Houston EMA

In 2019, there were 30,198 PLWH in the Houston EMA, with a rate of 478 per 100,000 population. The number of male PLWH (22,736) was three times that of female PLWH (7,462), as were their respective rates of 726 and 234. African Americans accounted for 48% of PLWH in the EMA although they comprised only 18% of the total Houston EMA population. The rate of African Americans living with HIV, at 1,274, was over five times the rate of Whites and over three times that of Hispanics/Latinx. In 2019, the highest prevalence rate by age was in the 45-54 age group, at 940. By transmission risk, 59% of living cases were attributed to MSM, followed by 28% due to Heterosexual transmission, and 8% due to transmission by PWID. Another 4% were attributed to the combined exposure category of MSM/PWID. Overall, the prevalence rate of PLWH has increased slightly from 457 per 100,000 in 2017 to 478 per 100,000 in 2019.

3) Persons at higher risk for HIV the Houston EMA

Detailed cross-tabulated data in this section was provided by TDSHS in previous years, so data presented reflects 2016 to 2018 data.

Among all populations in the Houston area, people at higher risk for acquiring HIV are more likely to be male and African American, with MSM reported as the most common transmission risk. African Americans are the racial/ethnic group with the highest rates and percentages of HIV diagnosis among both males and females. Among African American males with HIV, the rate of diagnosis for 2018 was 83 per 100,000, almost six times that of White males. MSM is the main transmission risk among new HIV cases, occurring predominantly among African American and Hispanic/Latino males, with rates of 369 and 373, respectively. African Americans aged 13-24 years had greater than eight times the diagnosis rate of Whites within the same age groups, at 81 and 10 per 100,000, respectively. African Americans aged 25-34 had approximately five times the rate of White people with HIV (TDSHS).

The overall rates of new HIV diagnoses in the Houston EMA have remained relatively stable since 2016. The rate of new HIV diagnoses in African American males has decreased overall, from 87 in 2016 to 83 in 2018. There may be an increase in new diagnoses among Hispanic/Latinx PWID and Heterosexual PLWH, where rates increased from 13 to 18 for PWID and from 94 to 101 for Heterosexual people with HIV from 2016 to 2018 (TDSHS).

4) Socioeconomic characteristics of PLWH

The *2020 Houston HIV Care Services Needs Assessment* (**NA**) published by the Ryan White Planning Council presents several socioeconomic characteristics reported by surveyed PLWH in the Houston area. NA results show that the mean annual household income of PLWH was $14,420, with 60% of respondents living below the Federal Poverty Level (**FPL**). In comparison, this annual income is almost five times lower than the average median household income in the Houston EMA

with an average of 14% living below FPL in the general population of the Houston EMA, based on census data from the American Community Survey, 2015-2019. Among surveyed PLWH, 36% reported not working due to disability followed by 21% who were currently unemployed but seeking employment. Approximately 32% were uninsured and relied solely on the Ryan White HIV/AIDS Program for services. Further, 32% reported unstable housing, with 11% of participants experiencing homelessness at the time of the survey.

Current RW service utilization data support the results above: among clients served in 2020, 61% were living below the FPL, with 10% of clients reporting unstable housing/homelessness. Data also showed that 62% of served clients were uninsured. Further, an estimated 16% appeared to have been experiencing language barriers, as indicated by the number of clients who reported Spanish as their primary language spoken at home (Centralized Patient Care Data Management System **CPCDMS**).

A.1.c) Description of relative rates of increase within new and emerging populations

Table 1. **Relative Rates of Change in New HIV Diagnosis, Houston EMA, 2017 to 2019**

Population Group	HIV Diagnosis Rate (per 100,000 population)		Relative Rate of Change
	2017	2019	
Total	20.0	20.8	4.0%
Male	32.6	33.7	3.4%
Female	7.6	8.1	6.6%
White	6.5	8.0	23.1%
African American	52.3	49.0	-6.3%
Hispanic/Latinx	19.8	20.6	4.0%
Other	9.8	13.9	41.8%
13-24	27.2	32.6	19.9%
25-34	49.3	48.0	-2.6%
35-44	26.9	28.4	5.6%
45-54	20.5	18.0	-12.2%
55+	6.9	8.2	18.8%

Data Source: TDSHS, 2017 and 2019 data

Table 1 above presents the analysis of relative rates of change among new diagnoses by demographic groups, using 2017 and 2019 surveillance data. Using the overall 2019 HIV diagnosis rate (21 per 100,000) as a benchmark, the following populations experienced disproportionate rates of new HIV diagnoses in 2019 in relation to the EMA as a whole (4%):

- Males: rate of 34 (62% higher)
- African Americans: rate of 49 (136% higher)
- Ages 13-24: rate of 33 (57% higher)
- Ages 25-34: rate of 48 (131% higher)
- Ages 35-44: rate of 28 (35% higher)

Using the rates listed in **Table 1** to calculate changes in relative HIV diagnosis rates from 2017 to 2019, changes occurred most notably among White individuals (increased 23%), Other racial/ethnic groups (increased 42%), youth aged 13-24 (increased 20%), adults aged 45-54 (decreased 12%), and older adults aged 55+ (increased 19%).

The analysis above indicates that African Americans (rate of 49) and individuals aged 25-34 (rate of 48) bore the highest disproportionate burden of new HIV diagnoses in the Houston EMA compared to the benchmark rate of 21 per 100,000. Decreasing infection rates among these two populations (African Americans by -6% and adults aged 25-34 by -3%), however, indicate that local HIV prevention and care service systems may have made progress in reducing HIV diagnosis rates. Data further indicate that service system changes are necessary to respond to the increasing impact of new diagnoses among youth with HIV aged 13-24 years, which is discussed below.

i. Information on emerging populations, unique challenges, and estimated costs

Emerging populations and unique challenges

The Houston EMA has experienced a four percent increase in its HIV diagnosis rate from 2017 to 2019 with an overall rate of 21 per 100,000. Based on data shown in **Table 1**, youth aged 13-24 was the emerging population that had both a significant increase in its relative rate (20% increase since 2017) *and* bore a disproportionate burden of new diagnoses (rate of 33) compared to benchmark rates. Analysis of viral suppression data also indicates that youth aged 13-24 experienced one of the disproportionately lowest viral suppression rates in 2019 with only 53% virally suppressed.

This relative increase in HIV diagnosis rates among individuals aged 13-24 may indicate an increasing need for HIV-related prevention and care services tailored to meet the needs of youth in the Houston EMA. According to the CDC, youth accounted for 21% of new HIV diagnoses in 2018 with 92% of new diagnoses occurring among young MSM. Based on Houston's 2020 NA, among youth participants, 19% reported not being retained in HIV care and 13% reported having no insurance at the time of data collection, compared to two percent of the total sample having no insurance. All youth respondents (100%) identified primary care as the most needed RW-funded service , followed by local HIV medication assistance (86%), ADAP enrollment workers (76%), and case management (67%). Compared to the total sample, higher proportions of youth participants indicated needing day treatment (50% vs 32%), outreach services (23% vs 5%), and ADAP enrollment workers (76% vs 60%). With regards to barriers to care, youth participants most often cited service education and awareness issues (21%) and issues regarding health insurance (7%). Service education and awareness barriers among youth participants pertained mostly to not knowing who to contact for services, as well as not knowing that the service was available. Barriers related to health insurance among youth pertained mostly to health insurance gaps (certain services/medications not covered by the participants current health insurance) and being uninsured. Compared to the total sample, a greater proportion of youth participant's gender identities were reported as transgender/gender non-conforming (17% vs 4%), multiracial (21% vs 4.7%), and gay/lesbian/bisexual/asexual (75% vs 39%).

The Houston EMA recognizes additional emerging subpopulations which may not yet show the greatest local burden of HIV transmission, or for which epidemiologic data are insufficient to determine burden, but which have behavioral, socioeconomic, or legal circumstances that increase vulnerability to HIV transmission or loss to care. Accurate gender identity for transgender individuals is not reflected in most epidemiologic and surveillance data. Often transgender individuals are categorized by sex assigned at birth, which does not accurately and adequately demonstrate current risks, needs, and barriers. For this reason, other local data sources such as

service utilization and needs assessments are used to identify barriers and potential responses to the emerging needs of the transgender populations. In 2020, the Houston RW Program served 259 self-identified transgender clients, or 2% of all clients served. Transgender individuals comprised 4% of the total sample surveyed in the 2020 NA and were more likely to have been recently released from incarceration and to have encountered physical and/or sexual violence in the 12 months prior to being surveyed. Transgender consumers also reported experiencing more barriers and difficulty accessing case management, adult day treatment, early intervention services (Harris County jail pre-discharge planning), health insurance assistance, local pharmacy assistance, and outreach services than cis-gender NA respondents. To address these needs and barriers, transgender people with HIV in the Houston EMA may benefit from additional pre-discharge planning (for those transitioning from the criminal justice system), community initiatives to decrease violence against the transgender community, employment and job training services, housing services including shelters that serve transgender clients, transgender-competency and affirming policies in primary care settings, and additional transportation options when public transportation may be inaccessible or unsafe.

Other unique challenges include geographic and environmental factors such as an EMA area of almost 6,000 square miles, temperatures that often exceed 100◦F in the summer, poor mass transit options, and frequent widespread flooding in low-lying areas create barriers for those who rely on public transportation to access medical care. While 64% of 2020 NA respondents reported having some form of health care coverage, analysis revealed that most health insurance-related barriers occurred because participants were experiencing coverage gaps for needed services or medications and were uninsured or underinsured. Additionally, respondents reported difficulty paying for HIV medications (29%), non-HIV medications (33%) and medications to treat mental health concerns (25%), even when receiving some form of medication assistance. With Houston/Harris County as one of the most ethnically diverse communities in the United States, it is surprising that language barriers are rarely identified as common barriers to care. Per Houston EMA *Standards of Care*, Ryan White-funded providers are required to have interpretive services available, Spanish bilingual staff, and staff trained in cultural competence available to serve individuals with limited English proficiency.

Estimated costs

African Americans and individuals aged 25-34 have shown disproportionate rates of HIV diagnoses, while youth with HIV is an emerging population in which rates are becoming more disproportionate within the Houston EMA. To understand the impact of HIV on these populations, it is essential to look at the estimated costs to the RW/A Program and the expenditures for the RW/A-funded services to better understand the needs of these populations.

In FY20, 48% of RW/A service funds were spent on core medical service delivery to African Americans. This amounts to an estimated total cost of **$9.1M**, of which 76% ($6.9M) was spent on primary medical care. African American PLWH also accounted for either the majority or significant portions of expenditures for emergency financial assistance (52%), health insurance assistance (36%), case management (61%), and local pharmaceutical assistance (38%).

An estimated 23% of RW/A service funds was spent on service delivery to individuals aged 25-34. This amounts to an estimated total cost of **$4.3M**, of which 79% ($3.4M) was spent on primary medical care. Individuals aged 25-34 also accounted for significant portions of expenditures under

emergency financial assistance (32%) and outreach (30%). Other top services delivered to adults aged 25-34 include local pharmaceutical assistance and health insurance assistance (15% and 11% of service category expenditures, respectively).

For youth aged 13-24, more than **$700K** was expended on service delivery, of which 79% ($553K) was spent on primary medical care. Other top services delivered to youth included emergency financial assistance, case management, outreach services, and transportation services.

ii. Increasing need for HIV-related services based on relative increase of HIV cases

In the three-year period since 2017, the Houston EMA experienced a four percent increase in new HIV diagnoses; disproportionate burden is still evident in certain populations along with rising rates in youth aged 13-24 and possibly transgender individuals, as discussed above, and these populations will have an increasing need for HIV-related services.

In 2019, 75% of the 30,198 PLWH in the Houston EMA accessed HIV medical care, with approximately half of those in care receiving RW/A-funded services. The Houston EMA's 2020 NA found that RW Program-funded services overall were highly accessible. For each funded service category, at least 78% of consumers who indicated needing that service also reported ease in accessing that service, and at least 80% of consumers who indicated needing a Core Medical Service reported ease accessing the service. Among the less accessible funded services were oral health care and health insurance assistance. When asked to describe why they had difficulty accessing these services, respondents most frequently reported barriers related to education and awareness (e.g. not knowing the availability or the location of the service provided), interactions with staff (e.g. lack of correspondence/follow-up) and wait times (e.g. being placed on a wait list). Housing issues (homelessness or intimate partner violence) were cited least often as barriers to funded services. The 2020 NA also analyzed need and accessibility for allowable services not currently funded in the Houston EMA. Among unfunded services respondents reported highest need for housing, food bank, and health education/risk reduction, and the lowest accessibility for housing, food bank, and other professional services.

The Houston EMA's *2017-2018 Out of Care Special Study* identified several emerging themes regarding service gaps for PLWH who were not in HIV medical care, or who had a history of being out of care on multiple occasions. Participants in the special study indicated there is a need in the community for proactive education and service linkage in Houston area emergency departments. Though RW/A-contracted providers are required to maintain "Point of Entry" (**POE**) agreements with such sites, many local private, rural, or free-standing emergency departments are typically not included in POE agreements. Participants also identified a need for more proactive or "warm hand-off" coordination between pre-discharge planners and Service Linkage Workers (**SLW**)/Medical Case Managers for those being released from incarceration. Culture shifts for newly diagnosed PLWH or those new to RW care were reported as contributing to the lack of awareness of services as observed in the 2016 NA. These individuals were not aware of support services available to them as they moved from non-HIV private or public care to the Ryan White care system. One participant shared, "I didn't know [about gas cards]. I thought it was like a regular doctor's office. You don't ask for gas at the doctor." Among participants who were out of care while employed, stigma and fear of stigma in the workplace prevented them from accessing or using their employer-sponsored health insurance. Participants who experienced persistent homelessness or housing instability reported entering or returning to care because a knowledgeable

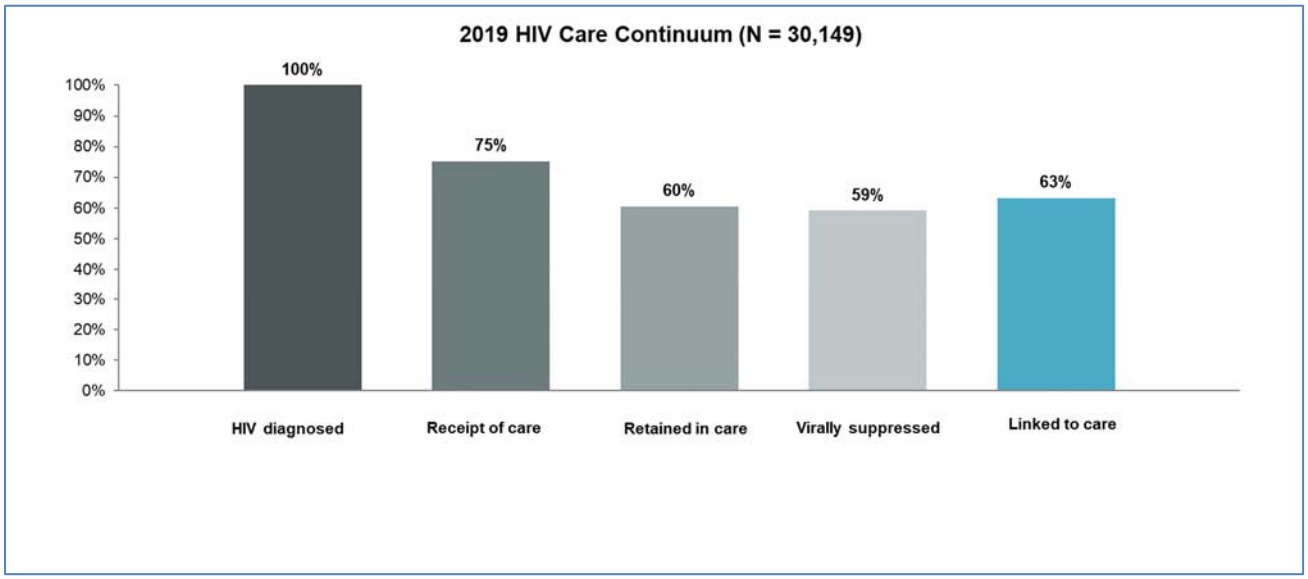
peer directed them to support services. However, these participants reported that both they and their peers used support services as survival resources, rather than with the intent of accessing and staying in care. Participants described this as a survival resource cycle for PLWH who were also experiencing homelessness that resulted in consumers accessing care to receive support services for multiple years, but rarely returning for follow-up appointments, not adhering to medications, and experiencing decreasing health and quality of life issues.

- **A.2) HIV Care Continuum (graphic depiction)**

A.2.a) Graphic depiction of the Houston EMA HIV Care Continuum

The Houston EMA HIV Care Continuum (**HCC**) illustrates community-wide access and service gaps for Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller counties and was created using data provided by the Texas Department of State Health Services. TDSHS manages surveillance and care data for the state of Texas and compiles various sources of data (e.g. public and private payer data) for establishing evidence of care. The Houston HCC is a diagnosis-based continuum containing population-based data. The data presented in the HCC reflects surveillance data for 2019 of persons aged 13+ years with diagnosed HIV, unless otherwise noted. **Figure 2** below presents the Houston EMA HIV Care Continuum for calendar year 2019. **Table 2** explains the care measures within the Houston HCC and the data sources for each measure. For expanded details on data methodology/limitations, please see page 10.

Figure 2. **Houston EMA HIV Care Continuum, 2019**



Data Source: TDSHS, 2019 data

Table 2. **Houston EMA HIV Care Continuum Measures**

Measure	Description		Data sources
Diagnosed	The number of persons ≥13 years with diagnosed HIV in the Houston EMA at the end of the calendar year.		Texas eHARS data
Receipt of Care	*Numerator:*	The number of persons ≥13 years with diagnosed HIV in the Houston EMA who had a care visit during the calendar year, as measured by documented test results for CD4 or viral load.	Texas eHARS, ELR, ARIES, ADAP, Medicaid, private payer data
	Denominator:	The number of persons ≥13 years with diagnosed HIV by previous year-end and alive at year-end.	
Retained in care	*Numerator:*	The number of persons ≥13 years with diagnosed HIV who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load.	
	Denominator:	The number of persons ≥13 years with diagnosed HIV by previous year-end and alive at year-end.	
Virally suppressed	*Numerator:*	The number of persons ≥13 years with diagnosed HIV whose most recent viral load test in the calendar year showed that HIV viral load was suppressed (<200 copies/mL).	Texas eHARS, ELR, ARIES, ADAP
	Denominator:	The number of persons ≥13 years with diagnosed HIV by previous year-end and alive at year-end.	
Linked to Care	*Numerator:*	The number of persons ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.	Texas eHARS, ELR, ARIES, ADAP
	Denominator:	The number of persons ≥13 years with newly diagnosed HIV during the calendar year.	

Data Sources: Texas Enhanced HIV/AIDS Reporting System (**eHARS**), electronic laboratory reporting (**ELR**), AIDS Regional Information and Evaluation System (**ARIES**), AIDS Drug Assistance Program (**ADAP)**

- **A.3) Unmet Need - *Attachment 4***

A.3.a) Identify whether an enhanced method was utilized in addition to the required method; describe any data system and/or other limitations

The Texas Department of State Health Services, in partnership with the Houston EMA and other TGA/EMAs in the state, provided the Unmet Need Framework based on the **required methodology**. The primary data source was the Texas HIV surveillance system, eHARS, linked in with ELR data. Other linked data sources utilized to estimate unmet need included private insurers, Medicaid, Texas HIV Medication Program (ADAP data), and care data from the state ARIES system. Based on the required methodology as reported in ***Attachment 4***, among PLWH in the Houston EMA, an estimated 21% were late diagnosed, 25% had unmet need and 22% were

in care but not virally suppressed. The table below compares the rates of Houston to other TGA/EMAs in Texas, and it is noteworthy that *Houston has the highest rate of PLWH with unmet need at 25% and also the highest rate of PLWH in care but not virally suppressed at 22%.*

Required Method	Houston	Fort Worth	Dallas	San Antonio	Austin
Late Diagnosed	21%	22%	21%	18%	19%
Unmet Need	**25%**	22%	21%	22%	15%
In Care, Not Virally Suppressed	**22%**	20%	20%	19%	14%

Data Source: TDSHS, 2018/2019 data

Data methodology, system and/or other limitations

As mentioned previously, the state's COVID-19 response and other challenges led to delays in reporting/surveillance such that 2019 data is the most updated data available for estimating unmet need. Please reference the letter from TDSHS on page i. A further lack of resources related to the state's planned implementation of a new data system and staffing shortages limited the state's ability to provide an estimate based on the enhanced methodology.

TDSHS provided the following statement on data methodology and limitations:

The information on treatment indicators included in the analyses is comprehensive but may not capture all information on HIV monitoring laboratory tests for Texans living with HIV. While all laboratories are required to report the results of all CD4 and viral load tests for Texas residents living with HIV, it is possible that some results may be unreported. This is most likely for laboratories outside Texas (when the test is for a Texas resident) and laboratories that submit their results through non-electronic means. *However, because TDSHS uses multiple sources of information to analyze met and unmet need, the chances of missing information on treatment services for an individual living with diagnosed HIV across all sources of data are minimal.* These data also do not include information on PLWH who have not yet been diagnosed.

Prescription data are also used as indicators of treatment. There are reasons associated with the suitability of prescription data as an indicator of care and practical methodological reasons for its inclusion.

1) Prescriptions for HIV treatment drugs are clearly an indicator of treatment, and prescriptions are usually refilled more times a year than lab tests are drawn or people have primary care visits, offering more opportunities to detect in care status. Prescriptions were dropped as an indicator because some organizations did not have access to these data. Texas does, and it enriches the data used for the analysis.

2) The coding nets used to retrieve information from public and private insurers uses filled prescriptions for HIV treatment as the primary way of identifying beneficiaries who are living with HIV, as Texas indicators are pulled from financial transaction data from the insurers and not from clinical data sources, to which insurers generally do not have access. There is no practical way to separate information on met need derived from prescriptions from the evidence of met need derived from outpatient visits in data from Medicaid or private insurance.

3) Finally, TDSHS continues to use the information on prescriptions in its analysis of met and unmet need and has elected not to provide local estimates that deviated from those that will be published by the State.

A.3.b) Description of needs of estimated number of people that are 1) late diagnosed; 2) have unmet need; and 3) are in care but not virally suppressed

1) Late diagnosed

Please note that the Houston EMA had 1,313 new HIV diagnoses in 2019, based on the most currently available surveillance data as reported in ***Attachment 4***. 2018 *late diagnosis* data is presented in the following discussion, as 2019 late diagnosis data is not yet available.

In 2018, the Houston EMA had 1,344 new HIV diagnoses with 21% being late diagnoses based on the first CD4 test performed or a documented AIDS-defining condition less than or equal to three months after initial diagnosis. According to the Houston EMA's *2020 Houston HIV Care Services Needs Assessment* (**NA**), the most commonly reported reasons given by respondents for delayed entry into HIV medical care were related to HIV stigma (denial about HIV status or fear of HIV status disclosure), financial barriers (not being able to pay for HIV medical care), and education and awareness of resources (not knowing where to go for HIV medical care or not knowing about resources to help pay for HIV medical care and medications). **Significant needs based on the barriers to entry into HIV medical care after diagnosis included lack of health insurance and medication assistance.** Despite 64% of all 2020 NA respondents reporting some form of health care coverage (public health insurance programs; private insurance, Medicaid/Medicare), analysis revealed that many participants were experiencing coverage gaps for needed services and medications resulting in difficulty paying for HIV medications (29%), non-HIV medications (33%), and medications to treat mental health concerns (25%), even when receiving some form of medication assistance.

When examining the 21% of individuals with a late HIV diagnosis in the Houston EMA, the highest proportions of late diagnoses were seen among Hispanic/Latinx individuals (46%), males (77%), and MSM (63%) respective to their demographic groups. According to the 2020 NA, the most commonly reported reasons for delayed entry in HIV medical care among Hispanic/Latino MSM participants were the same as among the total sample; with reasons for delayed entry into care being related to HIV stigma, financial barriers, and education and awareness of resources available. Hispanic/Latinx individuals have unique cultural and socioeconomic challenges that affect their utilization of medical care, especially HIV medical care. Traditional gender concepts of *machismo* and *marianismo*, and stigma surrounding homosexuality in Hispanic/Latinx cultures, can and do discourage individuals within this community from seeking and utilizing HIV prevention and care services. Within the EMA, Hispanic/Latinx individuals reside predominately within geographically isolated areas with limited public transportation and often lower socioeconomic status neighborhoods. Hispanic/Latinx individuals also face many challenges related to residency status, immigration, language barriers, lack of health insurance or gaps in health insurance coverage, and greater difficulty accessing the necessary documentation for verifying eligibility than other racial/ethnic groups within the EMA, which significantly affects this population's access to medical care.

2) Unmet need

In 2019, 25% among PLWH in the Houston EMA had unmet need as evidenced by no CD4 or viral load test in the calendar year. 2020 NA respondents' most frequently cited reasons for reporting a history of unmet need (falling out of care for any 12-month period since their diagnosis) commonly were identified as issues involving substance abuse, moving/relocating, and having

other priorities at the time. Geographic and environmental factors such as the large area of the EMA (almost 6,000 square miles), temperatures that often exceed 100° F in the summer, poor mass transit options, and frequent widespread flooding in low-lying areas create barriers for those who rely on public transportation to access medical care. Similar to late diagnoses, needs among this group include health insurance and medication assistance. Please refer to corresponding discussion under ***Late diagnosed*** on the preceding page for more details.

Among the 25% of individuals with unmet need in the EMA, 50% were African Americans. Among this population, the highest proportions were among heterosexual women (57%) and MSM (30%). Among African American NA respondents, the most commonly cited reasons for reporting a history of unmet need were there being other priorities in their life at the time (16%), their viral load being undetectable (12%), and their doctor or case manager leaving the agency they went to (10%). When examining barriers to care among African American MSM in the 2020 NA, the most commonly reported barriers were the individual not feeling sick at the time (15%), having an undetectable viral load (13%), and other priorities in life at the time (8%). The most commonly reported barriers among African American women in the 2020 NA were having other priorities at the time (15%), having an undetectable viral load (14%), and their doctor or case manager having left the agency they went to (11%). In addition to the barriers mentioned above, historic distrust of the medical community and medical providers, widespread socioeconomic barriers such as poverty, structural and institutional racism, unemployment, mass incarceration, unstable housing, and substance use in the African American communities have created significant and competing priorities that create barriers to utilization of HIV care services. Additionally, stigma of HIV within the African American communities has contributed to African American MSM being fearful of utilizing services for fear of their HIV status being disclosed within their social groups.

3) In care but not virally suppressed

In 2019, 22% of PLWH in care within the Houston EMA were not virally suppressed (viral load >= 200 copies/mL at their most recent test). The 2020 NA respondents' most frequently cited reason for not currently taking Antiretroviral Therapy (**ART**) medications were that individuals were experiencing side effects, missing a refill, or eligibility had expired. Similar to the aforementioned discussion of notable needs under late diagnoses and unmet need, this group included lack of health insurance and medication assistance as reasons for not taking ART. Despite 64% of all 2020 NA respondents reporting some form of health care coverage (public health insurance programs, private insurance, Medicaid/Medicare), analysis revealed that many participants were experiencing coverage gaps for needed services and medications. Additionally, respondents reported difficulty paying for HIV medications (29%), even when receiving some form of medication assistance.

Among individuals who were in care but not virally suppressed in 2019, males (73%), African Americans (56%), and MSM (55%) had the highest proportions of not being virally suppressed. The most cited reasons in the 2020 NA among African American MSM for not taking their ART medications were that they were undetectable (20%), they forgot to take their medications (20%), and that they had experienced bad side effects caused by the medications (13%). Similar to the discussion under unmet need, longstanding distrust of the medical community and mainstream medical providers, widespread socioeconomic barriers such as poverty, structural and institutional racism, unemployment, mass incarceration, unstable housing, and substance use in the African American communities have created significant and competing priorities that create barriers to

utilization of HIV care services. Additionally, stigma of HIV within the African American communities has contributed to African American MSM being fearful their HIV status could be disclosed within their social groups due to their utilization of RW services.

- **A.4) Co-Occurring Conditions**

  Below is the description of the impact of co-occurring conditions on HIV care. Due to the aforementioned challenges and delays in statewide reporting/surveillance, the currently available *co-occurring conditions* data is from 2018 or earlier. ***Attachment 5*** displays the prevalence estimates for each co-occurring condition. *Please note that TDSHS does not collect incidence data for co-occurring conditions and Houston-specific data on mental illness, substance use and homelessness among PLWH is limited or not available.*

  A.4.a) Hepatitis C virus

  According to the CDC, an estimated 21% of PLWH in the US are co-infected with Hepatitis C (**HCV**), although rates of HCV comorbidity vary substantially among HIV risk groups. Because HCV is a blood-borne virus, the HCV comorbidity rate is estimated to be especially high (62% to 80%) among PWID living with HIV. According to the CDC, HCV progresses more rapidly to liver damage in individuals living with HIV and is a leading cause of death among PLWH. HCV comorbidity may also complicate the management and treatment of HIV disease.[2] Additionally, co-infected individuals are more likely to transmit HCV due to higher viral loads and frequent lack of symptoms.[3]

  Based on data from the *Houston State of Health* data portal funded by the City of Houston and Harris County, the 2016 annual rate of HCV in the Houston/Harris County area was estimated to be 735 per 100,000. In comparison, HCV testing data from the RW Program in 2016 showed that among tested clients, an estimated 16% had comorbid infections with HCV (TDSHS). The EMA's FY19 chart review results documented that 96% of primary care clients had been screened for HCV at least once since their HIV diagnosis.

  A.4.b) Sexually transmitted diseases/infections (STD)

  STDs are primary risk factors for transmitting HIV and indicators of unprotected sexual activity. PLWH are at much greater risk for contracting an STD than the general population, and substantial evidence demonstrates that HIV and STD comorbidity increases the likelihood of transmitting HIV. Studies have shown that individuals with an STD are at least two to five times more likely to acquire HIV.[4] Undiagnosed and untreated STDs may cause long-term health consequences such as reproductive health issues, fetal and perinatal health problems, cancer, and even death (Healthy People 2020). Other complications may involve the increased risk for drug interactions with HIV medications.

  Surveillance data from 2018 provided by TDSHS show that 793 PLWH in the Houston EMA were infected with chlamydia, a rate of 2.7%, compared to a rate of 525 per 100,000 in the general Houston area. For gonorrhea, 851 cases among PLWH were reported, at a rate of 2.9%, compared to a rate of 160 per 100,000 in the general population. For infectious early syphilis (primary, secondary, and early latent stages), 719 PLWH were comorbid with a rate of 2.5% versus a rate of 25 per 100,000 in the general population. The EMA's chart reviews document that at least 80% of primary care clients had been tested for gonorrhea/chlamydia during FY19.

A.4.c) Mental illness

Many studies have shown that PLWH experience higher rates of comorbidity with mental health conditions. A multisite study in the US with over 2,800 PLWH reported that 36% had major depression and 16% had generalized anxiety disorder, compared with only 7% and 2%, respectively in the general population.[5] High levels of psychiatric disorders (such as increased depressive, anxiety, or PTSD symptoms) can also interfere with regular HIV testing and diagnosis, as well as successful linkage and retention in care to achieve HIV viral suppression.

Further, depression has also been shown to increase the risk of mortality among PLWH. Among 765 women with HIV disease at four US sites followed for up to 7 years, women with chronic depression were twice as likely to die as women with limited or no depressive symptoms, even after adjusting for predictors of mortality (CD4 counts, ART duration, and age). In the *Women's Interagency HIV Study* prospective cohort (N = 848), chronic depressive symptoms were associated with over three times the risk of mortality among women on ART treatment, and over seven times the risk of mortality among women not on ART, compared with women on ART with no depression.[5] Another study discovered that the death rate of depressed women living with HIV was almost twice as high as those without HIV.[6]

Among surveyed clients, Houston's 2020 NA indicates that an estimated 54% of PLWH reported having a current *diagnosis* of at least one common mental health condition, with 41% reporting depression followed by 24% reporting anxiety disorder or panic attacks. By comparison, an estimated 13% of adults reported mental health issues in the Harris County area (*Houston State of Health* 2018 data). On a positive note, Houston EMA's FY19 chart reviews document that 95% of primary care clients in the EMA were screened for mental illness.

A.4.d) Substance use disorder

According to the National Institute on Drug Abuse (*Drug Facts,* May 2012), those with substance use disorders are more likely to engage in high-risk behavior such as sharing injection-drug equipment or having unprotected sex, thereby increasing the risk of acquiring HIV. Among PLWH, substance use can negatively impact adherence to HIV treatment regimens and hasten disease progression.[7] Studies have shown substance use to impact HIV viral suppression and decrease CD4 counts.[8] The HRSA HIV/AIDS Bureau (**HAB**) states that PWID are especially susceptible to re-infection with multiple strains of HIV and to other blood-borne diseases such as Hepatitis C.

2018 surveillance data from TDSHS indicate that 3,448 (12%) HIV cases in the EMA were related to injection drug use. Houston EMA's 2020 NA found that approximately 37% of respondents indicated some type of recent alcohol or drug use with nearly a third (30%) reporting usage that interfered with accessing HIV medical care. This compares to an estimate of 6% with substance use disorders in the general population (SAMHSA *National Surveys on Drug Use and Health 2018*). The EMA's 2019 chart reviews reported that almost 100% of primary care clients were screened for substance use.

A.4.e) Homelessness/unstably housed

Homelessness adds significant complexities to medical care for individuals living with HIV disease. PLWH experiencing homelessness have more difficulty with medication adherence and the monitoring needed for effective treatment. The conditions and environment of homelessness

may also lead to behaviors that increase the risk of contracting HIV. They are disproportionately affected by such conditions as substance use, mental illness and infections that greatly impact the cost and complexity of providing care, according to the National Coalition for the Homeless. In addition to having higher rates of chronic diseases, persons experiencing homelessness are subject to exposure to extreme weather, nutritional deficiencies and being victimized by violence (National Coalition for the Homeless, 2007).

In the Houston EMA's *2017-2018 Out of Care Special Study* mentioned previously, participants reported that support services are often used as survival resources, rather than with the intent of accessing and staying in care. For example, participants experiencing homelessness described the resource cycle where consumers accessed care to receive support services for multiple years, but rarely returned for follow-up appointments and did not adhere to medications; as a result, they experienced decreasing health and quality of life issues. Needs Assessment results indicated that approximately 11% of PLWH participants were experiencing homelessness at the time of the survey, with homelessness defined as those who slept most often in a shelter, in a car, on the street or a combination of those places. Regardless of housing type, however, 32% of participants indicated that their current housing situation was unstable. By comparison, an estimated 0.06% in the general Houston population are experiencing homelessness (Coalition for the Homeless, 2017).

The Houston EMA's public hospital system, Harris Health System, participated in a multi-year, multi-site project, *SPNS – Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations Initiative,* as a part of RW Part F funding awarded to multiple sites in the U.S. One of the most urgent needs of homeless individuals with HIV found in the project was for emergency or "respite" housing. For example, after patients are discharged from hospitals, there is essentially no place to house them, especially if they have any history of a sexual offense or lack of proper documentation. This constricted housing access means sending these PLWH back to the streets while they are very ill, continuing the cycle of homelessness and related health complexities. When the project concluded in August 2017, the EMA increased allocations to Medical Case Management services at Harris Health System to support continuation of the crucial service delivery model developed during the project.

A.4.f) Former incarceration in the Texas Department of Criminal Justice (TDCJ)

According to the CDC, in 2010, the rate of inmates living with HIV in state and federal prisons was more than five times greater than the rate among the general population. Most inmates acquire HIV in their communities before incarceration, where they may engage in high-risk behaviors or are unaware of available prevention and treatment resources. In 2010, 91% of inmates with HIV disease were male with 19% living with advanced HIV diagnosis. Additional complexities are highlighted by stark racial differences in the prison population: African American men are five times more likely than White men and twice as likely as Hispanic/Latino men to be diagnosed with HIV. African American women are more than twice as likely to be diagnosed compared to White or Hispanic women.[9] 2019 HIV prevalence data provided by TDSHS show that among the TDCJ population, 50% are African American, while 20% are White and 26% are Hispanic/Latinx. Thirty percent of inmates reported identified as PWID while 39% identify as MSM. Surveillance and care data also show that among TDCJ inmates living with HIV in 2019, only 38% achieved viral suppression by the end of the year, compared to 59% achieving viral suppression among the general population in Houston.

Based on TDSHS estimates, the Houston/Harris County area continually receives the highest number of released prisoners living with HIV in Texas. The legal county of residence for inmates at intake is typically where an ex-convict will return post-release. TDCJ released an estimated 2,526 prisoners with HIV disease from 2016 to 2018, among which approximately 693 (27%) reported Harris County as their legal county of residence. *Note that Harris County's proportion of released inmates is 27% compared to a combined proportion of 32% for all other EMA/TGA counties in Texas* (Dallas 18%, San Antonio 6%, Fort Worth 5%, Austin 3%), showing that more TDCJ discharges are returning to the Houston/Harris County area than any other area in Texas. The 2020 NA showed that among surveyed PLWH in the EMA, an estimated 12% reported being recently incarcerated, in comparison to less than 0.2% incarcerated in the Harris County general population (*Harris County Adult Criminal Justice Data Sheet* 2014). These individuals, upon release, will likely become RW-eligible clients who will require services in the EMA on a continuing basis.

- **A.5) Complexities of Providing Care**

A.5.a) Impact and response to reduction in RWHAP formula funding

i) Impact – Beginning in FY08, the Houston EMA's formula award was impacted by "hold harmless" provisions. Based on data from the Government Accounting Office, Hold Harmless provisions in the Ryan White Program have had a negative impact on the Houston EMA. **For example, in FY13 alone, the EMA's formula funding decreased by $702,250 (-5.4%).** In the absence of RW Program authorization, however, the Houston EMA has not been affected by the "hold harmless" agreement since FY14. Due to this and other factors, with the exception of FY17, the Houston EMA has seen increases in its total Part A funds in subsequent grant awards, from FY14 to FY20 and no decrease in formula funding. However, this comparative increase has not counteracted the effects of years of relatively "level" funding when coupled with increasing numbers of living HIV/AIDS cases.

The following **Table 3** illustrates the impact of the decline in RW/A Formula funds per living case for the EMA. From FY08 to FY19, the EMA saw an increase of 12,062 in diagnosed HIV/AIDS cases and an increase of 5,614 in net unduplicated clients served by RW/A and MAI-funded services during this period. **The total funding per living HIV/AIDS case has decreased by 25% over that same time period.**

To compound this relative decrease in funding per living case over time, in FY21, the Houston EMA experienced an $189,805 decrease in overall funding compared to FY20. The decrease led to a reduction of $125K in Primary Medical Care; over $22K in patient medication access services, including Emergency Financial Assistance and Local Pharmaceutical Assistance; over $18K in Case Management service; and over $20K in Health Insurance Assistance, Oral Health Care, and other support services.

Table 3. **Impact of the Decline in RW/A Formula Funds per Living Case**

Grant Year	Formula Funding	Supp. Funding	MAI Funding	Total Funds	Change from Previous	Total Living Cases	Funding per Living Case	Total Clients Served By RW	Change
FY 08	12,780,890	5,647,525	1,666,021	20,094,436	621,637	18,136	$1,108	8,687	241
FY 09	12,781,667	5,769,956	1,668,253	20,219,876	125,440	19,076	$1,060	9,459	772
FY 10	13,003,056	5,519,546	1,525,669	20,048,271	-171,605	19,959	$1,004	9,983	524
FY 11	13,007,374	5,015,324	1,717,806	19,750,504	-297,767	20,875	$ 946	10,180	197
FY 12	13,003,056	5,015,324	1,773,377	19,989,206	238,702	21,644	$ 924	10,128	-52
FY 13	12,300,806	5,687,127	1,762,110	19,750,043	-239,163	22,830	$ 777	10,593	465
FY 14	13,116,972	6,503,414	1,930,538	21,550,924	1,800,881	23,914	$ 901	11,649	1,056
FY 15	13,606,509	6,888,741	2,011,206	22,506,457	955,533	24,979	$ 901	11,966	317
FY 16	13,766,704	7,004,747	2,057,949	22,829,400	322,943	26,041	$ 876	12,527	561
FY 17	14,088,300	6,567,876	2,117,885	22,774,061	-57,355	27,023	$ 843	13,636	1,109
FY 18	14,342,204	7,056,740	2,166,944	23,565,888	789,810	28,225	$ 835	14,576	940
FY 19	14,660,815	7,404,298	2,207,383	24,272,496	706,608	30,198	$ 804	14,676	100
FY 20	14,926,259	7,382,752	2,322,959	24,631,970	357,455	*	*	14,301	-375
FY 21	15,101,128	7,070,688	2,270,349	24,442,165	-189,805	*ongoing*	*ongoing*	*ongoing*	*ongoing*
Total Change from FY 2008					4,347,729	12,062*			5,614

Prior to FY 2007, MAI funds were included in an EMA's Formula award. Total cases are those reported in the epidemiology table of each respective grant year's application (HIV/AIDS Demographic Data).
**2020 Texas Department of State Health Services surveillance data delayed as of August 2021*

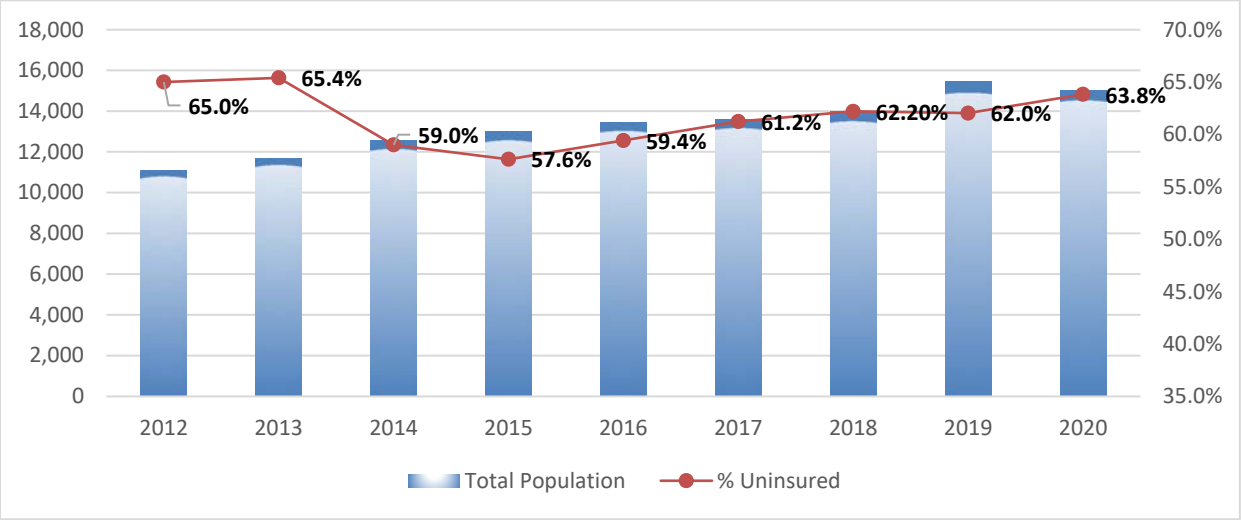
ii) Response – As documented in ***Attachment 9***, the overall response of Houston's Ryan White Planning Council (**RWPC**) over the period of FY21 through FY22 is to continue its focus on ensuring access to Primary Medical Care and other key Core Medical Services including Oral Health Care, Medical Case Management, medications and leveraging additional Health Insurance opportunities under the Affordable Care Act (**ACA**). Generally, funding for Support Services is allocated to only those services which have positive outcomes in ensuring access to health services, including non-Medical Case Management and Medical Transportation. However, EMA demographics and clinical performance measures point to a severe need to strengthen patient retention to care. The EMA's *2017-2018 Out of Care Special Study* found that some PLWH consider Support Services to be "survival resources" rather than support for treatment adherence. For example, homelessness PLWH accessed care to receive support services for multiple years, but rarely returned for follow-up appointments and did not adhere to medications, resulting in decreased health and quality of life issues. The RWPC is aggressively seeking innovative approaches to improve health outcomes, and as a result, also prioritizes support services that help promote retention: outreach, emergency financial assistance and referral to health care and support services. Even with these new additions, in FY21, over 80% of total service funds are allocated to Core Medical Services.

A.5.b) Description of health care coverage options available to PLWH in the Houston EMA
During the most recent Health Insurance Marketplace open enrollment period, the Houston EMA had 24 silver-level Marketplace plans available in the area, provided by six insurance carriers. The Houston EMA's marketplace coverage consists primary of smaller regional insurance carriers. In recent years, Blue Cross Blue Shield has been the EMA's only national insurance carrier.

i) How coverage options influence access to direct health care services and outcomes
Predictably, regional insurance carriers with smaller provider networks are less attractive options for clients for a variety of reasons. Consequently, in recent years as the Houston EMA has been

supported by one large national insurer, the rates of uninsured PLWH have increased. Fortunately, because Blue Cross Blue Shield (**BCBS**) has been the most utilized carrier since Marketplace availability began in Texas, BCBS has been a popular plan for both patients and RW/A primary care providers. Many individuals who have maintained Marketplace insurance plans with BCBS have been able to sustain consistent coverage. These clients have not been forced to change insurance provider as insurance carriers have left the marketplace over recent years. The six insurance carriers offering plans in the EMA are centralized in the largest and most urban county, Harris County. This year, all counties in the EMA have multiple carrier options, including BCBS, Ambetter and Community Health Choice, which all offer silver-level Marketplace plans in every county of the EMA. As indicated throughout the application, four of the RW/A-funded community-based adult primary care providers are Federally Qualified Health Centers (**FQHC**) that accept a wide variety of third-party payments, including private insurance. Additionally, all RW/A primary care providers were able to accept one or more of the Marketplace plans provided in the EMA. In the continued absence of Medicaid expansion in Texas, Marketplace plan enrollment remains the primary mechanism by which low income PLWH have an opportunity to gain health care access outside of the RW-funded services. However, as illustrated below, the EMA has experienced recent increases since FY15 in the percentage of clients who are uninsured.

Figure 3. **Uninsured Clients in the Houston EMA, 2012 – 2020**



Data Source: Centralized Patient Care Data Management System (**CPCDMS**), data from 2012 to 2020

Although there have been recent challenges with plan availability, coverage, and cost; unsurprisingly, patients with the benefit of greater access to preventive medical services, substance abuse treatment services, a wider range of specialist medical providers and greater personal choice that is afforded through health insurance coverage do fare better when examining health outcomes. Overall, patients receiving primary care funded through RW/A primary care services have a viral suppression rate of 79%. RW/A patients who receive assistance through the Health Insurance Premium and Cost Sharing Assistance service category for third-party payer coverage have a viral suppression rate of 81% in FY19. The challenges of 2020 resulted in an atypical and decrease to 74% for PLWH served by Health Insurance Premium and Cost Sharing Assistance. However, ensuring that clients are provided with information regarding health insurance options remains a priority for the EMA.

At the federal level, annual enrollment into Marketplace insurance plans received renewed emphasis in 2021 as result of the change in the presidential administration and in response to the COVID-19 pandemic. The Houston EMA has allocated $300K in FY20 carryover funds to the Health Insurance Assistance service category to support increased capacity needed as a result of the extended Marketplace enrollment period that was available to PLWH during the first half of 2021. To encourage consumer enrollment into Marketplace plans, and in accordance with Policy Clarification Notices 13-03 and 13-04, and RW payer of last resort mandates, the EMA maintains policies related to outreach during Marketplace plan annual enrollment, wherein eligible uninsured individuals with incomes between 100% and 400% FPL may purchase Qualified Health Plans through (in the case of Texas) a federally operated insurance marketplace offering competitive pricing and leveraging subsidies, while they remain available, to provide affordable high-quality health insurance.

The EMA continues to maintain positive enrollment outcomes. Over 1,000 current RW clients are enrolled in Marketplace plans. However, outreach to PLWH who are not receiving services within the RW system of care is an ongoing challenge in all aspects of the program. Additionally, ensuring PLWH with private or third-party insurance are educated on how to use and/or maintain insurance coverage is also a challenge. Although it is difficult to quantify the number of PLWH who lose coverage throughout the year, the EMA has made efforts to reach out to recently insured PLWH to identify challenges in maintaining health insurance coverage. In the 8+ years that private health insurance has been available to low-income residents through the Marketplace, PLWH report successful transitions from RW-funded care to private coverage.

A.5.c) Factors that limit access to health care

Although hundreds of PLWH have successfully transitioned from Ryan White as a primary payer for healthcare to private insurance, feedback from consumers has spotlighted confusion with the changing landscape of the Houston EMA's HIV system of care. As indicated throughout this application, four of the RW/A community-based organization (**CBO**) adult primary care providers are FQHC. This is a substantial change from several years ago when all of the adult primary care providers were traditional AIDS service organizations. Today, clients routinely interact with clinic support staff and other patients who are not familiar with the RW Program. The clinics now offer clinical services that are not funded by RW, and newly insured clients utilized RW insurance co-pay assistance to access additional clinical services. However, many are confused by how aspects of the RW Program, such as *Standards of Care* and the client grievance process, interface with these new services. Additionally, findings from the most recent *2020 Houston HIV Care Services Needs Assessment* (**NA**) indicates more transgender, homeless, MSM, and rural PLWH found Health Insurance Assistance services difficult to access when compared to all participants. To address education and awareness issues, the RWPC conducted community education outreach to educate consumers on how the HIV care system works in the EMA, how to navigate within the system, and how to effectively communicate and advocate for their service needs. Consumer education opportunities have been offered in a variety of venues and audiences, to increase consumer accessibility. Topics covered include identifying services in the community; where they are located; how to access them; the different types of payment (RW, Medicaid, Medicare, private insurance, etc.); how to better communicate, negotiate, and advocate within the care system; how to get assistance with the Health Insurance Marketplace (who is eligible, how does one enroll, who is available to help a consumer enroll); the RW Health Insurance Assistance Program; the tax implications of the ACA, where to obtain free help filing taxes, and more. In recent years, these

events have been hosted at RW-funded primary care clinics in English and Spanish where on-site service linkage are offered at the events. Continuation of this outreach has evolved in 2020 and 2021 as a result of the COVID-19 pandemic response. Consumer education has taken place virtually during RWPC and subcommittee meetings and supplemental community consumer trainings such as Project LEAP and the RWPC Youth Council.

All Insurance Coverage

%FPL	Total	%	Insured	%	Uninsured	%
0-100	9,471	63.0%	2,542	46.7%	6,929	72.2%
101-400	5,454	36.3%	2,824	51.9%	2,630	27.4%
>400	113	0.8%	74	1.4%	39	0.4%
Total	15,038	100.0%	5,440	36.2%	9,598	63.8%

Marketplace Coverage

%FPL	Total	%	Marketplace	%
0-100	9,471	63.0%	229	21.8%
101-400	5,454	36.3%	811	77.1%
>400	113	0.8%	12	1.1%
Total	15,038	100.0%	1052	7.0%

Data Source: CPCDMS, 2020 data

Unlike those RW Part A jurisdictions that have benefited from Medicaid expansion, the tables above illustrate that the vast majority of PLWH in the Houston EMA are below 100% FPL and must rely on RW-funded programs as their sole source of primary medical care. As a result, the Houston RWPC continues to focus resources on key Core Medical Services including Oral Health Care, Medical Case Management, and Primary Medical Care, with the latter accounting for over 50% of the total client services allocations for FY21.

B. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)

- **B.1) Planned EMA EIIHA activities for FY 2022 to 2025**

B.1.a) Primary activities undertaken, including system level interventions

Activities to identify and inform individuals living with HIV are intended to increase the proportions of PLWH engaged in the Houston EMA HIV Care Continuum (**HCC**) who are aware of their status (HIV-diagnosed), while activities to refer and link PLWH to HIV medical care and support services are intended to increase the proportion of diagnosed PLWH on the HCC who are in medical care (linked to HIV care). The EMA's FY22 *EIIHA Plan* will implement multiple individual and system-level interventions designed to decrease stigma and increase access to HIV testing and awareness among status-unaware PLWH and the general Houston area population.

1. Health communication strategies that change stigma and community perceptions of HIV testing and awareness: The FY22 *EIIHA Plan* includes community-level health communication interventions that incorporate HIV testing and awareness as normative behaviors, particularly in populations with high HIV prevalence and diagnosis rates. These interventions include Health

Education/Risk Reduction activities such as group-level Effective Behavioral Interventions; branded social marketing campaigns such as "Greater than AIDS", "Take Charge, Take the Test", "Testing Makes Us Stronger", "Let's Stop HIV Together", and "Doing It" situated in high morbidity zip codes within the EMA; Health Communication/Public Information outreach such as radio, online, and print promotion of the "Somos Familia" campaign; and intensive media and social media outreach for "I Am Life" (Houston Health Department's funded media campaign that uses local community ambassadors to help promote treatment as prevention, PrEP uptake and HIV testing among African American, Hispanic/Latinx, and transgender individuals). In addition to direct activities, the Houston Health Department (**HHD**) funds community partners to operate comprehensive HIV Education/Risk Reduction programs targeted to populations and settings with particular need of stigma reduction and HIV awareness and testing, such as public schools within high morbidity zip codes. Responsible parties for the *2017 Comprehensive Plan* will implement the following health communication activities in FY22:

- Exploring opportunities for cross-representation between the Houston HIV community and School Health Advisory Councils for all school districts within the Houston area;
- Educating Houston area faith community leadership on HIV information, risk reduction, and prevention tools;
- Holding consumer PrEP and treatment as prevention education forums;
- Training PrEP providers and prevention workers on best practices for educating and promoting PrEP among special populations;
- Identifying local media resources to serve as outlets for HIV education and community mobilization efforts; and
- Exploring transportation-based (e.g. ride sharing, public transportation) advertisements of PrEP and other HIV prevention and care messaging.

2. Routine HIV testing in clinical settings: Large-scale routine opt-out HIV testing will be provided in the EMA in FY22 through the CDC-funded Expanded Testing Initiative (**ETI**), a fully integrated strategy under HHD's core CDC HIV prevention grant. Fourth generation testing is used at routine testing sites. ETI currently supports routine testing at several clinical sites across two major healthcare systems throughout the EMA, including three emergency rooms, 15 community health centers, and 8 homeless service facilities. In 2019, 94,311 publicly funded HIV tests were provided in routine/opt-out settings in the EMA, with 1.1% overall positivity or 1,049 new and previously diagnosed individuals identified.[10] The following *2017 Comprehensive Plan* activities to support the expansion of routine HIV testing in the Houston area will be implemented in FY22:

- Disseminating routine testing implementation toolkits as needed to targeted private and non-Ryan White funded providers and FQHC to facilitate linkage to care;
- Expanding the distribution of HIV testing and PrEP information and resources to healthcare providers; and
- Educating providers serving special populations about routine HIV testing and PrEP and promoting inclusion of routine HIV testing and PrEP education in policies, procedures, and practices to facilitate linkage to care.

3. Targeted HIV testing in non-clinical settings: In response to testing and awareness needs among Houston populations at highest risk, the EMA's FY22 *EIIHA Plan* focuses targeted Counseling, Testing and Referral (**CTR**) services in a variety of non-traditional settings serving high-incidence populations. CTR services occur in Harris County Jail, Harris County Juvenile

Detention, Harris County Family Planning clinics, Healthcare for the Homeless Houston clinics and events, CBOs, and other sites in high-morbidity zip codes. Due to COVID-19 restrictions, the HHD's full-service Mobile STD Clinic was not able to attend neighborhood health fairs, outreach events, community-screening events, and HIV awareness day events in 2020 or 2021. However, with COVID-19 cases declining and the application of COVID-19 safety precautions, the HHD's Mobile STD Clinic is expected to start operations in the near future. Per the *2017 Comprehensive Plan*, HHD's community liaison will continue to educate HIV-related Task Forces, HHD-funded contractors, and other agencies on availability of the Mobile STD Clinic to increase community access to targeted testing in non-clinical settings. In 2019, prevention providers conducted 6,068 publicly funded targeted HIV tests in the EMA, with overall 2.9% positivity or 179 new and previously diagnosed individuals identified.[10]

Until 2015, prevention providers dedicated substantial resources for targeted HIV testing to an annual mass testing event called *Houston HITS* (Health Intervention and Testing Solutions) *Home*. *Houston HITS Home* is still implemented on a small scale in observance of National HIV Testing Day, and efforts to focus targeted testing throughout the year to various populations and high-morbidity areas have expanded the reach of HHD's HIV testing activities to more status unaware individuals, including those who have no history of HIV testing. In 2019, HHD and community partners held targeted HIV testing events in non-clinical settings, which included mobile testing for National Transgender HIV Testing Day, National Black HIV/AIDS Awareness Day, National Women and Girls HIV Awareness Day, Houston Splash, Houston Pride, Heavy Hitters Pride, Fiestas Patrias, National Gay Men's HIV/AIDS Awareness Day, National Latino AIDS Awareness Day, and at local churches, barbershops, boutiques, and other small businesses in high morbidity zip codes.

4. *Result notification and disease investigation: Contract protocol for targeted testing/CTR providers requires result notification for both positive and negative test events. Individuals with a positive test event at CTR and non-targeted/ETI sites must be notified within seven days, or the prevention provider must make a referral to the local health jurisdiction for result notification and follow-up. Per state law, providers must report all laboratory evidence of HIV directly to the local health jurisdiction for follow-up by a Disease Intervention Specialist (**DIS**). In Houston/Harris County, program performance standards further require that contact with all new cases be attempted within 24 hours of receipt of a test result, a field visit occur within 48 hours, and 85% of new cases interviewed within seven days. In 2019, providers and DIS ensured 85.2% of newly diagnosed individuals who received CDC/HHD-funded targeted testing were aware of their positive status. Adherence to these contract protocols and performance standards for result notification will continue in FY22.

5. *Partner counseling and referral: Identification and notification of partners as a routine component of disease investigation in the EMA for all newly diagnosed PLWH will continue in FY22. Partner services for sex and injection equipment-sharing partners of newly diagnosed PWLH include identification and location of partners, notification of potential exposure, offer of HIV testing, and if testing is accepted, notification of their HIV status by a DIS staff member. In Houston/Harris County, DIS staff work with specific RW-funded providers and HHD contractor to provide CTR services to partners of both newly diagnosed and previously diagnosed PLWH. In 2019, 85.2% of all PLWH newly diagnosed through HIV testing received partner services.

Responsible parties for the *2017 Comprehensive Plan* will implement the following activities to supplement traditional partner services in FY22:

- Coordinating transportation with housing sites to extend the *Road to Success* consumer HIV service navigation training program to housing clients;
- Holding consumer education forums about PrEP and treatment as prevention; and
- Exploring transportation-based advertisements of PrEP and other HIV prevention and care messaging.

6. Mass distribution of the EMA resource inventory, the "Blue Book": Ryan White Planning Council (**RWPC**) support staff compile a comprehensive resource inventory of HIV prevention, testing, care, treatment, and support services available in the Houston EMA and four additional adjacent counties served by RW Part B, which is bound and printed as the *Blue Book* resource guide. The *Blue Book* is disseminated broadly throughout the area to individuals and providers for use in making referrals to services, as well as self-navigation through the HIV prevention and care system. RWPC support staff, providers, and community members also use the *Blue Book* to refer undiagnosed individuals to prevention and testing services. The *Blue Book* contains information about RW/A-funded and other primary medical care and case management agencies, including agency hours of operation, bus routes, a map, and availability of Spanish-speaking staff. More than 150 agencies are included in the current *Blue Book*, which provides addresses, contact information, descriptions of services provided, documentation needed to access services, and special accessibility considerations for each agency, such as whether services are free, offered in Spanish, accessible for consumers with disabilities, or tailored to serve special populations. The most recent version of the *Blue Book* is the 2021-2022 edition, which was developed and printed in February 2021. One feature in the 2021-2022 edition of the *Blue Book* is an entire section dedicated to PrEP, including a description of PrEP, listing of 26 local providers and clinics that offer PrEP, and financial resources for obtaining PrEP medication. The RWPC support office distributes approximately 25,000 printed copies of the *Blue Book* each year. Staff have also made the *Blue Book* available online on the RWPC website. In FY22, RWPC Support Office staff will redevelop a smartphone application to link to the *Blue Book* and finalize a new edition to reflect new providers and system changes.

7. Point of Entry agreements: RW-funded HIV primary care providers are required to maintain formal "Point of Entry" (**POE**) agreements with a minimum of five community locations where individuals are notified of their positive HIV status, including public STD clinics, incarceration or detention facilities, governmental entities, CBOs, community health centers, and FQHC. POE agreements define the minimum number of PLWH to be formally referred by each entity to that primary care provider each year. The POE requirement will remain in FY22 as part of the *EIIHA Plan*.

8. Non-medical case management (Service Linkage): The foundation of the EMA's system-wide strategy to link newly diagnosed PLWH to HIV medical care is the locally defined version of non-Medical Case Management, or Service Linkage/Service Linkage Worker (**SLW**). The function of Service Linkage is to provide intensive care coordination with newly diagnosed PLWH to link them to HIV medical care within three months of diagnosis or less. Per the *2017 Comprehensive Plan*, in FY22, HHD, Ryan White Grant Administration (**RWGA**), and the RWPC will continue strategies to reduce the time between diagnosis and entry into HIV medical care to facilitate timely linkage to care, in alignment with the *HIV National Strategic Plan 2025* one-

month linkage window. Due to system-wide success of the SLW model in the EMA, linkage to HIV medical care will continue in FY22 as part of the *EIIHA Plan* targeting the following populations and locations:

- Newly diagnosed youth aged 13-24 with a focus on out-of-care and at-risk youth;
- Newly diagnosed PLWH informed at HIV testing sites, including routine HIV testing locations in clinical settings;
- Newly diagnosed PLWH informed at public STD clinics;
- Newly diagnosed PLWH informed at RW-funded HIV primary care providers; and
- Service Linkage targeted to PLWH in outpatient substance use treatment.

The RWPC has approved bundling of Service Linkage with HIV Primary Care, Medical Case Management (**MCM**), Local Pharmaceutical Assistance Program, Emergency Financial Assistance – Medication Assistance, Emergency Financial Assistance – Other, and Outreach Services (Primary Care Re-Engagement) in FY22 to support single-stop, seamless engagement along the HCC. Responsible parties for the *2017 Comprehensive Plan* will implement the following activities for effective referral to support services in FY22:

- Coordinating transportation with housing sites to extend the Road to Success consumer HIV service navigation training program to housing clients;
- Disseminating routine testing implementation toolkits to targeted private and non-Ryan White funded providers and FQHC to facilitate linkage to care;
- Educating providers serving special populations about routine HIV testing and PrEP, promoting inclusion of routine HIV testing and PrEP education in policies, procedures, and practices to facilitate linkage to care; and
- Exploring opportunities to collaborate with community health workers to support timely linkage to care.

9. *Medical case management (MCM): While non-medical case managers assist newly diagnosed clients to initially access care services, medical case managers provide care coordination for clients with multiple complex psychosocial and/or health-related needs to support linkage and retention to care. Medical Case Managers assist newly diagnosed clients by addressing housing, financial, transportation, mental health and substance use, and other high priority needs that can negatively impact initial engagement into medical care and treatment. Though MCM may serve any HIV-diagnosed population in the EMA, MCM targets specific populations and locations with highest need, including the EMA's public hospital system (Harris Health System), rural counties, newly diagnosed African Americans, Hispanic/Latinx individuals, children, veterans, women, and youth.

10. *Verification of confirmed entry into HIV medical care: The final primary activities for the EMA's FY22 *EIIHA Plan* is continued verification of entry into HIV medical care following referral and linkage, which occurs at the provider, data management, and system levels:

- All RW-funded Core Medical Service providers are required to maintain a process for documenting client attendance at scheduled visits or sessions.
- An electronic interface between the EMA's data system, CPCDMS, and the local HIV prevention data management system provides electronic verification of the first HIV medical care visit with a RW provider following referral by a SLW in the public STD clinic setting.
- RWGA quality management staff monitor and evaluate RW-funded SLW and MCM providers according to RWPC-reviewed performance measures. These performance measures serve as

quantifiable verification that newly aware PLWH referred by a SLW or MCM accessed HIV medical care and outline the proportions of PLWH expected to access HIV primary care within set timeframes following receipt of SLW or MCM services. In FY20, 49% of all PLWH who received SLW, 50% of those who received MCM, and 56% of those received Clinical Case Management subsequently accessed HIV primary care at least twice with appointments being three months or more apart, an indicator of retention in HIV care on the HCC.[11]

B.1.b) Major collaborations with other programs and agencies

The RWPC and RWGA will maintain the same collaborative relationships established in prior fiscal years to implement the FY22 *EIIHA Plan* in the Houston EMA. These include collaboration among planning bodies; with HIV prevention, surveillance, and disease control program; among all RW Parts and RW-funded service providers and some non-RW care providers; and collaboration with regard to data collection and sharing. Below are examples of specific programs/agencies that have participated in the EMA's *EIIHA Plan* since initial implementation:

* AIDS Foundation Houston (HIV prevention contractor)
* AIDS Healthcare Foundation (RW-funded provider, FQHC, and HIV prevention contractor)
* African American State of Emergency HIV Task Force (**SOE**)
* Avenue 360 Health and Wellness (RW-funded provider, FQHC, and HIV prevention contractor)
* Baylor College of Medicine
* Community Planning Group (**CPG**)
* End New Diagnoses (**END**) HIV Houston Coalition
* Harris Health System (RW-funded provider and HIV prevention contractor, RW/C and D recipient)
* HOPWA, including HOPWA-funded agencies and facility residents
* Houston Health Department (CDC prevention recipient and local health jurisdiction), including HIV surveillance staff in the Bureau of Epidemiology
* Legacy Community Health (RW-funded provider, FQHC, and HIV prevention contractor)
* M-pact Houston (MSM HIV Task Force)
* Ryan White Grant Administration (Administrative Agency for RW/A and MAI)
* Ryan White Planning Council
* St. Hope Foundation (RW-funded provider, FQHC, and HIV prevention contractor)
* Serving the Incarcerated and Recently Released Partnership of Houston (**SIRR**)
* Texas Department of State Health Services
* The Resource Group (Administrative Agency for RW/B and State Services and recipient of RW/C/D)
* Latino HIV Task Force
* Youth HIV Task Force

Partners in TDSHS provide most of the epidemiological information included in the *EIIHA Plan*, as well as for HIV testing and awareness data for state-funded tests. The Houston Health Department (**HHD**), the CDC prevention recipient and local health jurisdiction, provides oversight for prevention contractors; coordinates targeted, mass, and routine testing for Houston/Harris County; provides data on CDC-funded HIV testing and awareness; and works to mobilize the greater Houston community around HIV-related issues. As administrative agencies, the RWGA (RW/A and MAI) and The Resource Group (RW/B and State HIV Services funding) provide oversight for RW-funded providers, provide additional epidemiological, utilization, and expenditure data, and manage contracts necessary to accomplish *EIIHA Plan* outcomes. RWPC and the CPG, the Houston EMA prevention and care services community, EIIHA Workgroup, and planning bodies, review epidemiological data to establish the target populations for the *EIIHA Plan*. HIV prevention contractors and RW-funded providers such as AIDS Healthcare Foundation, Avenue 360, Legacy Community Health, Harris Health System, and St. Hope Foundation provide HIV prevention and care services in the Houston EMA to meet outcomes and improve engagement along the HCC. Harris Health system, as a direct recipient of RW/C and D, focuses its efforts

within Harris County to enhance the HIV system of care. Local Task Forces and coalitions such as African American State of Emergency Task Force, Latino HIV Task Force, M-pact Houston, SIRR, Youth HIV Task Force, and END HIV Houston work in the local Houston community to support engagement at all stages of the HCC, from providing community education and holding testing events in commemoration of HIV awareness days, to promoting ART use and viral suppression through sharing personal experiences as people living with of affected by HIV. The *2017 Comprehensive Plan* Coordination of Effort strategy details additional sectors to target annually for coordination and partnership, including:

a. Advocacy groups
b. Aging (e.g., assisted living, home health care, hospice, etc.)
c. Alcohol and drug abuse providers and coalitions at the local and regional levels
d. Business and Chambers of Commerce
e. Community centers
f. Chronic disease prevention, screening, and self-management programs
g. Faith communities
h. Medical professional associations, medical societies, and practice groups
i. Mental health (e.g., counseling associations, treatment facilities, etc.)
j. New HIV-related providers such as FQHC and Medicaid Managed Care Organizations
k. Philanthropic organizations
l. Primary education, including schools and school districts
m. Secondary education, including researchers, instructors, and student groups
n. Workforce Solutions and other vocational training and rehabilitation programs

Finally, RWGA has partnered extensively with HHD to support Ending the HIV Epidemic (**EHE**). HHD is the CDC recipient for EHE funding to lead community planning activities in Harris county. Building on the success of the established Integrated Comprehensive Plan partnerships, RWGA has collaborated with HHD in the development of the EHE Community Planning structure. The EHE Community Planning framework consists of five workgroup focus areas: Outreach & Community Engagement; Status Neutral Systems; Research, Data & Evaluation; Policy & Social Determinants; and Education & Awareness. These committees are comprised of community leaders, health care advocates, PLWH and HD staff.

B.1.c) Anticipated outcomes of the EMA's overall EIIHA strategy

Anticipated outcomes of the FY22 *EIIHA Plan* are designed to contribute to the goals of the HIV National Strategic Plan updated to 2025, improve health outcomes along the HIV Care Continuum (**HCC**), and align with objectives and benchmarks from the Houston *2017 Comprehensive Plan*. The following table displays the anticipated outcomes of the *EIIHA Plan* and aligns them with the four required EIIHA components.

<table>
<tr><th colspan="3">FY22 EIIHA Plan Outcomes for the Houston EMA</th></tr>
<tr><td colspan="3"><u>Outcome 1</u>: Increase the proportion of PLWH in the EMA who are diagnosed from 86%[a] to 95%[b] by the end of 2025, in response to <u>Component 1</u>: Identification of individuals unaware of their HIV status
[a]Undiagnosed estimate shows 86% of people living with HIV in the EMA are diagnosed (2019)
[b]The HIV National Strategic Plan (HNSP) 2025 Indicator 1 sets the national goal for serostatus awareness to at least 95% of PLWH</td></tr>
<tr><th>Alignment to HNSP 2025 Goals</th><th>Alignment HCC Health Outcomes</th><th>Alignment to Comprehensive Plan</th></tr>
<tr><td><u>Goal 1.1:</u> Increase awareness of HIV.
<u>Goal 1.2:</u> Increase knowledge of HIV status.
<u>Goal 3.2:</u> Reduce disparities in new HIV diagnoses, in knowledge of status, and along the care continuum.</td><td>Increases the proportion of individuals who are diagnosed, decreases the number of unaware HIV infected individuals, and increases the number of PLWH able to engage in the HCC.</td><td>Objective 1: Decrease the number of new HIV infections diagnosed in the Houston Area by ≥25% by 2022.
Objective 2: Maintain or increase the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their status to ≥93.8% by 2022.
Special Populations Strategy Benchmark 1: Decrease the number of new HIV transmissions among diagnosed youth (13-24), homeless, incarcerated, PWID, MSM, transgender and gender non-conforming, women of color, and aging (50 and over) by ≥25% by 2022.</td></tr>
<tr><td colspan="3"><u>Outcome 2</u>: Increase the proportion of newly diagnosed PLWH who receive publicly funded targeted testing in the Houston EMA who are informed of their HIV positive status to at least 95%[a,b] in response to <u>Component 2</u>: Informing individuals that tested positive of their HIV diagnosis
[a]HIV testing and awareness data for the EMA show 97% of newly diagnosed PLWH diagnosed via publicly funded targeted HIV testing were informed of their status in 2015 when baseline was established. This proportion was 85% in 2019
[b]HNSP 2025 Indicator 1 sets the national goal for serostatus awareness to at least 95% of PLWH
Note: Status notification for newly diagnosed receiving routine/opt-out testing was 100% in 2015.</td></tr>
<tr><th>Alignment to HNSP 2025 Goals</th><th>Alignment HCC Health Outcomes</th><th>Alignment to Comprehensive Plan</th></tr>
<tr><td><u>Goal 1.1:</u> Increase awareness of HIV.
<u>Goal 1.2:</u> Increase knowledge of HIV status.
<u>Goal 3.1:</u> Reduce HIV-related stigma and discrimination.
<u>Goal 3.2:</u> Reduce disparities in new HIV diagnoses, in knowledge of status, and along the care continuum.</td><td>Increases the proportion of individuals diagnosed through publicly funded HIV tests and informed of their status, decreases the number of unaware HIV-infected individuals, and increases the number of PLWH able to engage in the HCC.</td><td>Objective 2: Maintain or increase the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their status to ≥93.8% by 2022.
Prevention & Early Identification Strategy Benchmark 5: Maintain or increase the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their status to ≥93.8% by 2022.</td></tr>
<tr><td colspan="3"><u>Outcome 3</u>: Increase the proportion of newly diagnosed individuals linked to HIV medical care within 1 month of their HIV diagnosis from 63% [a] to 95% [b] by the end of 2025, in response to <u>Component 3</u>: Referral to care of newly diagnosed individuals and <u>Component 4</u>: Linkage to care of newly diagnosed individuals
[a]Linkage to care data show 63% of newly diagnosed PLWH in the Houston EMA were linked to HIV medical care within 1 month of diagnosis (2019)
[b]HNSP 2025 Indicator 5 sets the national linkage goal for the newly diagnosed to at least 95% within 1 month of their HIV diagnosis</td></tr>
<tr><th>Alignment to HNSP 2025 Goals</th><th>Alignment HCC Health Outcomes</th><th>Alignment to Comprehensive Plan</th></tr>
<tr><td><u>Goal 1.1:</u> Increase awareness of HIV.</td><td>Increases the proportion of newly diagnosed individuals linked to HIV care within 1</td><td>Objective 3: Increase the proportion of newly diagnosed individuals linked to clinical</td></tr>
</table>

Goal 1.2: Increase knowledge of HIV status. **Goal 1.4:** Increase the capacity of health care delivery systems, public health, and the health workforce to prevent and diagnose HIV. **Goal 1.5**: Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment. **Goal 3.1:** Reduce HIV-related stigma and discrimination. **Goal 3.2:** Reduce disparities in new HIV diagnoses, in knowledge of status, and along the care continuum.	month, increases the number of PLWH linked to care and increases likelihood of those individuals being retained in care and achieving viral suppression.	care within one month of their HIV diagnosis to ≥85% by 2022. **Prevention & Early Identification Strategy Benchmark 7:** Increase the proportion of newly diagnosed individuals linked to clinical care within one month of their HIV diagnosis to ≥85% by 2022. **Gaps in Care Strategy Benchmark 2:** Increase the proportion of newly diagnosed individuals linked to clinical care within one month of their HIV diagnosis to ≥85% by 2022. **Special Populations Strategy Benchmark 2:** Increase the proportion of newly diagnosed youth (13-24), homeless, recently released from incarceration, PWID, MSM, transgender and gender non-conforming, women of color, and aging (50 and over) individuals linked to clinical care within one month of their HIV diagnosis to ≥85% by 2022.

- **B.2) Description of planned efforts to remove legal barriers..**

  Routine testing is available in the Houston EMA, though opt-out HIV testing has not been implemented consistently throughout the state of Texas. The 88th Texas Legislative session will begin January 2023. If a state law or regulation should present a barrier to routine testing, the state's first coalition of consumers for HIV advocacy, the *Texans Living with HIV Network*, is organized to adopt the elimination of such policy barriers as a legislative priority for future state legislative sessions. The END HIV Houston Coalition has adopted recommendations to identify clinicians and administrative health professionals to act as champions of routine HIV testing in discussions with Texas lawmakers and to advocate for mandatory opt-out HIV testing legislation. The biggest legal barrier to prevention activities for PWID throughout the state of Texas is that syringe exchange activities are illegal and has been for well over a decade. In its 87th legislative session the Ruth McClendon Act was introduced which would create a syringe exchange pilot program in seven Texas counties (Bexar, Dallas, El Paso, Harris Nueces, Travis, and Webb Counties) but this bill was voted off the Texas House floor. Syringe exchange sites offer a safe space for PWID to obtain the resources they need, such as HIV and HCV testing and linkage to care. In the Houston Area, the *Houston Harm Reduction Alliance* is a local organization that is helping to create, promote and advance policies, programs, and practices for PWID. Annual activities under the *2017 Comprehensive Plan* include educating public officials on changes in governmental policies that create barriers to HIV prevention. Other *2017 Comprehensive Plan* activities slated for FY22 to expand testing implementation of routine HIV include educating providers serving special populations about routine HIV testing and PrEP and promoting inclusion of routine HIV testing and PrEP education in policies, procedures, and practices to facilitate linkage to care.

C. SUBPOPULATIONS OF FOCUS

- **C.1) Three subpopulations with disparities in health outcomes**

The Comprehensive HIV Planning Committee approved the FY22 *EIIHA Plan* subpopulations of focus on behalf of the RWPC on July 19, 2021. The three populations that were selected for the FY22 *EIIHA Plan* are**: 1)** Black/African Americans, **2)** Hispanic/Latinx, and **3)** MSM/PWID.

Black/African Americans

Multiple unique challenges and opportunities are encountered in working with African American (**AA**) communities in the Houston EMA to identify, inform, refer, and link individuals to HIV medical care. De-prioritization of health care (including HIV testing and engagement in HIV primary care) in addition to the context of widespread socioeconomic barriers, historic distrust of medical providers and mainstream medical community, and cultural/community barriers to HIV awareness make testing and linkage challenging. Poverty, structural and institutional racism, unemployment, mass incarceration, unstable housing, and substance use in AA communities within the Houston EMA have created economic and structural barriers to seeking HIV testing and primary care. Competing priorities often reduce the primacy of health care for low-income AA in the Houston EMA in favor of meeting more essential or immediate needs. Data collected for the 2020 NA revealed that substance use was the most common reason that PLWH with a history of unmet need reported for falling out of care. With an EMA area of almost 6,000 square miles, and temperatures that often exceed 100°F in the summer, reliance on public transportation presents a unique challenge to accessing HIV testing and primary care for AA living in the EMA without alternative transportation. Houston/Harris County providers and public health workers continually strive to address distrust of medical professionals. One asset in this process has been the Houston Health Department's Strategic AIDS/HIV Focused Emergency Response (**SAFER**) Initiative, which provides HIV/STD testing and prevention services with the AA communities most affected by HIV through municipal neighborhood Multi-Service Centers or the Mobile STD Clinic. Being a Black individual living with HIV remains very stigmatized in the AA community, as are gay/bisexual AA males. The 2020 NA showed that denial and fear of stigma were the most common reasons newly diagnosed PLWH were not linked to HIV medical care within one month. Consequently, the perception of HIV as a "gay/bisexual" disease may contribute to some heterosexual AA women underestimating their risk and not seeking testing. HIV testing can be perceived as a sign of distrust of sexual partners among all genders and race/ethnic groups.

Hispanics/Latinx

As with other communities of color in the Houston EMA, many Hispanics/Latinx (**HL**) reside in geographically isolated and often lower socioeconomic status neighborhoods, contending with unemployment, crime, incarceration, unstable housing, and substance use. Additionally, HL can face challenges related to residency status, immigration, language barriers, and difficulty accessing documentation necessary for verifying eligibility with greater frequency and severity than White and AA PLWH. The Migration Policy Institute estimates as many as 341,000 undocumented/unauthorized immigrants from Mexico (234,000), El Salvador (49,000), Honduras (28,000), Guatemala (18,000), and South America (12,000) live in Harris County. [12] Undocumented/unauthorized immigrants from these countries make up 83% of all estimated unauthorized immigrants in the county.

The Syracuse University Transactional Records Access Clearinghouse (**TRAC**) Immigration Project estimates that between October 1, 2019 and June 30, 2020, there were 11,103 immigration-related deportation cases that ended in removal or voluntary departure in Houston courts, a 63% increase from FY18.[13] TRAC estimates that 97% of these individuals have been or will be deported to Honduras, Guatemala, El Salvador, Mexico, or Nicaragua. Stakeholders in the Houston HIV community have shared that concerns about the adoption of a "zero-tolerance" prosecution policy for undocumented immigrants, increasing arrests by Immigration and Customs Enforcement, and fears of detention and deportation have increased the difficulty of providing early identification and linkage to care to HL immigrants in the Houston area who are unaware of their positive HIV status, and referral and linkage for those who are undocumented and aware of their positive HIV status. Additionally, community stakeholders have expressed concerns that changes regarding "public charge" policy discourage legal immigrants from using public resources to manage their HIV and prevent new transmissions. While these changes to the policy may no longer be in place, this fear may be "baked in" in for some groups within the HL community. Unique cultural challenges in the local HL community are also a concern for this target population. Traditional gender concepts of *machismo* and *marianismo*, along with stigma surrounding homosexuality in Central and South American-origin cultures, can discourage both heterosexual and MSM HL men and HL women from seeking HIV testing or care due to fear of discrimination, rejection, isolation, and even violence. This is especially true when attempting to access and cultivate HIV testing and awareness buy-in with HL aged 25 and older, who are more likely to retain these values.

MSM/PWID

MSM/PWID are at increased risk for acquiring and transmitting infectious disease through bloodborne exposure due to sharing of unsterile drug injection equipment as well as having unprotected intercourse with partners who are living with HIV or are unaware of their HIV status.[14] The risk of HIV transmission is increased among this population due to stigma and legal policies that prevent MSM/PWID from accessing the services necessary to prevent the transmission of HIV and other infectious diseases. Societal stigma against substance use prevents many PWID who need services from accessing services due to shame and fear of criminalization.[14] Current legal and policy frameworks criminalize drug use and often leave individuals who use or inject drugs incarcerated instead of facilitating and promoting evidence-based best practices such as promoting syringe access, treatments such as methadone and buprenorphine, mental health treatment, and case management.[15]

- **C.2) How unmet need framework data inform process for identifying the subpopulations of focus**

  A joint RWPC and CPG ad-hoc EIIHA Workgroup convenes each year under the RWPC's Comprehensive HIV Planning Committee to contribute to the EMA's process for selecting *EIIHA Plan* subpopulations of focus. The EIIHA Workgroup reviewed the Houston EMA EIIHA planning process, adopted selection criteria, reviewed previous years' data compiled for each criterion, examined the data in the unmet need framework, and made data requests for supplemental data to help make data-informed decisions regarding the subpopulations of focus on March 23, 2021. The EIIHA Workgroup convened again on July 14, 2021 and reviewed the adopted selection criteria, reviewed data compiled for each criterion, and selected the FY22 *EIIHA Plan* subpopulations of focus. As TDSHS did not release the 2020 unmet need data in time for the EIIHA Workgroup at the July 14th meeting, 2019 unmet need framework data was used with diagnoses through the end of 2019.

Selection criteria used included the following:

**1. An HIV diagnosis rate that exceeds the rate for the Houston EMA (20.8 per 100,000 population) [Source: TDSHS. New diagnoses as of 12/31/19. Released 2/26/21]*
**2. Highest number of PLWH estimated to be unaware of their positive HIV status within each demographic or risk factor category [Source: TDSHS, Undiagnosed estimate 2019. Released 2/26/21]*
**3. A 3-month linkage to care proportion below the linked proportion for the Houston EMA (79%) [Source: TDSHS, Linkage to Care 2019. Released 2/26/21]*
**4. An Unmet Need proportion that exceeds the proportion for the Houston EMA (25%) [Source: TDSHS, Unmet Need 2018. Released 2/26/21]*
**5. Designation as a Special Population in the 2017 Comprehensive Plan [Source: 2017-2021 Houston Area Comprehensive HIV Prevention and Care Service Plan. Submitted to HRSA/HAB 9/28/16]*
**6. Selection as a Target Group in the FY21 EIIHA Population Selection & Matrix*
[Source: FY20 Houston EMA EIIHA Strategy & Matrix. Approved by the Comprehensive HIV Planning Committee 7/23/20]
**7. A late/concurrent diagnosis proportion that exceeds the proportion for the Houston EMA (22%) [Source: TDSHS. Late diagnosis by population 2018. Released 2/26/21]*

FY22 EIIHA Plan Subpopulation	**Discussion of the epidemiological, social determinants of health, and other data supporting selection as a subpopulation of focus based on selection criteria above**
• Black/African Americans (**AA**)	• The rate of new diagnoses among AA (49.9.4 per 100,000 population) is significantly higher than the rate of new diagnoses for the EMA as a whole (20.8 per 100,000 population). • The undiagnosed estimate for AA (2,214 estimated unaware) is the second highest of all other race/ethnicity groups in the EMA. • Timely linkage to care is also lower for AA in the EMA than any other race/ethnicity. 25% of all AA, 19% of AA females and 27% of AA males who were diagnosed in 2019 were <u>not</u> linked to care within three months of diagnosis. 14% of AA males remained unlinked to HIV medical care one year after diagnosis, the lowest linkage to care rate of all sex and racial/ethnic subpopulations in the EMA. • The unmet need/out of care proportion is higher among AA (26%) than for the EMA as a whole (25%). • Women of color (**WOC**), defined as individuals who identify racially or ethnically as AA, Hispanic/Latina, or Multiracial women, are a *2017 Comprehensive Plan* target population. • AA were an *EIIHA Plan* target population in FY21. • AA met 6 out of 7 criteria considered in the FY22 EIIHA target population selection matrix.
• Hispanics/Latinx (**HL**)	• 26% of HL diagnosed in 2018 in the EMA had late/concurrent diagnoses, a higher proportion than AA (18%). 35% of HL females and 26% of HL males diagnosed in 2016 had late/concurrent diagnoses, higher than any other sex and race/ethnicity cross tabulation in the Houston EMA. When examined by age, ethnicity, and sex for 2015 data (the most current available with age included in the cross tabulation), HL males and females aged 35 and over had some of the highest late diagnosis proportions in the Houston EMA: o HL females aged 35-44 = 55% o HL females aged 55+ = 50% o HL males aged 35-44 = 41% o HL males aged 45-54 = 35% o HL males aged 55+ = 59%

FY22 EIIHA Plan Subpopulation	Discussion of the epidemiological, social determinants of health, and other data supporting selection as a subpopulation of focus based on selection criteria above
	• WOC, defined above, are a *2017 Comprehensive Plan* target population. • HL met 4 out of 7 criteria considered in the FY22 EIIHA target population selection matrix.
• Men who have Sex with Men / Persons who Inject Drugs/Substances (**MSM/PWID**)	• MSM comprised 71% of all new HIV cases in the Houston EMA in 2019. • It is estimated that 3,468 MSM and 208 MSM/PWID in 2019 were living with HIV in the Houston EMA but were unaware of their status. • 25% of MSM/PWID living with HIV in the EMA have unmet need. • MSM of color in the EMA historically experience disproportionate cultural and economic barriers to HIV awareness, early identification, and engagement in the HCC. This is particularly true for young MSM of color. • The linked proportion of MSM/PWID was 75%, the second lowest proportion of individuals linked to care with the group having the lowest proportion of individuals linked to care being PWID (71%). • MSM, defined as men who engage in male-to-male sexual practices and identify as gay or bisexual, those who engage in male-to-male sexual practices and do not identify as gay or bisexual, and those who engage in gay or bisexual male culture regardless of gender identity, are a *2017 Comprehensive Plan* target population. • Substance abuse was noted in the 2020 Needs Assessment as a contributor to barriers to HIV prevention and care services. • MSM were an *EIIHA Plan* target population in FY21. • MSM met 3 out of 6 criteria and MSM/PWID met 3 out of 6 criteria considered in the FY21 EIIHA target population selection matrix (HIV diagnosis rate was not available for risk factor populations). Males in general met 4 out of 7 criteria considered in the selection matrix.

It is important to note that limitations on available data still present a challenge for determining subpopulations of focus for EIIHA activities. An essential function of the EIIHA process has been to reach community-level consensus on local populations in greatest need of early identification, notification, referral, and linkage using various data sources. Even with access to many local, state, and national sources of EIIHA-related data, limitations inherent in these data systems have restricted the ability of the EMA to evaluate the EIIHA-related needs of some at-risk populations. Currently available epidemiologic data consistently fails to assess the need for testing, referral, and linkage in at-risk populations such as those who are transgender, intersex, housing insecure, or recently released from incarceration, as these categorizations are absent from most HIV-related datasets. Moreover, limitations on the number and type of target populations for EIIHA each year mean that the RWPC may not be able to select some groups for inclusion in the *EIIHA Plan*, despite indications of high need through the data evaluated. Reaching consensus under these circumstances has been an ongoing challenge in developing an EIIHA plan in the Houston EMA since plan requirements were first implemented.

- **C.3) Activities for each required EIIHA component and how activities align with needs of subpopulations of focus**

1. Community mobilization of target populations (responds to EIIHA Components 2 and 4):
Increasing HIV awareness and linkage among the target populations begins with coordinated community level efforts to elevate HIV as a priority health concern. The FY22 *EIIHA Plan* includes population-specific community Task Forces that provide culturally appropriate HIV outreach, education, and testing to mobilize target populations around HIV. These include the African American State of Emergency Task Force, Latino HIV Task Force, and M-pact (The MSM

HIV Task Force). The SAFER initiative, which provides HIV prevention and testing activities in high-morbidity neighborhoods, will continue in FY22 pending decreases of COVID-19 cases in the Houston EMA and COVID-19 safety precautions can be made to protect the staff and clients that are served. The Houston Health Department (**HHD**) has funded work through the Montrose Center, a local community center for LGBTQ+ individuals in the Houston area, to help increase mobilization of PWID through the Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) Program. The Community PROMISE Program utilizes community champions to help measure risk, to serve as a messenger for HIV prevention and HIV testing, and to promote increased health outcomes and health equality among MSM, PWID and transgender people.

2. Community norm and perception change around HIV testing and awareness (responds to EIIHA Components 1 and 2): Community buy-in must be cultivated before HIV testing and awareness can be normalized in the subpopulations of focus. Structural-level interventions that change the negative connotations often associated with HIV testing and combat stigma in the target populations are essential components of the FY22 *EIIHA Plan*, including community-wide branded social marketing campaigns tailored to members of the subpopulations of focus (e.g., "Greater than AIDS" for African Americans; "Take Charge, Take the Test" for African American Women; "Testing Makes Us Stronger" for African American MSM; "I Am Life" PrEP uptake for MSM and transwomen); routine HIV testing in clinical settings commonly utilized by these populations for routine health care services (e.g. emergency rooms, community health clinics, FQHC, etc.); and targeted testing events designed to address stigma surrounding HIV testing in high morbidity neighborhoods and within a variety of subpopulations through co-branding with other community initiatives. The EMA has also made great strides in developing buy-in for HIV testing and awareness within the EMA's Hispanic/Latinx communities. The HHD and the Latino HIV Task Force have traditionally collaborated with Univision Channel 45 and local providers to answer HIV-related questions, promote testing, and share testing resource information in Spanish via a live televised phone bank. Through the HHD-funded Community PROMISE Program at the Montrose Center, community champions help to assess the needs of those in the community who are negative or may have an unknown status by focusing on behaviors within the MSM, PWID and transgender community and what behavioral changes need to happen to increase HIV testing, reduce HIV/STD transmission, or improve health equity. Role models are chosen to share their stories of successes or challenges to provide encouragement and help behaviors change within that community. Service linkage and Counseling, Testing and Referral using rapid test methods are also employed to identify participants who have an unknown status or are out-of-care. Prevention Specialists also use Motivational Interviewing to help participants advance along the stages of change.

3. Targeted activities to identify and inform (responds to EIIHA Components 1 and 2): HIV prevention interventions proven to increase HIV testing and awareness in the general status-unaware population described previously will also be tailored for implementation in the FY22 *EIIHA Plan* subpopulations of focus. These include group-level evidence-based interventions implemented by publicly funded Health Education/Risk Reduction providers (e.g. VOICES/VOCES for African American and Hispanic/Latino men, SISTA for African American women, and Reasons/Razones for Hispanic/Latino MSM) and targeted Counseling, Testing and Referral (**CTR**) services in non-traditional settings in close contact with the subpopulations of focus; including high-morbidity neighborhoods via the Mobile STD Clinic, *Houston Splash* (the

largest social gathering of African American MSM in Houston/Harris County), and other community events contingent on the decrease of COVID-19 cases in the Houston EMA and implementation of adequate precautions to ensure the safety of participants and staff. Through the HHD-funded Community PROMISE Program at the Montrose Center, community champions help to assess the needs of those in the community who are negative or may have an unknown status by focusing on behaviors within the MSM, PWID and transgender community and what behavioral changes need to happen to increase HIV testing, reduce HIV/STD transmission, or improve health equity. Role models are chosen to share their stories of successes or challenges to provide encouragement and help behaviors change within that community. Service linkage and CTR using rapid test methods are also employed to identify participants who have an unknown status or are out-of-care. Prevention Specialists also use Motivational Interviewing to help participants advance along the stages of change.

4. Targeted activities to refer and link (responds to EIIHA Components 3 and 4):
Service Linkage Workers (**SLW**) target linkage and referral for newly diagnosed members of the target populations. The RWPC has approved allocations to continue funding SLW and MCM targeting African Americans, and Hispanic/Latinx individuals in FY22. SLW and MCM staff specialize in assessing the unique priority needs of members of these target populations and making referrals to needed medical, social, community, legal, financial, and other services that support successful linkage to and retention in HIV medical care. Additionally, all RW-funded agencies are required to maintain Spanish-speaking staff to provide culturally and linguistically appropriate services to Spanish monolingual clients. This accommodation is essential in linkage to care and care coordination for Hispanic/Latinx individuals aged 25 and over in the Houston EMA. Through the HHD-funded Community PROMISE Program at the Montrose Center, community champions help to assess the needs of those in the community who are negative or may have an unknown status by focusing on behaviors within the MSM, PWID and transgender community and what behavioral changes need to happen to increase HIV testing, reduce HIV/STD transmission, or improve health equity. Role models are chosen to share their stories of successes or challenges to provide encouragement and help behaviors change within that community. Service linkage and Counseling, Testing and Referral using rapid test methods are also employed to identify participants who have an unknown status or are out-of-care. Prevention Specialists also use Motivational Interviewing to help participants advance along the stages of change.

5. Cultural competence training for the HIV prevention/care system (responds to EIIHA Components 1, 2, 3, and 4): The FY22 *EIIHA Plan* includes efforts to improve the ability of the HIV prevention and care system to effectively identify, inform, link, and refer all priority groups in the context of their unique social, economic, and cultural challenges. Care standards for HIV prevention and care frontline staff, including CTR providers along with SLW/MCM/Outreach workers, require completion of annual individual-level, domain-based, cultural competence training; and, biannually, HIV prevention and care frontline staff convene for joint all-day training sessions. Additional enhancements to the competence of the HIV prevention and care system in the EMA with regards to priority populations occur through continued implementation of the *2017 Comprehensive Plan*, which includes strategies and activities dedicated to addressing the needs of special populations.

METHODOLOGY

A. PLANNING RESPONSIBILITIES

- **A.1) Letter of Assurance from Planning Council Chair(s)** – Please see ***Attachment 6*** for the letter that addresses planning, priority setting and resource allocation, training, and assessment of the administrative mechanism.

- **A.2) Resource Inventory**

A.2.a) Coordination of Services and Funding Streams – Please see ***Attachment 7*** for the table of Houston's HIV resources inventory.

WORK PLAN

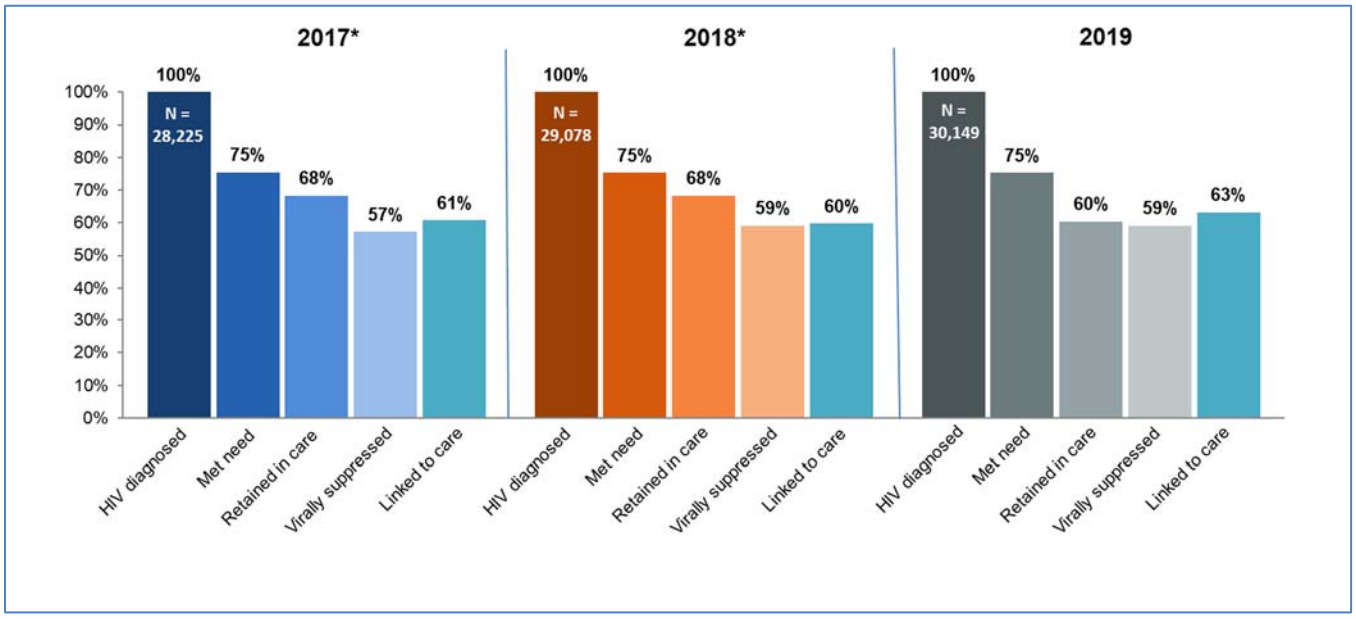
A. HIV CARE CONTINUUM SERVICES TABLE AND NARRATIVE

- **A.1) FY 2022 HIV Care Continuum Services Table –** Please see ***Attachment 8.***

- **A.2) HIV Care Continuum Narrative**

A.2.a) Changes to the Houston HIV Care Continuum, Impact, and Response

Figure 4. **Houston EMA HIV Care Continuum, 2017-2019**



Data Source: TDSHS, data from 2017 to 2019
*Data presented in 2017 and 2018 includes PLWH who are younger than 13 years of age

As illustrated in **Figure 4**, there has been little change in rates of PLWH engagement across the HIV Care Continuum from 2017 to 2019. Overall Met Need rates were 75% in each of the three

years. Similarly, there were incremental variations in retention in care (8% decrease), viral load suppression (2% increase) and linkage to care rates (2% increase) over the three-year period.

To affect greater change and improved trends across the continuum of care, the EMA has looked to the more flexible use of *Ending the HIV Epidemic: A Plan for America* funds (**EHE**) to implement innovative approaches to disrupt the HIV service delivery status quo, with the goal of decreasing new HIV diagnoses through equity and access.

Although EHE funding focuses on PLWH who reside in Harris County, an estimated 91% of all PLWH in the Houston EMA reside in Harris County. Innovations and improvements for the Houston/Harris County area may drive trends in the EMA. Initiation of EHE funding in FY20 focused on broad implementation of rapid initiation of antiretroviral therapy strategies *(Rapid Start)* and intensive care coordination for PLWH who are newly diagnosed or returning to care after being out of care for greater than 12 months. Rapid access to the HIV treatment and support services needed to achieve sustained viral load suppression has been an ongoing, persistent need in the EMA. This strategy strives to improve outcomes across the HIV Care Continuum in the EMA by ensuring that all people living with HIV have access to early and continuous HIV care services. Clinic-based *Rapid Start* protocols quickly link PLWH to care to improve opportunities of retention and viral suppression, and subsequently reduce the number of new HIV diagnosis in the EMA.

Rapid initiation is defined to be within seven days from the day of HIV diagnosis; people with advanced HIV disease should be given priority for assessment and initiation.[16] The Houston area EHE model has set a benchmark of 72 hours for *Rapid Start* protocols implemented under this funding. This service delivery model has been of interest for several RW-funded providers in Houston/Harris County. However, restrictions related to verification of patient income made subrecipients hesitant to initiate treatment services prior to completing the eligibility determination. Although the Houston/Harris County jurisdiction has long provided a 60-day window in which services can be provided while eligibility determination is completed, subrecipients nevertheless assumed the risk of recouping any RW funds utilized for clients ultimately determined to be ineligible. EHE funding removes this barrier and allows for RW/A-funded primary care providers to offer a range of core and support services to quickly initiate HIV treatment and achieve viral suppression.

To rapidly begin utilizing EHE funding and realize positive health outcomes, RWGA employed existing RW/A primary care subrecipients and contracts to begin EHE services on March 1, 2020. In Houston/Harris County, primary care contracts are bundled with several complementary wrap-around services to maximize continuity of patient care and establish a patient medical home. All RW/A primary care subrecipients are also funded to provide Emergency Financial Assistance for short-term medication assistance, Local Pharmaceutical Assistance, Medical Case Management, non-Medical Case Management, and Outreach services. These wrap-around services also support those EHE patients who are newly diagnosed or returning to care. Implementation during subsequent years will focus on program scale-up and tailoring to meet the linkage, retention, and viral suppression needs of difficult to reach, disproportionately impacted special populations identified through analysis of unmet need data. For example, the virally suppressed proportion of all diagnosed PLWH in the Houston EMA in 2019 was 59%. From 2013 through 2017, an estimated 21,392 PLWH resided in the EMA. Among those individuals, at least 30%, or 6,438

PLWH, were out of care, using the broadest definition of unmet need requiring at least one viral load test in a 12-month period. However, analysis of viral suppression data by age, race/ethnicity, sex at birth, and transmission risk factor indicates that three subpopulations in the Houston EMA experienced the most disproportionately low viral suppression in 2019:

- Youth aged 13-24 – 53% virally suppressed
- African American males – 54% virally suppressed
- African American females – 58% virally suppressed

Youth aged 13-24 is an emerging population in the EMA and accounted for 564 non-suppressed PLWH. African American males accounted for 4,313 non-suppressed PLWH and African American females accounted for 2,083 non-suppressed PLWH.

The 2020 NA survey revealed service gaps and potential barriers to viral suppression among these subpopulations. Compared to other age ranges, youth reported a higher need for ADAP enrollment assistance, adult day treatment, health insurance assistance, local pharmacy assistance, and primary medical care to access and be retained in HIV medical care. When asked about barriers to care, youth most commonly reported education and awareness issues, such as not knowing that a needed service exists or is available, and transportation issues, such as having no available mode of transportation. Further discussion about the needs of youth PLWH can be found on page 5. While additional analysis of barriers for cross-tabulated race/ethnicity by gender at birth and transmission risk factor are pending, initial analysis revealed that African American participants reported greater difficulty accessing cases management (medical and non-medical), medical nutrition therapy, and outpatient substance use treatment resource compared to the total sample. Among MSM participants, primary care, local pharmacy assistance, outreach, ADAP enrollment assistance, health insurance assistance, oral health care, and early intervention services were more difficulty to access compared to the total sample. Females (sex at birth) reported having greater difficulty accessing local pharmacy assistance, medical nutrition therapy, vision, mental health services, oral health care, and medical transportation. Stakeholders in the Houston HIV community have indicated that African American females may experience unique stressors that decrease the likelihood of achieving viral suppression despite retention in care, such as competing priorities, roles as primary caretakers for young and aging family members, and both institutional and personal intersectional racism and sexism.

It is important to note that available Texas surveillance data used to construct and analyze the Houston EMA HCC do not portray the need for activities to increase testing, linkage, retention, ART access, and viral suppression among many other vulnerable key populations such as among those who are transgender, intersex, experiencing homelessness, or those recently released from incarceration. Activities designed to provide these targeted interventions and create a local HCC for populations traditionally not represented in epidemiologic or surveillance data will be addressed in the 2021 *Comprehensive Plan*.

B. FUNDING FOR CORE AND SUPPORT SERVICES

- **B.1) Service Category Plan**

B.1.a) Ryan White Part A and MAI Service Category Plan Table – Please see ***Attachment 9*** for the service category plan tables for Part A and MAI.

B.1.b) MAI Service Category Plan Narrative

i. MAI service implementation

Due to unique challenges faced by African Americans and Hispanics/Latinx in the Houston EMA, these minorities groups are targeted with MAI-funded services in addition to services funded through Ryan White Part A (**RW/A**). As detailed in the *Subpopulation of Focus* section, African American MSM face significant disparities in achieving optimum health outcomes.

The Houston EMA's MAI-funded activities address the needs of MAI-eligible HIV-positive minority individuals in the EMA through MAI-funded primary care and MCM initiatives. Specifically, activities ensure continuation of effective community-based **primary medical care** services targeted to African American and Hispanic/Latinx PLWH. Three (3) MAI-qualified CBOs operate a total of four (4) primary care clinic sites in areas with high HIV prevalence. These clinics are in locations accessible to the targeted populations, including being located near public transportation. These programs are also funded under RW/A and include RW/A-supported psychiatry, non-Medical Case Management, and Local Pharmaceutical Assistance targeted resources to address co-occurring conditions including mental health and substance use. Services also include assessments/referrals to treatment programs and support treatment adherence, and they provide culturally competent/linguistically appropriate medication education and ensure effective participation by minority PLWH in the medical care services offered at their sites.

MAI-funded **community-based** MCM services are also targeted to African American and Hispanic/Latinx PLWH. In FY21, the RWPC allocated funding to three (3) MAI-qualified CBOs to provide additional MCM services to African Americans and Hispanics/Latinx. These three (3) CBOs also operate RW/A-funded community-based primary medical care services targeted to African American and Hispanic/Latinx PLWH. Procurement of MAI-funded MCM services has strengthened existing connections to primary care services, such as RW/A-supported psychiatry, non-Medical Case Management and Local Pharmaceutical Assistance resources. Targeted MCM services increase the opportunity for care coordination assistance from staff that is culturally competent and linguistically appropriate.

ii. How MAI services may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities

African Americans

An analysis of core socioeconomic and health indicators shows that African Americans (**AA**) are one of the most disenfranchised populations in the Houston EMA. Almost one in five AA in the EMA is living below the FPL (18%); 15% have no health insurance; 9% are unemployed (the highest rate in Houston/Harris County); 9% have less than a high school education; and 12% are disabled, according to the Census Bureau's American Community Survey (**ACS**) 2015-2019.

According to a recent household survey of Houston, 62% of AA are in economic hardship and have difficulty paying for basic needs such as food and rent. This same survey showed that more AA are in poor or fair health than the average resident. Data on AA overall in Texas reveal the highest rates of risk factors and health conditions such as diabetes, high blood pressure, and tobacco use. In general, the socio-economic and health status of AA in the Houston EMA means that those who present to the HIV care system may be in poorer health overall and have less access to resources for health care or basic needs. The need for capacity to respond to these challenges in the EMA is also great. Current estimates show that AA account for 48% of all PLWH in the EMA and 53% of all RW program clients. The rate of HIV among AA in the EMA is also positively correlated with extreme poverty, i.e., the more impoverished AA are, the higher their rate of HIV.

According to 2019 Texas surveillance data, 45% of African American PLWH in the EMA are not virally suppressed. However, this population fares better with the benefit of RW care services. Seventy-four percent of AA RW program clients are virally suppressed for the same time period. Fifty-one percent of all persons not retained in care in the Houston EMA are AA, and 42% of newly diagnosed PLWH in the EMA (42%) are also AA. Overall, AA in the EMA reported no significant difficulties accessing HIV services compared to other racial/ethnic groups, according to *2020 Houston HIV Care Services Needs Assessment* (**NA**). However, they were more likely to report transportation and housing as important for their care. They were also more likely to report being told they were ineligible for services and to report incarceration history as a barrier to care. A demographic analysis of RW service utilization in 2020 shows that AA are under-utilizing Health Insurance Assistance, Local Pharmaceutical Assistance, Medical Nutritional Therapy, Oral Health, Vision Care, and Substance Abuse Treatment service categories.

Hispanics/Latinx

Hispanics/Latinx (**HL**) are the largest population group in the Houston EMA (at 39% of the total population), and they are also one of the most disenfranchised. This is due not only to poor socioeconomic conditions but also to the isolation from the service delivery system that occurs from residency status and language barriers. An estimated one in five HL (20%) in the Houston EMA live below FPL, 30% are uninsured, and 37% of HL adults have less than a high school education (ACS 2015-2019). Among HL in the EMA, 39% are foreign-born, and 38% are considered "linguistically isolated," meaning they speak English less than "very well" (ACS 2015-2019). The health status of most HL is also less than average, with higher rates of diabetes, obesity, poor nutrition, and physical inactivity than Texas as a whole. Like African Americans, HL in the EMA may be in poorer overall health and have fewer resources for health care or basic needs. However, many are also prohibited from public services due to citizenship and/or language barriers. These challenges clearly intersect with the HIV service delivery system. For example, more HL than any other group in Houston/Harris County progress to AIDS within one year of their diagnosis (46%), indicating late entry into care (TDSHS 2018 data). Within the RW Program, an estimated 16% of clients are monolingual Spanish speakers and/or use Spanish as their primary language (CPCDMS).

Hispanics/Latinx in the Houston EMA have experienced notable service gaps. Compared to all respondents in the EMA's most recent local NA, HL reported more difficulty accessing Primary Medical Care, Health Insurance Assistance, Legal Assistance, and Local Pharmaceutical Assistance services. They were also more likely to cite support groups, legal services, and translation services as important for their care. Of all racial/ethnic groups in the NA, HL were the

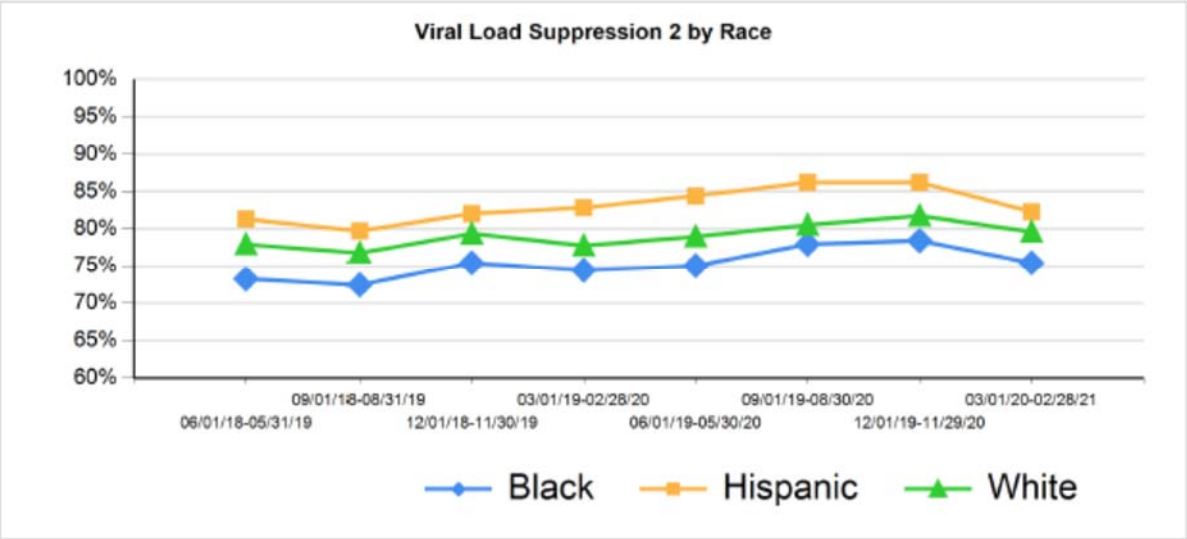
most likely to report not having a case manager and to not seek health care because of inability to pay. However, when reviewing health indicators such as viral suppression rates, HL tend to have better outcomes, as illustrated in the table and chart at the end of this section.

African American MSM

In addition to the numerous complex needs and service gaps that effect African Americans, African American (**AA**) MSM face additional challenges that impact their ability to achieve positive health outcomes. Although MSM are not a specific subgroup within Houston's MAI funds targeted to AA, this population does have unique needs that are being addressed by tailored initiatives in the EMA. In 2018, RWGA required all primary medical care subrecipients to participate in the HRSA/HAB-sponsored *end+disparities* ECHO Collaborative. This national, 18-month collaborative, which concluded in 2019, aimed to increase viral load suppression in one of four disproportionately affected HIV subpopulations and increase local QI capabilities. As illustrated below, local RW program data shows significant disparities in positive health outcomes when compared to the total RW program population, as well as other MSM subpopulations. At initiation of the collaborative, the AA MSM viral suppression rate was 61% while the viral suppression rate was 71% for the total population. By December 2019, the AA MSM viral suppression increased to 72%, demonstrating an 11-percentage point increase. Although effects of the COVID-19 pandemic did negatively impact improvements in 2020, RWGA has refocused on this work in 2021 as COVID-19 response activities subside.

Overall viral load suppression rates for FY20 by race/ethnicity are detailed in the table and chart below.

VL Suppression 2 by Race/Ethnicity									
	09/01/19 - 08/30/20			12/01/19 - 11/29/20			03/01/20 - 02/28/21		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	3,184	2,842	865	3,209	2,816	893	3,089	2,699	851
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,084	3,296	1,074	4,091	3,266	1,092	4,095	3,279	1,069
Percentage	78.0%	86.2%	80.5%	78.4%	86.2%	81.8%	75.4%	82.3%	79.6%
Change from Previous Quarter Results	2.9%	1.8%	1.6%	0.5%	0.0%	1.2%	-3.0%	-3.9%	-2.2%



B.1.c) Unmet Need

i. Interventions focused on improving outcomes for PLWH with unmet need that 1) are late diagnosed, 2) have unmet need , and 3) are in care but not virally suppressed

Unmet Need	Strategy	Activity
Late Diagnosed	Health communication strategies to help change stigma and community perceptions of HIV testing and awareness	1. Group-level Behavioral Interventions • Explore opportunities for cross-representation between the Houston HIV Community and School Health Advisory Councils • Educate Houston-area faith community leadership on HIV information, risk reduction, and prevention tools 2. Brand social marketing campaigns in high morbidity zip codes within the Houston EMA • *Greater than AIDS* • *Take Charge, Take the Test* • *Testing Makes Us Stronger* • *Let's Stop HIV Together* • *Testing 1 2 3* • *I Am Life* • *Somos Familia*
	Routine HIV testing in clinical settings	1. CDC-funded Expanded Testing Initiative (**ETI**) at several clinical sites across major healthcare systems within the Houston EMA 2. Disseminate routine testing implementation toolkit to targeted private and non-Ryan White funded providers and FQHCs 3. Educate providers serving special populations about routine HIV testing
	Targeted HIV testing in non-clinical settings	1. Counsel, Test, and Referral services in non-traditional settings: • Harris County Jail • Harris County Juvenile Detention

Unmet Need	Strategy	Activity
		• Harris County Family Planning Clinics • Healthcare for the Homeless Houston Clinics • Community events and health fairs • Community-based organizations • Mobile STD Clinic through the Houston Health Department • At home testing offered by FQHCs
Unmet Need	Increase education and awareness of Houston EMA services	1. The Blue Book – RWPC support staff compile a comprehensive resource inventory of HIV prevention, testing, care, treatment, and support services available in the Houston EMA and 4 additional counties served by the RW Part B Program. The Blue Book is available as a physical copy as well as online.
	Non-medical case management	1. Non-medical case management, or Service Linkage/SLW, help to link newly diagnosed PLWH to HIV medical care and support services as well as re-link PLWH to medical care and/or support services to stay in care.
	Outreach Workers	1. Outreach workers target retention and re-engagement efforts towards clients with consecutive missed primary care provider and/or HIV lab appointments. Outreach workers also help with additional difficulties that the client may have such as; unsuppressed viral loads, substance abuse, ART treatment failure and individuals who are experiencing housing insecurity.
In care but not virally suppressed	Increasing education and awareness of Houston EMA services	1. The Blue Book – RWPC support staff compile a comprehensive resource inventory of HIV prevention, testing, care, treatment, and support services available in the Houston EMA and 4 additional counties served by the RW Part B Program. The Blue Book is available as a physical copy as well as online.
	Non-medical case management	1. Non-medical case management, or SLW, help to link newly diagnosed to HIV medical care and support services as well as re-link PLWH to medical care and/or support services to stay in care.
	Medical case management	1. Medical case management Services include treatment adherence counseling, coordination and follow-up of medical treatments, and client advocacy and support. Medical Case Managers promote adherence to medical care by addressing housing, financial, transportation, mental health and substance use, and other high priority needs that can negatively impact treatment adherence.

ii. How activities to re-engage PLWH with unmet need intersect with plans or strategies

EHE funding awarded to Houston/Harris County is being used synergistically with the RW Part A program to implement activities that will improve outcomes for individuals with unmet need. In addition to the HIV testing and prevention social media campaigns, EHE funding is used to further promote awareness of HIV treatment services, including billboards and radio advertising in both English and Spanish. EHE funding is also being used to support Rapid Start ART, which strives to provide ART within 72 hours of either HIV diagnosis or return to care encounters. The implementation of Rapid Start required subrecipients to re-evaluate process flows to reduce wait time to medical visits and to receive ART in hand. Creating a more efficient and seamless return to care process increases client satisfaction and increases the likelihood that clients will successfully re-engage into care. Ridesharing is another new EHE activity that supports individuals with unmet need. Transportation is a long-standing barrier to care, and ridesharing is the quickest and most convenient way to assist clients with unmet need getting to eligibility appointments, leading to access of outpatient/ambulatory health services, ADAP and/or local pharmaceutical assistance and support services. Part A and EHE workplan activities have been developed to complement each other to maximize outcomes for individuals experiencing unmet need.

The table below includes planned activities from the EMA's Ending the HIV Epidemic efforts that address engaging PLWH with unmet need into care.

Unmet Need	EHE Activity	RWHAP Part A/MAI Activity
	Rapid Start ART	1. Outpatient Primary Care + ADAP + LPAP + EFA (for meds) + Medical Case Management + Service Linkage provides ongoing medical care, including coordination of care, treatment adherence and linkage to supportive services to Unmet Need patients who begin treatment via Rapid Start efforts funded under EHE
	Ride Share	2. Medical transportation resources including bus passes, taxi vouchers, gas cards and van-based transport provide consistent transportation options for Unmet Need PLWH who transition to ongoing care at any RWHAP-funded medical provider.
	Promoting awareness of HIV treatment services, including billboards and radio advertising in both English and Spanish.	3. Branded social marketing campaigns in high morbidity zip codes within the Houston EMA • *Greater than AIDS* • *Take Charge, Take the Test* • *Testing Makes Us Stronger* • *Let's Stop HIV Together* • *Testing 1 2 3* • *I Am Life* • *Somos Familia*

RESOLUTION OF CHALLENGES

Challenges/Barriers	Proposed Resolution	Intended Outcomes	Current Status
Part A Program			
Determining service priorities and allocating funds for FY 2022 because 2020 data was either unavailable or unusual due to the COVID-19 pandemic.	After reviewing available data, the Council agreed to use the FY 2021 service priorities and allocations in FY 2022 since the FY 2021 service priorities and allocations were based upon pre-COVID data.	The FY 2021 service priorities were based upon data that was collected from over 589 PLWH in 2019 and early 2020, hence the FY 2021 priorities were determined using pre-COVID data. Regarding allocations, when determining allocations for FY 2022 primary care, for example, the committee looked at the cost and number of inpatient primary care visits in 2020. Both the cost and number of patient visits decreased significantly because the predominant method of providing care changed to telehealth.	Making changes to the FY 2021 service priorities and allocations seems imprudent because there is little to no reliable data to justify changes. Therefore, the Council voted unanimously in July 2021 to use the FY 2021 service priorities and allocations in FY 2022.
Maintaining Open Meetings Act requirements for Ryan White Planning Council and Committee meetings during COVID-19 stay at home orders.	The Council approved changes to its meeting policy, which relates to quorum while under a declared health emergency.	The intended outcome was to lower the number of members required to safely make in-person quorum at Council and committee meetings during a declared health emergency so that the Council could continue to function. For example, the building that houses the Council Office of Support has three large meeting rooms. Two have been remodeled to accommodate COVID-19 contact tracers and the third room will not easily accommodate social distancing with a large group.	The day after the Council approved described changes to its meeting policy, the Governor made changes to the Texas Open Meetings Act allowing quorum to be met via teleconferencing instead of in person. If that changes, the quorum is low enough to safely allow the required in-person members to meet in the Office of Support conference room and reception area. Surprisingly, there has been robust attendance at the Houston RW Planning Council and Committee meetings and the original numbers required to meet quorum have been met at all meetings, even while meetings continue to be held virtually.
Increase participation from Spanish speaking PLWH in Houston EMA Ryan White planning processes	Provide more Ryan White information in Spanish, teach planning skills and provide translators and bi-lingual mentors to support Spanish speaking PLWH so that they are not intimidated by Ryan White processes.	a number of critical documents, such as service definitions, were translated into Spanish and posted on the Council website. Bi-lingual Council staff are working with two educators to develop a training program and secure Spanish speaking health planners to teach the 13-week course.	Students are currently being interviewed so that Proyecto VIDA can start in September 2021. Graduates of the program will be available in time for the CEO to appoint those who are interested to the 2022 Planning Council, translators will be secured to assist during Ryan White Council and committee meetings and bi-lingual Council members will be assigned as mentors to the new members.

EVALUATION & TECHNICAL SUPPORT CAPACITY

A. CLINICAL QUALITY MANAGEMENT (CQM) PROGRAM

- **A.1) Changes made to CQM program based on previous years' experience and outcomes**

Ryan White Grant Administration (**RWGA**) utilizes performance measure data, needs assessment data, and client feedback to guide the Quality Management (**QM**) program. For the last couple of years, there has been increasing client concern shared with the RWPC regarding the lack of affordable housing in Houston and how it negatively affects HIV care and treatment. Fortunately, RWGA was accepted into the Center for Quality Improvement and Innovation's (**CQII**) new national quality improvement initiative to mitigate barriers associated with social determinants of health, including housing instability, experienced by PLWH. As part of the *create+equity Collaborative*, housing data was analyzed and revealed that housing instability in Houston is high (12.6%) and that those with housing instability have significantly lower viral load suppression rates compared to the total population (73% versus 79%). RWGA, and all funded subrecipients, are active participants in the collaborative and have recently selected *The Undetectables* intervention for local implementation. Additionally, RWGA QM staff plan to participate in an upcoming NASTAD-facilitated housing learning collaborative designed to improve collaboration with local housing authorities and explore strategies for improving access to affordable housing.

Another priority for the QM program is improving access to ART. In FY19, DSHS shared data demonstrating that 21.8% of Houston EMA clients had been dropped from ADAP due to inability to complete the recertification process. ART access is vital to viral suppression goals, prompting RWGA to initiate multiple activities to address this issue. RWGA spearheaded bimonthly meetings with State partners who administer ADAP and Care Services, creating the infrastructure for greater communication, collaboration, and streamlining of RW eligibility practices. The eligibility changes that occurred as a result of the COVID-19 pandemic, along with the increased utilization of telehealth and ART prescriptions being delivered by the USPS, played a role in reducing the ADAP drop rate to 4.9% and increased the Houston EMA's viral load suppression rate from 77% to 82% in CY20. The Improving Medication Access QI project was initiated in order to sustain these improvements while the State's ADAP eligibility requirements were reinstated. The goal of this project is to increase medication adherence and viral suppression by improving the ease and convenience of obtaining medication. A survey was administered to subrecipients to gauge the practices being used to facilitate access to ART, such as mailed out medications, courier service, and automated reminder calls/texts. This survey identified a wide variation of activities and many best practices. Subrecipients have initiated QI work plans to implement change ideas with the goal of improving access to ART.

Both the *create+equity Collaborative* and the Improving Medication Access QI projects are utilizing Life QI, a newly acquired web-based platform designed to monitor QI projects. Historically, it has been challenging to document and monitor the progress of subrecipient QI projects through traditional methods, such as emailing QI workplans back and forth. RWGA became aware of this new QI improvement tool through a TDSHS CQM Summit, where Administrative Agencies shared CQM best practices. RWGA subrecipients are currently utilizing Life QI to document and monitor progress on both of these QI initiatives.

- **A.2) How CQM data improved patient care, health outcomes, patient satisfaction, and/or improved service delivery**

Performance indicator data is primarily collected via Houston EMA's client-level database, the Centralized Patient Care Data Management System (**CPCDMS**). Providers enter registration, encounter, and medical update information for each client, including demographic, co-morbidity, laboratory, biological marker, service utilization and health outcomes data at each client visit. Using this information, RWGA is continually developing reports that summarize trends in client demographics, service utilization and outcomes. RWGA has developed customized CPCDMS reports based on the HRSA/HAB Health Performance Measures as well as other performance measures. The Recipient validates CPCDMS data through the annual clinical chart abstraction, conducted by RWGA QM staff.

Performance Measures and service utilization are monitored regularly (quarterly to annually, depending on the measure) to identify when CQI activities are needed. For example, review of CQM data identified disparities in viral load suppression rates among African American (**AA**) MSM (62.1% compared to 71.9% for the total population in 2017). This data guided RWGA to develop a QI initiative designed to increase viral suppression rates in this population. In 2018, RWGA required all primary care subrecipients to participate in the CQII *end+disparities ECHO Collaborative*. This national, 18-month collaborative aimed to increase viral suppression in one of four disproportionately affected HIV subpopulations and increase local QI capabilities. Participants developed and implemented a quality improvement project to reach these goals, while receiving additional support through biweekly Affinity ECHO sessions, monthly Regional Group meetings and quarterly Learning Session meetings. Since implementation of the QI initiative, viral suppression rates increased in FY20 to 75% for AA MSM and 79% for the total Houston EMA RW population, demonstrating a 12.9 percentage point and 7.1 percentage point improvement respectively. While both AA MSM and the total EMA population experienced substantial improvements, the disparity gap was reduced by 5.8 percentage points.

The RWPC fully integrates CQM data into its annual *How to Best Meet the Need* and *Priority Setting and Resource Allocations* (**PSRA**) processes. The FY20 *Outcome Measures, Client Satisfaction and Clinical Chart Review* reports were used during the RWPC's FY22 planning process, providing the RWPC quality-related data in addition to service utilization and expenditure data for its FY22 planning efforts. During its PSRA processes, the RWPC uses a template that requires the documentation of performance measure data for each prioritized service. Over the past several planning cycles, outcomes data was instrumental in determining which supportive services provide the necessary clinical outcomes to justify funding under the RW Program. For example, Medical Transportation outcomes documented that 67% of patients utilizing RW/A-funded Van Transportation subsequently accessed RW-funded Primary Medical Care, thereby justifying continued funding in FY22. Outcomes data for each service category is similarly reviewed in the annual PSRA process. In addition, after reviewing retention-in-care data, the RWPC decided to fund Outreach Services as a new service category in FY17 and continues this funding in FY22, to improve retention-in-care rates.

All RWGA CQM activities are in line with the CQM Policy Clarification Notices #15-02 and are described in detail in the 2021-2022 *Houston EMA Quality Management Plan.*

ORGANIZATIONAL INFORMATION

A. GRANT ADMINISTRATION

- **A.1) Program Organization – *Attachments 1 and 11***

A.1.a) The Chief Elected Official (**CEO**) has designated Harris County Public Health Services (**HCPH**) as the agency responsible for the administration of RW/A and MAI funds in the Houston EMA. The Ryan White Grant Administration (**RWGA**) Section is the unit within HCPH that performs these administrative tasks. RWGA implements a comprehensive monitoring process that focuses on fiscal and programmatic components of contracts for services utilizing eleven (11) full-time positions budgeted under RWGA and two (2) positions budgeted under CQM. RWPC support is the responsibility of four (4) full-time employees assigned to the Harris County Judge's office (the County Judge is the CEO of the Houston EMA). Please see ***Attachment 1*** for a detailed description of staff positions and biographical sketches. Assigning RWPC support staff to the CEO's office helps to ensure appropriate differentiation of Recipient administration and CQM activities versus RWPC planning activities. Currently there are two vacancies in RWGA Part A and MAI-funded positions. To identify qualified candidates for vacant positions, RWGA coordinates recruitment activities with HCPH Human Resources staff and Harris County Human Resources and Risk Management. The RWGA manager collaborates with HCPH Human Resources staff to ensure that competitive compensation is offered which aligns with job duties, required experience and education. Position posting through the County-wide employment site and initial collection and review of qualified application submission is conducted by Harris County Human Resources and Risk Management. There are currently no vacancies in RWPC Support. The organizational chart included in ***Attachment 11*** illustrates the organization of RWGA.

No rent or utility expenses are budgeted under the Grantee Administration/Council Support or CQM budgets as these costs are provided in-kind by Harris County. No Program Support (capacity building) funds are budgeted in FY21 or FY22.

A.1.b) Administering Part A Funds by Fiscal Agent - *Not Applicable to the Houston EMA*

- **A.2) Grant Recipient Accountability**

A.2.a) Monitoring

i) FY21 subrecipient monitoring

Under the leadership of the RWGA Project Coordinator for Grants Management, the Quality Analysts Team (**QAT**) ensures the coordination and implementation of programmatic monitoring processes for Ryan White Part A funded service providers; provision of on-going technical assistance to providers; development and implementation of site visit guidelines, client grievances/complaints procedures and technical assistance tools; the integrity of data in the CPCDMS; and timely resolution of consumer concerns/complaints involving RW/A-funded services.

The Ryan White Grant Administration QAT performs comprehensive and standardized site visits of all agencies receiving RW/A funds annually. Comprehensive and standardized site visits were conducted in both FY20 and FY21 despite challenges related to the COVID-19 pandemic. The purpose of the site visit is to ensure that eligible clients get the highest quality care possible in accordance with all applicable federal, state, and local governing bodies and current standards of care. Annually, a Quality Analyst will email a Site Visit Notification letter to the agency within sixty (60) days of the site visit. The letter will notify the agency of the scheduled site visit date(s) and time for the entrance conference. Following the receipt of the site visit notification letter, if any subrecipient COVID clinic protocols would prohibit or otherwise impede an on-site review, the QAT are notified so that plans can be modified to conduct the site visit virtually. During the entrance conference, the Lead Quality Analyst provides a site visit agenda, a list of tasks, employee names and client records to be reviewed. Agencies will allow Quality Analysts full access to physical charts and/or electronic records for all randomly selected codes. Quality Analyst staff are allowed to review records from a remote location (e.g. RWGA Offices), when feasible, and/or when necessary to adhere to clinic COVID mitigation protocols, with agency consent. The site visit tasks will include, but not be restricted to, the following elements: all agency policies and procedures for the service(s) funded by Ryan White Part A will be reviewed to ensure compliance with applicable Federal, State and local laws, rules and regulations; interviews will be conducted with key staff regarding the programmatic component(s) of the agency and progress towards achieving contract objectives; client records will be reviewed against the applicable Site Visit Guidelines, RWGA *Standards of Care*, HRSA Monitoring Standards and contract requirements to ensure Compliance; and QAT will conduct an environmental review in the areas where clients receive services (home-based services not applicable) to determine if there are any identifiable hazards and ensure that the agency maintains all requisite licensures and certifications in accordance with city, county, state and/or federal regulations. QAT also review personnel records for staff funded by RW/A to determine if the minimum qualifications for the position(s) have been met as indicated by the contract or *Standards of Care*, *Request for Proposals*, job description, agency policy and procedure and/or Site Visit Guidelines, and the agency's supporting documentation to evaluate compliance with training requirements. Physical inventory, on-site or virtually, is done on all items purchased with RW/A funds in excess of $500.

At the completion of the review, the Quality Analyst Team will meet with the designated Agency staff member to address the initial findings. The agency will be given an hour to address the initial findings. The designated staff member will review the record(s) with the QAT. All findings not supported by the required documentation will remain and be issued a citation in the site visit report. The QAT will have an exit conference which will conclude the site visit. The exit conference will address the programmatic strengths and weaknesses of the agency. A final report that will include background of the services, the scope of the review, and the results will be emailed to the subrecipient within thirty (30) working days following the exit conference. The QAT will conduct follow-up visits on all RW/A-funded agencies, when applicable.

During the follow-up visit, the Lead Quality Analyst will discuss the site visit report, *Plan of Corrective Action*, and collect all outstanding documentation. The QAT will review the selected client records and make notations of any findings and/or areas needing additional improvements. At the end of the review, the QAT will discuss any areas of concerns and address questions. If the review indicates that the action steps in the *Plan of Corrective Action* have not been met, the agency will be asked to submit a new plan. The plan will be due within five (5) business days from

receipt of the follow-up visit report. The agency will receive a final written statement of progress close-out letter within ten (10) business days of the follow-up site visit. During FY21, 8 of 10 site visits were conducted on site. Two subrecipients scheduled virtual site visits, with entrance and exit conferences and all programmatic and fiscal review conducted virtually through MS Teams or subrecipient meeting software of choice.

ii) Process for subrecipient compliance with single audit requirements

All subrecipients are required to fully comply with all applicable RW Program audit requirements as outlined in Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Health and Human Services Awards (45CFR part 75). The annual process of ensuring subrecipient compliance with this requirement is outlined as follows. A copy of audit reports prepared in accordance with requirements stated in contract shall be submitted to the County the earlier of nine (9) months after the fiscal year-end or thirty (30) calendar days from receipt of the audit report. If the Subrecipient is a for-profit organization or entity, the Subrecipient shall provide written assurance from an independent public accountant that no profit has been realized from funds received under a RW Part A contract. The RWGA Grants Management (**GM**) Project Coordinator will document receipt of all audit reports in the Audit Report Requirements Log and forward the report to the GM Financial Analyst for review. Upon completion of review by the Financial Analyst, the GM Project Coordinator will forward the audit report to the County Audit Department. The GM Project Coordinator will ensure the audit report is copied and filed in the subrecipient's audit file. The report should be filed in the corresponding contract grant year (i.e. Audit report for fiscal year ending 12/31/20 will be filed in the 2020-21 grant year file). The GM Project Coordinator will provide the County Audit Department a copy of the Audit Report Requirements Log, if requested. The GM Project Coordinator is responsible for updating the Audit Report Requirements Log as reports are received and for sending a reminder notice 30 days prior to the due date. The GM Project Coordinator is responsible for monitoring the due date of all audit reports and notifying agencies of delinquent audit reports. Delinquent audit reports will be reported to the RWGA Manager. For FY21, all subrecipient single audit reports have been received within expected timeline.

iii) Single audit findings and corrective actions **-** No (0%) subrecipients have had any significant problems documented in independent audits submitted to RWGA within the past year.

Process and Timeline for Corrective Actions – As detailed above, once the agency receives the final site visit report, the subrecipient Executive Director or designee must submit the *Plan of Corrective Action* (**PCA**) form that stipulates the agency's plans to address the findings, as well as timeframes for implementation, to RWGA within fifteen (15) calendar days from receipt of the final site visit report. RWGA reviews the PCA form to ensure the agency has addressed all site visit findings and/or recommendations. If so, RWGA provides a written notification of approval to the subrecipient. RWGA conducts a follow-up site visit within 60 days of receipt of the agency's implementation plan to assess progress. Within 10 working days of the follow-up site visit, RWGA issues the subrecipient a written statement of progress. Identifying a fiscal or program-related concern, RWGA follows a specific PCA. Subrecipients that repeatedly have fiscal or program-related problems are provided with 1:1 technical assistance. In all cases when a concern is identified a PCA must be submitted.

No findings and no ($0.00) improper charges for grant-related expenditures or other corrective actions pursuant to independent audits have been reported in FY21. Ineligible units of service billed to the Recipient, such as those for services provided to Medicaid-eligible clients or for clients without an HIV diagnosis documented in the client record, are identified through the fiscal and programmatic monitoring processes described above. RWGA recouped $3,015 in unallowable FY20 billing, representing less than 1% of the total of $20,457,056 expended on client services. The unallowable charges were for incidences such as, no proof of diagnosis and/or no documentation that the billed visit or encounter occurred, rather than for billing RW for Medicaid or other third-party payer covered services. Recouped funds are returned to HRSA per grant guidelines. When identified, corrective actions include requiring reimbursement for ineligible units and reconciling units of service documented in the CPCDMS to reflect the disallowed units.

Number of Subrecipients that Received Technical Assistance for FY21 - At the beginning of each grant year, RWGA conducts a mandatory technical assistance (**TA**) meeting for all subrecipients. This meeting provides subrecipients with all information regarding contract compliance to which they are held accountable throughout the grant year. Topics include reporting requirements, subrecipient expense reports (invoices for reimbursement), reimbursement process requirements, site visit guidelines, programmatic performance monitoring guidelines and procedures for investigating client complaints and grievances. Unfortunately, the FY20 annual meeting was cancelled due to initial COVID-19 pandemic response activities, including recommendations to minimize large in-person gatherings. Although COVID mitigation protocols continue to impact RWGA's ability to host in-person meetings, RWGA conducted its annual TA meeting virtually in March 2021. As required, all RW/A subrecipients had staff in attendance. During the year, at least one additional mandatory TA meeting is conducted and individual subrecipients are provided TA on an "as needed" basis. During FY21 there has been no 1:1 service provider TA meetings, or additional individual TA scheduled for calendar year 2021. In addition, RWGA QM staff facilitate CQM TAs, as needed. CQM staff has conducted 1 TA during 2021 with RW/A funded providers and other RW AA colleagues. Additionally, all six RW/A and MAI-funded adult medical subrecipients have participated in CQM virtual site visits inclusive of agency specific TA.

A.2.b) Third-Party Reimbursement

i) Process to ensure subrecipients are monitoring third party reimbursement

RWGA utilizes several strategies to coordinate between RW/A and third-party payers. To ensure that all subrecipients are Medicaid-eligible, RWGA requires that agencies responding to *Request for Proposals* for services that are covered under Medicaid and/or Medicare must document Medicaid/Medicare certification in their applications. Contracts clearly dictate that RW funds are the payer of last resort and funded agencies must implement policies and procedures for screening clients' eligibility for RW-funded services. During fiscal and programmatic monitoring site visits, a statistically significant number of client records are selected and reviewed for Medicaid, Medicare, CHIP, private insurance, and the Qualified Health Plans available through the Affordable Care Act (**ACA**) Marketplace. The State of Texas has not elected to implement Medicaid Expansion under the ACA. Therefore, uninsured clients with an income below 100% FPL remain ineligible for ACA-related coverage at this time. Services charged to RW determined to be eligible for payment under other funding streams are documented by the GMT. RWGA then

recoups those monies and those funds are either reallocated by the RWPC (if recouped from the current fiscal year contract) or returned to HRSA as applicable.

ii) Jurisdiction FPL and method used to conduct screening and eligibility

During the annual *How to Best Meet the Need* process, the RWPC in collaboration with RWGA, review income eligibility requirements for each funded service category. The FPL to determine client income eligibility is determined using service priority, capacity, and non-RW service availability information. For FY21, most services require an income at or below 300% FPL. However, Local Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing, and Medical Transportation have a local financial eligibility set at 400% of FPL due to the high cost to access these services and limited available for assistance outside of the RW system of care, even for those that are gainfully employed.

RW/A and MAI-funded subrecipients in the Houston EMA document screening for third-party payer eligibility through the following required processes: all clients receiving RW/A and MAI-funded services go through a comprehensive standardized registration process via the CPCDMS upon initial intake into care. This process gathers information regarding income and eligibility for third-party coverage and is shared via the data system with all other RW-funded agencies where the client may subsequently access care. Consistent with HAB policy, clients must have an annual registration (eligibility) update to ensure eligibility information in the data system remains current. Per HAB policy, clients may verbally attest to no changes in their eligibility at the six-month interval. All RW-funded subrecipients that provide any service eligible for reimbursement under Medicaid or other health insurance benefits must maintain an ongoing standardized process to ensure all clients who are eligible for Medicaid, Medicare, private health insurance, Qualified Health Plans or other programs are screened on a continual basis to ensure RW funds are the payer of last resort. Each subrecipient's third-party payer eligibility determination process is reviewed during annual site visits to ensure its effectiveness. RWGA utilizes an automated process to verify Medicaid, Medicare and private insurance eligibility online, thereby enabling monitoring staff to review billings for third-party payer eligibility in a timely manner.

iii) How the recipient monitors the tracking and appropriate use of program income

All subrecipients must submit a *Final Financial Report* no later than 45 days after the end of the grant year. This report, supported by the subrecipient's general ledger and subject to audit by RWGA, must detail the amount of funding generated by the units of service provided under the subrecipient's agreements with the County, the funds actually expended by the subrecipient under each program's cost center, and an explanation of all program income. The program income explanation includes revenue from client sliding fees and insurance collections and details how it was expended to further the program's objectives consistent with grant requirements. For FY20, 100% of subrecipients provided these required reports and accounted for their program income consistent with grant requirements. Additionally, beginning in FY19, RWGA has expanded program income documentation to include a more detailed reconciliation of 340b generated program income revenue. Recipient facilitated training includes ongoing TA with 340b subrecipient providers on requirements for documentation submission.

A.2.c) Fiscal Oversight

i) Fiscal and program monitoring coordination - The GMT oversees fiscal reporting/monitoring and is responsible for the processing of contracts and initiating reimbursement payments to subrecipients. Both groups collectively rely on the published protocols in the *RWGA Technical Assistance Manual*, which compiles all forms, policies, procedures, and guidelines into a single manual and is furnished to all subrecipients at the beginning of the grant year. Additionally, all required forms and other documents are available on the RWGA website. The QAT, with direct support and leadership from the Financial Analyst, monitors the fiscal, budgetary, and programmatic performance of subrecipients and investigates client complaints and grievances. To ensure full integration of Fiscal and Programmatic monitoring, the Financial Analyst participates in site visit planning and coordinates financial site visits with programmatic site visits.

The Financial Analyst and the QAT are responsible for the oversight and monitoring of all fiscal reporting requirements pertaining to contracts. The QAT, with the assistance of the GMT and the Financial Analyst, ensures subrecipients submit all required reports on time and monitor subrecipients' expenditures for allowable and administrative costs. The GMT processes all subrecipient expense reports and ensures reimbursement for services in a timely manner. In addition, the team ensures that grant funds are utilized and expended according to the service priorities and funding allocations approved by the RWPC.

The protocol used by the Financial Analyst and QAT when conducting fiscal monitoring is the *RWGA Site Visit Guidelines*. Following is an excerpt of relevant tasks included in the financial review:

- Review of subrecipient's financial policies and procedures to ensure the financial management system addresses generally accepted accounting principles;
- Interviews are conducted with key financial staff assigned to RW/A and MAI;
- Standard desk review of the financial statements and a review of the last independent audit report is performed, if applicable, to determine if the agency has any noncompliance issues;
- Review of service units charged is conducted to ensure that RW is the payer of last resort;
- Client records are reviewed to ensure that legislative requirements and local guidelines regarding eligibility for services and standards of care are followed.

Fiscal monitoring activities at site visits include an intensive review of each agency's financial management infrastructure, including a review of accounting systems, purchases, payroll, billing procedures, internal controls, and cost analyses. The Financial Analyst is instrumental in implementing these reviews. Subrecipients are required to submit two fiscal reports to RWGA monthly. The *Contractor Expense Report* is used to monitor subrecipients' expenditure rates to ensure contracts are not exhausted before year-end and that no funds go unexpended. Formula, Supplemental, MAI and Carryover funds are tracked via monthly CERs submitted by subrecipients. RWGA provides monthly reports, aggregated by service category, to the RWPC to document expenditures compared to allocations. The monthly *Part A and MAI Procurement Report* (**PR**) identifies all funds allocated, obligated, and expended by service category and type, including administration, CQM and RWPC Support. RWGA further tracks and reports expenditures by Formula, Supplemental and Carryover to ensure that funds are expended in accordance with the Unobligated Balance (**UOB**) policy. WICY expenditure rates are also tracked

via the *Contractor Expense Report*. An *Administrative Cost Report* must be submitted by subrecipients monthly to ensure that the 10% aggregate cap is maintained.

ii) Process used to track formula, supplemental, unobligated, and carryover funds

RWGA implements a comprehensive subrecipient reimbursement process to help ensure 100% of Supplemental and Carryover funds are expended by the end of the grant year. This same process further ensures that no more than 5% of Formula funds will be unexpended by the end of the grant year. This data is summarized in the monthly PR provided to the RWPC, CEO and HCPH administration. Each subrecipient monthly invoice is accounted for under Formula, Supplemental or MAI funding as applicable, as are Carryover funds. This tracking capability is embedded in an MS Excel master spreadsheet that maintains all contract expenditure data. Each individual contract is set up as a separate tab in the master spreadsheet maintained by the Financial Analyst. An *Administrative Cost Report* must be submitted by subrecipients monthly to ensure that the 10% aggregate cap is maintained. The CPCDMS has automated reports that enable RWGA and subrecipients to easily monitor expenditures by unit of service. Subrecipients need only to specify date and contract code to generate the desired report. This methodology for accounting of expenditures has been successful in ensuring the EMA does not incur UOB penalties. However, relying on the processes described above, the EMA will again ensure there is less than 5% of the EMA's Formula award unexpended at the end of the FY21 grant year. The RWPC monitors service category expenditures monthly via the aforementioned PR. Additional checks and balances by RWGA (e.g. sharing monthly PRs with the RWPC, CEO and HCPH administration) assure that FY21 funds will be expended efficiently. Over the 30-year tenure of the RW Program, the EMA has submitted 100% of its end of year *Final Financial Reports* as required.

Monitoring and Redistribution of Unexpended Funds

RWGA provides monthly Part A and MAI PR to the RWPC. The RWPC reviews these reports and reallocates funds to service categories where there is documented unmet need. Additionally, the MOU between the RWPC and Recipient authorizes RWGA to transfer up to 10% of an under-spending service category to a service category with documented unmet need (e.g. waiting lists, undue delays in scheduling intake appointments, etc.). In addition, the RWPC has authorized RWGA to proactively transfer funds in the final quarter of the grant year to ensure no UOB penalties are incurred. These policies enable RWGA to quickly transfer potential unexpended funds to services where client need exceeds capacity. RWGA must report any such transfers to the RWPC no later than the RWPC's next Steering Committee meeting. This process enables RWGA to quickly adjust RWPC-approved allocations in response to exigent needs and ensures the EMA will have no more than 5% in unspent FY20 Formula funds at year end.

iii) Process for reimbursing subrecipients - RWGA implements a comprehensive fiscal monitoring process, including the timely processing of subrecipient monthly invoices. This is aided by the configuration of the RWGA Section, **wherein all programmatic and financial monitoring, technical support, oversight, and monthly invoice processing is performed within the same unit** (see ***Attachment 11***, Organizational Chart), all of whom are housed within the RWGA office suite. The CPCDMS enables real-time desk reviews of subrecipient billing and provides the backup documentation for monthly invoices. **In FY20, RWGA averaged 21 days from submission of an accurate invoice to issuance of payment to the subrecipient**. All vendor payments must be approved by the Harris County Commissioners Court during one of its two bi-monthly meetings, which may result in a small variation in processing time from year to year

depending on the Court's meeting dates. As outlined above and illustrated in the Organizational Chart, the program and fiscal staff are both located within the RWGA section. The Project Coordinator for Grants Management supervises the QAT, and the Grants Management staff work closely with the Financial Analyst to ensure comprehensive, fully integrated fiscal oversight of funded subrecipients.

All quality control, verification, and assignment to Formula, Supplemental, MAI or Carryover expenditure processing is housed within RWGA. Once an invoice has been fully reviewed, processed, and approved, it is entered into the County's automated accounting system (STARS as PeopleSoft software) and payment is issued. As a final check and balance, the RWGA manager or designee must approve all invoices in the PeopleSoft accounting system prior to a payment being issued to the subrecipient. This final approval ensures payments made to subrecipients are consistent with approved invoices. All steps of the invoice submission process are tracked by RWGA to ensure timeliness of payment goals have been met. Program and Fiscal staff utilize the CPCDMS to monitor subrecipient service provision. As these staff are all housed in RWGA, program and fiscal staff interact on an ongoing basis including convening ad-hoc meetings whenever an issue or reporting problem surfaces. Real-time data collection assures that any problems or issues needing attention are quickly identified and corrective actions can be initiated promptly, often prior to an invoice being submitted. RWGA has developed automated reports that can be run during the month to quickly identify service utilization issues and thereby initiate prompt corrective actions prior to an agency submitting their invoice. This reduces time lost to resubmitting invoices and speeds up payment. All policies and procedures, forms and other materials and information needed by subrecipients are maintained on the RWGA website (www.hcphtx.org/rwga). This provides subrecipients with access to all forms and instructions needed to submit accurate invoices and other reports.

B. MAINTENANCE OF EFFORT

See ***Attachment 12*** for the table identifying the MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for most recent complete fiscal year. The table includes a narrative that describes the process.

REFERENCES

[1] Centers for Disease Control and Prevention. *Estimated HIV incidence and prevalence in the United States, 2015–2019.* **HIV Surveillance Supplemental Report 2021**; 26 (No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed September 2021.

[2] Centers for Disease Control and Prevention. *People Coinfected with HIV and Viral Hepatitis.* http://www.cdc.gov/hepatitis/populations/hiv.htm. Page last reviewed September 21, 2020; accessed July 2021.

[3] Fox R. *Hepatitis C Infection*. Guide for HIV/AIDS Clinical Care, HRSA HIV/AIDS Bureau. January 2011.

[4] Centers for Disease Control and Prevention. *CDC Fact Sheet, The Role of STD Prevention and Treatment in HIV Prevention.* April 2010.

[5] Remien R, Stirratt M, et al. *Mental health and HIV/AIDS, the need for an integrated response.* **AIDS**. July 15, 2019, Volume 33, Issue 9. https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx

[6] Cook J, Grey D, et al. *Depressive Symptoms and AIDS-Related Mortality among a Multisite Cohort of HIV-Positive Women.* **Am J Public Health**. July 2004.

[7] Centers for Disease Control and Prevention. *HIV and Substance Use.* Last reviewed April 21,2021. https://www.cdc.gov/hiv/risk/substanceuse.html. Accessed September 2021.

[8] Lucas G, et al. *Longitudinal assessment of effects of drug and alcohol abuse on HIV-1 treatment outcomes in an urban clinic.* **AIDS**. March 2002, Volume 16, Issue 5.

[9] Centers for Disease Control and Prevention. *HIV among Incarcerated Populations in the United States.* February 18, 2018. https://www.thebodypro.com/article/hiv-in-correctional-settings. Accessed September 2021.

[10] Houston Health Department. *HIV Testing & Linkage Data – 2019*. May 2021.

[11] Houston Ryan White Grant Administration. *FY 2020 Performance Measure Highlights*. June 2021.

[12] Migration Policy Institute. *Unauthorized Immigrant Populations by Country and Region, Top Stated and Counties of Residence, 2012-16.*

[13] Syracuse University Transactional Records Access Clearinghouse Immigration Project. *Outcomes of Deportation Proceedings in Immigration Court by Nationality, State, Court, Hearing Location, and Type of Charge, Fiscal Year 2020.*

[14] Centers for Disease Control and Prevention. *Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services.* **Mortality and Morbidity Weekly Report.** Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm

[15] Strathdee, S. A., Beletsky, L., & Kerr, T. *(2015). HIV, drugs and the legal environment. The International journal on drug policy, 26 Suppl 1(0 1), S27–S32.* *https://doi.org/10.1016/j.drugpo.2014.09.001*

[16] *Guidelines for Managing Advanced HIV Disease and Rapid Initiation of Antiretroviral Therapy*. Geneva: World Health Organization; 2017. 3, RECOMMENDATION FOR RAPID INITIATION OF ART. Available from: https://www.ncbi.nlm.nih.gov/books/NBK475972/

Attachment 1. Staffing Plan, Job Descriptions and Biographical Sketches for Key Personnel

FTE = Part A unless otherwise noted

FTE	Part A Program Staff	Job Description	Required Education & Experience	Incumbent Qualifications
0.9	Manager - Ryan White Grant Administration Section *Carin Martin, MPA*	Overall management of Ryan White Part A and MAI grants; liaisons with Recipient and Planning Council	Master's Degree (MBA, MPH, MSW); 5 years mgmt. exp. in administration of health care programs in excess of $10M	MPA, 14 years Ryan White Part A experience 7 yrs. Clinical Quality Management exp.
0.95	Data Analyst/ Epidemiologist *Judy Hung, MPH*	Compilation/analysis of Epi, Demonstrated Need, Unmet Need, outcomes and utilization data; oversees ARIES imports	Master's Degree/Public Health, Biostatistics, Statistics or related field; 2 years practical experience	BA in Biology/Bus., MPH, 15+ yrs. experience as RW Part A Epidemiologist, 7+ yrs. additional data analysis experience
0.9 CQM .05 Admin	Project Coordinator/CQI *Heather Keizman, RN, MSN, WHNP-BC*	Implementation of standards of care and QI projects; conducts clinical chart reviews	Bachelor's Degree in Nursing and clinical licensure as RN; 3 yrs. paid exp. in healthcare CQI	BS & MS in Nursing, 20+ years nursing exp., 4 yrs. exp. as NP in HIV care, 10 yrs. exp. in HIV QM
0.95	Project Coordinator/ CPCDMS Data System *Sherry Jin, MPH*	System coordinator, develops training protocols, ensures implementation to all agencies, provides T/A to system users	Bachelor's/Bus. Admin, prefer Master's/Computer Science, Public Health or related field; 3 yrs. exp. in data management	MPH (Epidemiology), 20+ yrs. exp. in communicable disease surveillance, 3 years Ryan White exp.
1.0	Systems Administrator *Steve Massey*	Support of all hardware and software applications	Bachelor's/Computer Science or related field, or Microsoft certification; 3 yrs. Sys Admin	MCP, Microsoft Certified Prof., AAS, 15+ years CPCDMS experience, 20+ yrs. PC Tech exp.
1.0	Project Coordinator/ Grants Management *Eric James*	Oversees all grants management activities; coordination with Purchasing Dept. and Auditor's Office	Bachelor's; 5 yrs. paid federal/state experience in fiscal management	BA (English), 15+ yrs. RW contract management exp.,
0.95	Financial Analyst *Vacant*	Assures compliance with all OMB and PHS requirements, performs scheduled and ad-hoc audits of Subrecipients	Bachelor's/Accounting or related field; 2 to 4 years accounting experience, governmental/non-profit	Not Applicable

FTE	Part A Program Staff	Job Description	Required Education & Experience	Incumbent Qualifications
0.95	Accounting Coordinator *Sadith Soto*	Maintains spreadsheets on all contracts, reviews agency billing, processes requests for payment	AA degree/Accounting; 4 yrs. paid exp. in Financial Admin Health, 5 yrs. accounting exp.	MA (Accounting), 6 yrs. Bookkeeping/payment processing exp.; <1 yr. RW exp.
1.0	Administrative Secretary *Nancy Garcia*	Performs customary and routine administrative support activities	High School Grad; 3 yrs. of admin/clerical support exp.	25+ years administrative support exp.; <1 yr. RW exp. **Bilingual (English/Spanish)**
0.9 CQM 0.1 Admin	Project Coordinator/ QM Development, *Mauricia Chatman, MPH*	Implements quality improvement activities to improve health outcomes, & patient satisfaction.	Graduate Degree/Nursing, Health Care Admin, or related field; or BA + 5 yrs. Ryan White Program administrative experience 1 yr. health care experience required	MPH; 4 yrs. RW exp., 5 yrs. HIV services exp., <1 yr. QI exp.
0.95	Quality Assurance Coordinator *Art Delgado, BS*	Performs QA/QM reviews, conducts site visits, prepares reports, and investigates consumer complaints	BA or Master's/Social Work, Health Care Admin, Public Health or Social Science; 6 yrs. F/T paid exp. in QA	BS (Sociology), 20+ years exp. with RW Part A QA activities, **Bilingual (English/Spanish)**
1.0	Senior Quality Analyst *Robert Taylor, MA*	Performs QA/QM reviews, conducts site visits, prepares reports, and investigates consumer complaints	BA or Master's/Social Work, Health Care Admin, Public Health or Social Science; 6 yrs. F/T paid exp. in QA	MA in Divinity, 20+ years overall HIV Services with 9 years RW exp.
1.0	Ryan White Program Coordinator *Vacant*	Assists with developing and implementation of programmatic objectives and strategies across grant sections.	Bachelor's Public Health or related field; 3 yrs. exp. in program evaluation or health policies	Not Applicable

FTE	CEO Liaison and Planning Council Support Staff	Job Description	Required Education & Experience	Incumbent Qualifications
1.0	Planning Council Office of Support (RWPC/OS) Director *Victoria Williams, MSW*	CEO/Planning Council/AA liaison and ensures the legal fulfillment of all RW Part A Planning Council responsibilities.	BA required/Master's preferred in Public/Community Health, Administration, or related field	MSW, 30+ yrs. experience in the HIV/AIDS field, 20+ yrs. RWPC experience.
1.0	RWPC/OS Planner *Ricardo Mora, MPH*	Plans/facilitates implementation of comprehensive planning and needs assessment activities	Master's in Public/Community Health, Health Admin or related health sciences field	MPH, 6 years of experience in HIV epidemiology, surveillance, research and program monitoring and evaluation.
1.0	RWPC/OS Coordinator *Diane Beck*	Assists Planning Council members in understanding and carrying out duties	BA preferred; 2 years exp. in HIV-related health required	HS graduate, 20+ yrs. RWPC experience
1.0	RWPC/OS Asst. Coordinator *Rodriga Avila*	Assists the Council Coordinator in distributing information	Bachelor's degree preferred	BA, Arts. 20+ yrs. experience as volunteer in HIV, 4 yrs. RWPC experience, **Bilingual (English/Spanish)**

Appendix: A

FY 2022 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part A HIV Emergency Relief Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area **Houston EMA**, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)[5, 6]
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of people with HIV, as well as the size and demographics of the estimated population of people with HIV who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying people with HIV who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)
The EMA/TGA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative expenses only.

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[5] All statutory references are to the Public Health Service Act, unless otherwise specified.
[6] TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

Pursuant to Section 2604(c)
The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA/TGA will, for each of such populations in the eligible area expend, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of people with HIV, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
b. during the period of performance, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the health care system for the purpose of facilitating EIS for individuals diagnosed with HIV infection.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature _____ Date July 20, 2021

County Judge Lina Hidalgo

Attachment 3. HIV/AIDS Demographics Table

2019	Living HIV/AIDS Cases			New HIV Diagnoses		
	#	%	Rate	#	%	Rate
Total	30,198	100%	478	1,313	100%	21
Male	22,736	75%	726	1,056	80%	34
Female	7,462	25%	234	257	20%	8
White	5,176	17%	240	172	13%	8
African American	14,398	48%	1,274	554	42%	49
Hispanic/Latinx	9,065	30%	367	509	39%	21
Other	1,559	5%	278	78	6%	14
<13 years	49	0%	5	1	0%	0
13-24 years	1,211	4%	116	339	26%	33
25-34 years	6,202	21%	651	457	35%	48
35-44 years	6,956	23%	767	257	20%	28
45-54 years	7,522	25%	940	144	11%	18
55-64 years	6,040	20%	865	92	7%	13
65+ years	2,218	7%	311	23	2%	3
MSM	17,717	59%	-	928	71%	-
IDU	2,398	8%	-	64	5%	-
MSM/PWID	1,253	4%	-	30	2%	-
Heterosexual	8,473	28%	-	291	22%	-
Pediatric	342	1%	-	1	0%	-
Adult Other	16	0%	-	0	0%	-
Socioeconomic Indicators	**RW Clients Served**			**RW Clients with New Diagnoses**		
Total RW Clients Served	15,038	100%	-	676	100%	-
Homeless	1,498	10%	-	43	6%	-
< 100% FPL	9,238	61%	-	449	66%	-
Uninsured	9,259	62%		500	74%	

Data Source: Texas DSHS 2019 eHARS surveillance data provided as of August 2021; National Center for Health Statistics Vintage 2019 postcensal population estimates prepared in collaboration with the U.S. Census Bureau, available from https://www.cdc.gov/nchs/nvss/bridged_race.htm as of July 9 2020; socioeconomic data based on RWHAP clients served in 2020, CPCDMS; rate is calculated per 100,000 population

Attachment 4a. Houston EMA Unmet Need Framework

Reporting Template A - Unmet Need					
HOUSTON EMA			**Approach?**	**Required**	
			Linked Databases Used?	**Yes**	
Definition/Description		**Number**	**Percent**	**Data Source**	**Year(s) of Data**
A	**B**	**C**	**D**	**E**	**F**
HIV SURVEILLANCE DATA					
Late Diagnosed					
1	**Late diagnoses:** Number of people with late diagnosed HIV in the most recent calendar year in the jurisdiction based on residence at time of diagnosis. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition ≤3 months after a diagnosis of HIV infection	275	20.9%	HIV Surveillance data	2018/2019
2	**New diagnoses:** Number of people in the jurisdiction with HIV diagnosed in the most recent calendar year based on residence at time of diagnosis	1,313			
Unmet Need					
3	**Unmet need:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year	7,459	24.7%	HIV Surveillance data and linked databases[1]	2019
4	**Population size:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or any other HIV-related lab data (e.g., CD4, VL, genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period	30,198		HIV Surveillance data	2019
In Care, Not Virally Suppressed					
5	**Not virally suppressed:** Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was ≥200 copies/mL in the most recent calendar year	4,879	21.5%	HIV Surveillance data and linked databases[1]	2019

Attachment 4b. Houston EMA Unmet Need Priority Populations

Reporting Template B - Priority Populations													
HOUSTON EMA												**Approach?**	**Required**
		Totals	**Numerical Inputs**				**Auto-Calculated Percentages**						
							Within Categories			**Across Categories**			
	Category	**# of People Living with Diagnosed HIV infection**	**# New Diagnoses**	**# Late Diagnoses**	**# Unmet Need**	**# In Care, Not Virally Suppressed**	**% Late Diagnosed**	**% Unmet Need**	**% In Care, Not Virally Suppressed**	**% Late Diagnosed**	**% Unmet Need**	**% In Care, Not Virally Suppressed**
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**
HIV SURVEILLANCE DATA													
1	Total	30,198	1,313	275	7,459	4,879	20.9%	24.7%	21.5%	100.0%	100.0%	100.0%
2	**PRIORITY POPULATIONS (Determined by Jurisdiction)**												
	African American	14,398	587	98	3,691	2,722	16.7%	25.6%	25.4%	35.6%	49.5%	55.8%
	Hispanic/Latinx	9,065	509	126	2,271	1,229	24.8%	25.1%	18.1%	45.8%	30.4%	25.2%
	MSM/PWID	1,253	34	11	312	240	32.4%	24.9%	25.5%	4.0%	4.2%	4.9%

Attachment 5. Co-occurring Conditions Table*

Co-occurring Conditons	General Population	PLWH	Data Sources
Hepatitis C	Estimated to be 735 per 100,000	Estimated to be 16%	*Houston State of Health* (houstonstateofhealth.com) – annual Hepatitis C rate 2016*;* Hepatitis C testing data 2016, Texas DSHS
Chlamydia	32,883 cases 525 per 100,000	793 cases 2.7%	Texas STD*MIS and eHARS 2018 data; National Center for Health Statistics 2018 postcensal population estimate
Gonorrhea	10,040 cases 160 per 100,000	851 cases 2.9%	Texas STD*MIS and eHARS 2018 data; National Center for Health Statistics 2018 postcensal population estimate
Early Syphilis[1]	1,586 cases 25 per 100,000	719 cases 2.5%	Texas STD*MIS and eHARS 2018 data; National Center for Health Statistics 2018 postcensal population estimate
Mental Illness	Estimated to be 14%	Estimated to be 54%	*Houston State of Health* (houstonstateofhealth.com) – mental health data 2017*; 2020 Houston HIV Care Services Needs Assessment*
Substance Abuse	Estimated to be 6.2%	Estimated to be 37%	SAMHSA *National Surveys on Drug Use and Health 2018*; US Census 2018 population estimate; *2020 Houston HIV Care Services Needs Assessment*
Homelessness	3,605 cases 61 per 100,000	Estimated to be 11%	*Coalition for the Homeless, Houston/Harris County/Fort Bend County/Montgomery County 2017 Point-in-Time Count Report*; US Census population estimates 2016; *2020 Houston HIV Care Services Needs Assessment*
Former Incarceration	Estimated to be 193 per 100,000	Estimated to be 12%	Harris County Adult Criminal Justice Data Sheet 2014; *2020 Houston HIV Care Services Needs Assessment*

[1] Includes Primary, Secondary and Early Latent Syphilis

* *TDHS does not collect incidence data for co-occurring conditions so this data is not available*

Attachment 6.
Letter of Assurance from the Chair of the Houston Ryan White Planning Council

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Suite 240, Houston, Texas 77027

August 5, 2021

Dear Ms. Abrahms-Woodland:

This letter assures the following:

a.i.) The most recent comprehensive needs assessment was conducted in 2019 and 2020.

a.ii.) Over 93 members of the Houston Area community participated in the development of the 2017-2022 Houston Area Comprehensive HIV Prevention and Care Services Plan. Of these individuals, at least 35% (33) were people living with HIV and 24% (22) were people living with HIV and non-aligned consumers who use Ryan White funded services. At least 7 of these individuals were also active members of the 2019 and 2020 Texas HIV Syndicate, which is responsible for developing the Statewide Coordinated Statement of Need (SCSN). The Texas Department of State Health Services (TDSHS) included significant portions of the 2017-2022 Houston Area Comprehensive HIV Services Plan in the SCSN.

b.i.a) Data from the 2020 Comprehensive Needs Assessment, 2020 HIV Care Continuum, 2020 unmet need framework estimates, 2019 Epidemiological Profile and 2020 Supplement were used in the FY 2022 priority setting and allocations process to ensure that the needs of populations with HIV, including those with unmet need, disparities in access and services, historically underserved communities, and unaware of their HIV status were addressed.

b.i.b) Using the local 2019 Epi Profile, 2020 Epi Supplement and other data from the TDSHS, resources were allocated in accordance with the local demographic incidence of HIV and AIDS, including appropriate allocations for services for women, infants, children, and youth.

b.ii) In 2021, there are over 54 active members of the Planning Council and its standing committees. Of these individuals, 28 (52%) are people living with HIV (PLWH) and 23 (43%) are PLWH who are non-aligned, Ryan White consumers. Through discussions at meetings and data from the 2020 Comprehensive Needs Assessment, which documented the needs of over 589 consumers, PLWH were actively involved in planning and allocations and the priorities of PLWH were considered throughout the process.

b.iii) The FY 2021 period of performance formula, supplemental, and MAI funds awarded to the EMA were expended according to the priorities established by the Planning Council.

c.) The annual, all-day Houston Planning Council membership training took place on 01/21/21. Training included a review of: legislative mandates, PC bylaws and policies, and other topics pertinent to effective PC participation. Members who were appointed late in the year received a half-day of training on 02/09/21 or 08/06/21. The first 30 minutes of all Council meetings are dedicated to topics such as the: Houston HIV Care Continuum (04/08/21), Priority Setting and Allocations processes (07/08/21), Intimate Partner Violence and HIV (06/10/21), Trauma Informed Care (TBD), the Opioid Epidemic (10/14/21) and more.

d.) The 2021 Assessment of the Administrative Mechanism documented the timely allocation/contracting of funds and payments to contractors.

Sincerely,

Allen W. Murray

Allen Murray, Chair, Houston Ryan White Planning Council

Attachment 7. Coordination of Services and Funding Streams Table

Funding Source	FY 2021 Funding Amount		Number of Agencies	Prevention Services				Core Medical-related Services														Supportive Services																					
	Dollar Amount	%			HIV Testing & Policy Alignment Efforts	PLWH/Partner Prevention Services	Condom Distribution		Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatment (Tx)	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium &Cost-Sharing	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Mgmt, incl. Tx Adherence	Substance Abuse Outpatient Care		Non-Medical Case Management Services	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Linguistic Services	Medical Transportation	Other Professional Services: Legal Services	Outreach Services	Psychosocial Support Services	Referral for Health Care & Support Services	Rehabilitation Services	Respite Care	Substance Abuse Services (residential)	Treatment Adherence Counseling
Part A	$24,442,165	21%	10						X		X	X		X					X		X		X		X				X		X									
Part B	$53,291,471	46%	7							X		X		X		X																								
Part C	$1,661,067	1%	3		X	X			X												X		X		X				X											
Part D	$1,259,669	1%	3						X											X			X																	
Part F	$205,000	0%	1																																					
CDC	$10,170,217	9%	11		X	X	X						X													X					X		X							
SAMHSA	$-	0%																																						
HOPWA	$12,386,018	11%	13																				X	X			X			X										
Federal	$200,000	0%	1																																					
State	$2,980,969	3%	6										X	X			X	X					X					X												
Local	$1,507,843	1%	1																																					
EHE	$6,698,645	6%	6		X	X			X																X					X										
CARES Act	$1,170,182	1%	1						X																X															
Total	$115,973,246	100%																																						

Table 8. HIV Care Continuum Table

Diagnosis-Based HIV Care Continuum Services Table						
Stages of the HIV Care Continuum						**Service Category (One or More May Apply)**
I. Diagnosed: Percentage of persons aged ≥13 years with HIV infection who know their serostatus.						Early Intervention Services
Goal	Prevent new HIV infections.	**Objective**	By 2025, increase the percentage of people with HIV infection who know their serostatus to at least 95 percent. (Source: HNSP, Indicator 1***)			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. Data Source: NHSS 202012 (Reference Source: Vol 31*).	31,080		**Denominator:** Number of persons aged ≥13 years with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year. ****			
Baseline						
Numerator (same as above)	30,149		**Denominator** (same as above)	30,149	100%	
II. Receipt of Care: Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.						Outpatient/Ambulatory Medical Care (Primary Care) Medical Case Management Local Pharmaceutical Assistance Oral Health Care Mental Health Services Health Insurance Premium/Cost-Sharing Assistance Home & Community-based Health Services Substance Abuse Services - Outpatient Early Intervention Services Emergency Financial Assistance Medical Nutritional Therapy Hospice Services Non-medical Case Management (Service Linkage) Referral for Health Care & Support Services Medical Transportation Services Outreach Services Linguistic Services Legal Services
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	24,850		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	30,149	82%	
Baseline						
Numerator (same as above)	22,695		**Denominator** (same as above)	30,149	75%	
III. Retained in Care: Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.						Outpatient/Ambulatory Medical Care (Primary Care) Medical Case Management Local Pharmaceutical Assistance Oral Health Care Mental Health Services Health Insurance Premium/Cost-Sharing Assistance Home & Community-based Health Services Substance Abuse Services - Outpatient Early Intervention Services Emergency Financial Assistance Medical Nutritional Therapy Hospice Services Non-medical Case Management (Service Linkage) Referral for Health Care & Support Services Medical Transportation Services Outreach Services
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	26,250		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	30,149	87%	

Diagnosis-Based HIV Care Continuum Services Table

Stages of the HIV Care Continuum						Service Category (One or More May Apply)
Baseline						Linguistic Services Legal Services
Numerator (same as above)	18,230		**Denominator (same as above)**	30,149	60%	
IV. Viral Suppression: Percentage of persons with diagnosed HIV infection whose most recent HIV viral load test in the past 12 months showed that HIV viral load was suppressed.						Outpatient/Ambulatory Medical Care (Primary Care) Medical Case Management Local Pharmaceutical Assistance Mental Health Services Health Insurance Premium/Cost-Sharing Assistance Home & Community-based Health Services Substance Abuse Services - Outpatient Early Intervention Services Emergency Financial Assistance Medical Nutritional Therapy Non-medical Case Management (Service Linkage) Referral for Health Care & Support Services Medical Transportation Services Linguistic Services
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200 copies/mL at the most recent viral load test. Data Source: NHSS 202012 (Reference Source: Vol 25 No	22,500		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	30,149	75%	
Baseline						
Numerator (same as above)	17,845		**Denominator (same as above)**	30,149	59%	
V. Linkage to Care: Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.						Outpatient/Ambulatory Medical Care (Primary Care) Medical Case Management Mental Health Services Substance Abuse Services - Outpatient Early Intervention Services Emergency Financial Assistance Non-medical Case Management (Service Linkage) Referral for Health Care & Support Services Medical Transportation Services Linguistic Services
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with newly diagnosed HIV infection who are linked to HIV medical care within one month of diagnosis to at least 95%. (Source: NHSP, Indicator 5***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	1025		**Denominator:** Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.	1,269	81%	
Baseline						
Numerator (same as above)	802		**Denominator (same as above)**	1,269	63%	

Attachment 9a. Part A Service Category Plan Table

Service Categories	2021 Allocated					2022 Anticipated				
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Priority #	Anticipated Amount	Unduplicated Clients	Service Unit Definition	Service Units
Core Medical Services										
AIDS Pharmaceutical Assistance (LPAP)	3	$ 1,797,832	5600	1 Unit = 1 Local Med Program Transaction & Cost of Med	N/A	3	$ 1,910,360	5600	1 Unit = 1 Local Med Program Transaction & Cost of Med	N/A
Health Insurance Premium & Cost Sharing Assistance	5	$ 1,373,566	2150	Actual Cost of Assistance	N/A	5	$ 1,483,137	2150	Actual Cost of Assistance	N/A
Medical Case Management (Incl. Treatment Adherence)	2	$ 1,719,523	6700	1 Unit=15'	77200	2	$ 1,930,000	6700	1 Unit=15'	77200
Medical Nutrition Therapy	8	$ 339,033	520	1 Unit = 1 Visit or 90 days of Supplements	2165	8	$ 341,395	520	1 Unit = 1 Visit or 90 days of Supplements	2165
Oral Health Care	4	$ 165,252	300	1 Unit=1 Visit	1530	4	$ 166,404	300	1 Unit=1 Visit	1530
Outpatient/ Ambulatory Health Services	1	$ 10,890,012	8740	1 Unit=1 Visit	39800	1	$ 10,965,788	8740	1 Unit=1 Visit	39800
Substance Abuse Outpatient Care	10	$ 45,677	35	1 Unit = 1 Group or Individual Session	1300	10	$ 45,677	35	1 Unit = 1 Group or Individual Session	1300
CORE MEDICAL TOTAL		$ 16,330,895.00					$ 16,842,761.00			
Support Services										
Emergency Financial Assistance	15	$ 1,534,745	1605	1 Unit = 1 Local Program Transaction & Actual Cost of Assistance	N/A	15	$ 1,545,439	1605	1 Unit = 1 Local Program Transaction & Actual Cost of Assistance	N/A
Medical Transportation	14	$ 421,971	3375	1 Unit = 1 mi., 1 bus pass, or 1 $20 gas card	N/A	14	$ 424,911	3375	1 Unit = 1 mi., 1 bus pass, or 1 $20 gas card	N/A
Non-Medical Case Management Services	13	$ 1,258,234	7500	1 Unit=15'	63350	13	$ 1,267,002	7500	1 Unit=15'	63350
Outreach Services	17	$ 417,094	700	1 Unit=15'	7636	17	$ 420,000	700	1 Unit=15'	7636
SUPPORT TOTAL		$ 3,632,044.00					$ 3,657,352.00			
GRAND TOTAL		$ 19,962,939.00					$ 20,500,113.00			

FY 2021 PART A Allocations		
	Core Medical Services	Support Services
2021 Percentages	81.81%	18.19%

FY 2022 PART A Allocations		
	Core Medical Services	Support Services
2022 Percentages	82.16%	17.84%

FY 2021 PART A + MAI Allocations		
	Core Medical Services	Support Services
2021 Percentages	83.66%	16.34%

FY 2022 PART A + MAI Allocations		
	Core Medical Services	Support Services
2022 Percentages	83.98%	16.02%

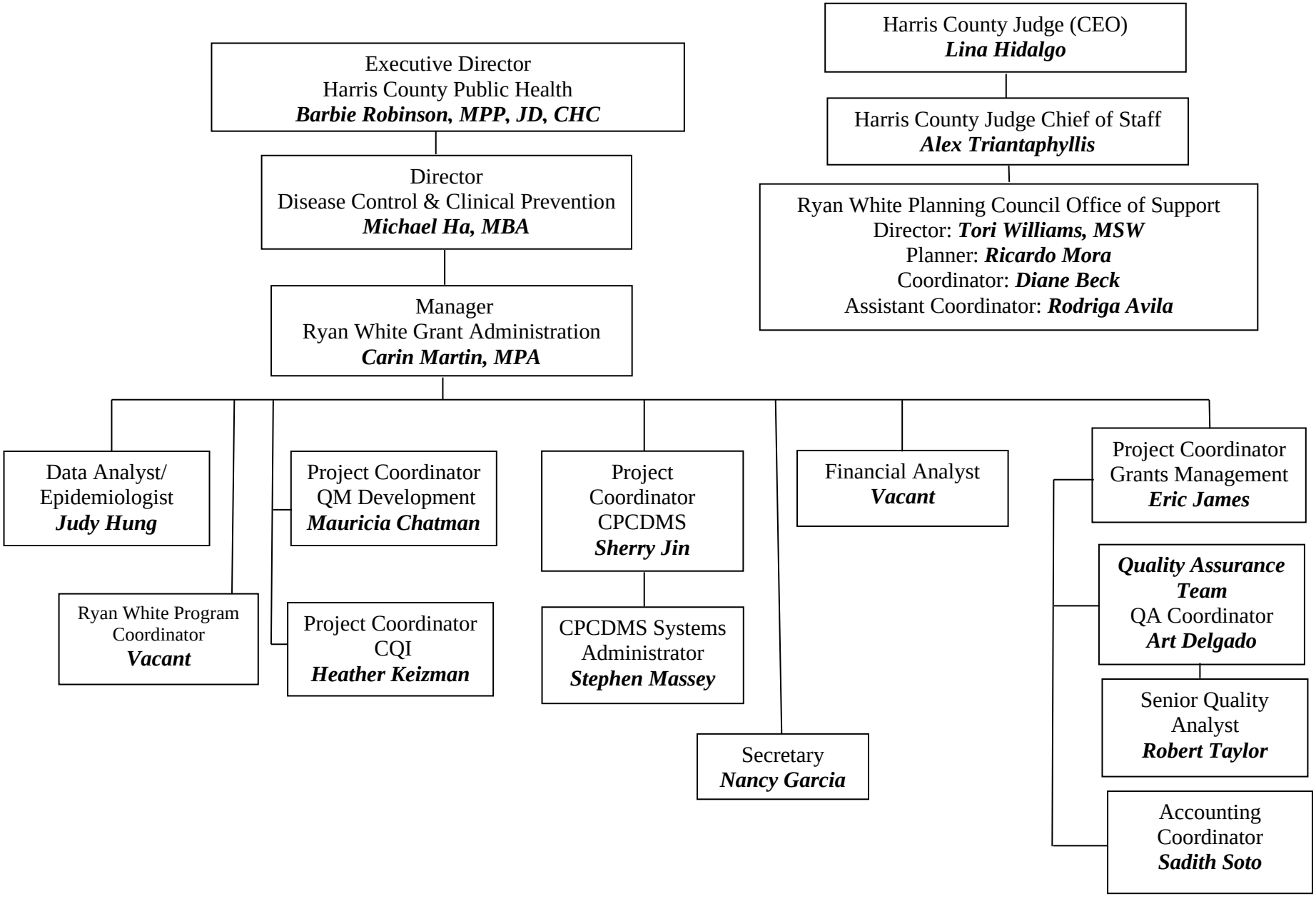
Attachment 9b. MAI Service Category Plan Table

Service Categories	2021 Allocated						2022 Anticipated					
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Priority Population(s)	Priority #	Anticipated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Subpopulation(s) of Focus
Core Medical Services												
Medical Case Management (Incl. Treatment Adherence)	2	$ 320,100.00	5908	1 Unit=15'	16005	African American; Hispanic	2	$ 320,100.00	5908	1 Unit=15'	16005	African American; Hispanic
Outpatient/ Ambulatory Health Services	1	$ 1,950,251.00	1669	1 Unit=1 Visit	7705	African American; Hispanic	1	$ 2,002,859.00	1669	1 Unit=1 Visit	7705	African American; Hispanic
CORE MEDICAL TOTAL		$ 2,270,351.00						$ 2,322,959.00				
Support Services												
SUPPORT TOTAL		$ -						$ -				
GRAND TOTAL		$ 2,270,351.00						$ 2,322,959.00				

FY 2021 MAI Allocations		
	Core Medical Services	Support Services
2021 Percentages	100.00%	0.00%

FY 2022 MAI Allocations		
	Core Medical Services	Support Services
2022 Percentages	100.00%	0.00%

Attachment 11. Houston Ryan White Part A Program Organizational Chart



Attachment 12. Maintenance of Effort Documentation

Part A Maintenance of Effort Report - Maintenance of Effort Report Limited to HIV-Related Core Medical and Support Services Expenditures

HOUSTON EMA - NON-FEDERAL EXPENDITURES

FY Prior to Application (Actual)	Current FY of Application (Estimated)
Actual prior FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services. Amount: $__≥ 10,618,874___	Estimated current FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services. Amount: $_≥ 10,618,874_

Description of Process - The Houston EMA monitors Maintenance of Effort (**MOE**) using the following process: the sole County organizational unit with consistent local HIV-related eligible Core Medical and Support Service expenditures under Ryan White MOE guidelines is Harris Health System (**HHS**). Formerly the Harris County Hospital District, HHS is a governmental entity that provides health care services open to all residents of Harris County. Per this procedure, the Manager of Ryan White Grant Administration (**RWGA**) contacts the Manager of Grants Accounting at the HHS in June of each year to determine the actual level of MOE-eligible HIV-related expenditures for the preceding fiscal year. This information is recorded and aggregated by RWGA using a form furnished by HRSA. Harris County has determined that no other Ryan White-eligible Core Medical and Support Service categories will be included in the MOE base. As Harris County has budgetary approval over the HHS's annual budget, actual budgetary line-item allocations and subsequent expenditures may be appropriately documented and tracked for the purposes of monitoring the MOE. Harris County has determined it will report actual expenditures up to, but not exceeding, the total amount of eligible MOE expenditures reported in the previous grant year. There have been no changes in the data set or purpose of expenditures in the Recipient's MOE report.

RWHAP PART A BUDGET SUMMARY
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

	Part A			Minority AIDS Initiative (MAI)			Total
Object Class Categories	**Administration**	**CQM**	**HIV Services**	**Administration**	**CQM**	**HIV Services**	
a. Personnel	$ 1,055,802	$ 159,813	$ -	$ -	$ -	$ -	**$ 1,215,615**
b. Fringe Benefits	$ 477,551	$ 67,844	$ -	$ -	$ -	$ -	**$ 545,395**
c. Travel	$ 25,000	$ 5,200	$ -	$ -	$ -	$ -	**$ 30,200**
d. Equipment	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
e. Supplies	$ 24,065	$ 13,939	$ -	$ -	$ -	$ -	**$ 38,004**
f. Contractual	$ 177,673	$ 177,673	$ 20,500,113	$ -	$ -	$ 2,322,959	**$ 23,178,418**
g. Other	$ 186,479	$ 62,580	$ -	$ -	$ -	$ -	**$ 249,059**
Direct Charges	**$ 1,946,569**	**$ 487,049**	**$ 20,500,113**	**$ -**	**$ -**	**$ 2,322,959**	**$ 25,256,690**
Indirect Charges	**$ 169,915**	**$ -**		**$ -**	**$ -**		**$ 169,915**
TOTALS	**$ 2,116,484**	**$ 487,049**	**$ 20,500,113**	**$ -**	**$ -**	**$ 2,322,959**	**$ 25,426,605**
Program Income							**$ -**

2022 Funding Ceiling: $ 25,664,273

Part A Funding $ 23,103,646
MAI Funding $ 2,322,959
Total: **$25,426,605.01**

Administrative Budget 10%:
Part A Within Limit **MAI** Within Limit

CQM Budget 5%:
Part A Within Limit **MAI** Within Limit

PART A ADMINISTRATIVE BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$40,186	1.00	Nancy Garcia, Administrative Secretary	Performs customary and routine administrative support activities	$ 40,186
$56,828	1.00	Vacant, RW Program Coordinator	Manages administrative and support functions, supervises the secretary position	$ 56,828
$87,516	0.95	Art Delgado, Quality Assurance Coordinator	Performs QA/QM reviews, conducts site visits, prepares reports, and investigates consumer complaints	$ 83,140
$67,237	1.00	Robert Taylor, Senior Quality Analyst	Performs QA/QM reviews, conducts site visits, prepares reports, and investigates consumer complaints	$ 67,237
$55,638	0.95	Sadith Soto, Accounting Coordinator	Maintains spreadsheets on all contracts, reviews agency billing process requests for payment	$ 52,856
$84,955	1.00	Eric James, Project Coordinator/Grants Management	Oversees all grants management activities; coordination with Purchasing Dept. and Auditor's Office	$ 84,955
$74,802	0.95	Sherry Jin, Project Coordinator/ CPCDMS Data System	System coordinator, develops training protocols, ensures implementation to all agencies, provides T/A to system users	$ 71,062
$89,075	1.00	Steve Massey, Systems Administrator	Support of all hardware and software applications	$ 89,075
$66,371	0.95	Vacant, Financial Analyst	Assures compliance with all OMB and PHS requirements, performs scheduled and ad-hoc audits of Subrecipients	$ 63,052
$82,992	0.95	Judy Hung, Data Analyst/Epidemiologist	Compilation/analysis of Epi, Demonstrated Need, Unmet Need, outcomes and utilization data; oversees ARIES imports	$ 78,842
$99,000	0.90	Carin Martin, Program Manager	Overall management of Ryan White Part A and MAI grants; liaisons with Grantee and Planning Council	$ 89,100
$72,164	0.10	Mauricia Chatman, Project Coordinator - Quality Management Development	Adminstrative duties in support of clinical quality improvement activities	$ 7,216
$97,388	0.05	Heather Keizman, Project Coordinator - Clinical Quality Improvement	Adminstrative duties in support of clinical quality improvement activities	$ 4,869
			Personnel Total	**$ 788,420**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
7.38%	Social Security	$ 58,185
	Group Health $15,000 per FTE	$ 165,000
15.10%	Retirement	$ 119,051
0.88%	Workers Comp	$ 6,938
0.32%	Unemployment	$ 2,523
	Fringe Benefit Total	**$ 351,698**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
0.575	1,014	Nancy Garcia, Administrative Secretary	Staff travel for administrative support including coordination of contracts, vendor payments, meeting set up, etc.	$ 583
0.575	1,014	Vacant, Program Coordinator	Staff travel for administrative support including coordination of contracts, vendor payments, meeting set up, etc.	$ 583
0.575	1,014	Art Delgado, Quality Assurance Coordinator	Staff travel to site visits throughout the EMA	$ 583
0.575	1,014	Robert Taylor, Senior Quality Analyst	Staff travel to site visits throughout the EMA	$ 583
0.575	1,014	Vacant, Financial Analyst	Staff travel to site visits throughout the EMA	$ 583
0.575	1,017	Carin Martin, Program Manager	Staff travel to CQM meetings, site visits, and community events throughout the EMA	$ 585
			Local Travel Sub-Total	**$ 3,500**

Long Distance			
Type of Travel	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification** *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	**Amount**
In and Out of State	Vacant, Financial Analyst	2 trips for HRSA approved training related to monitoring and OMB requirements, including mileage or airfare as applicable (2 round trips fligts at $600 ea), hotel (2 trips for up to 4 nights at $250 ea.), meals (2 trips of up to 4 days of meals for $55 daily) and parking.	$ 4,000
In and Out of State	Carin Martin, Program Manager	4 quarterly Texas/Louisiana HIV care coordination meetings and 1 Part B HIV care coordination meeting, mileage (2 trips up to $300 ea.) or airfare as applicable (3 round trips fligts at $600 ea), hotel (5 trips for up to 12 total nights at $250 ea.), meals (5 trips for up to 4 days of meals for $55 daily) and parking.	$ 6,500
		Long Distance Travel Sub-Total	**$ 10,500**
		Travel Total	**$ 14,000**

Equipment *[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]*		
List of Equipment	**Budget Impact Justification** *[Description of need to carry out the program's objectives/goals]*	**Amount**
	Equipment Total	**$ -**

Supplies *[Supplies is defined as property with a unit cost under $5,000. **Note:** Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*		
List of Supplies	**Budget Impact Justification** *[Description of need to carry out the program's objectives/goals]*	**Amount**
Office Supplies	Includes pens, pencils, notepads, notebooks for public documents, toner, report folders and more, essential for completion of daily operation. No unit greater than $5,000.	$ 8,000
Office Supplies - Computers/Laptops/Printers	Computers, Laptops, Printers for eleven FTE positions to replace obsolete equipment to facilitate more efficient completion of program tasks associated with fiscal and programmatic site visits and admin operations. No unit greater than $5,000.	$ 6,288
Office Supplies - Office furniture, file cabinets, etc.	Office furniture, file cabinets, etc. to replace worn office furniture to create more efficient work environment. No unit greater than $5,000.	$ 5,857
	Supplies Total	**$ 20,145**

Contractual			
List of Contract	**Deliverables**	**Budget Impact Justification** *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	**Amount**
Computer consulting	CPCDMS maintenance and development	50% of enhancements and maintenance costs for the CPCDMS client-level data system targeted to EMA activities (approximately 1,045 hrs x $170/hr.)	$ 177,673
		Contracts Total	**$ 177,673**

Other *[List all costs that do not fit into any other category]*		
List of Other	**Budget Impact Justification** *[Impact on the program's objectives/goals]*	**Amount**
Association Subscription	Supports continuing education and knowledge for credentialed staff to promote high level of expertise in fiscal and programmatic compliance related skills	$ 1,200
Equipment Rental	Fees for rental of copiers & postage machine (not including cost of postage), and other office equipment	$ 14,363
Equipment Maintenance	Maintenance fees for copiers and other office equipment	$ 15,000
Postage	Postage and delivery services (e.g., FedEx) necessary to send printed information to HRSA, service providers and the public	$ 1,000
Publications	Supports continuing education and knowledge for credentialed staff to promote high level of expertise in fiscal and programmatic compliance related skills	$ 3,000
Advertising	Cost of advertising for personnel positions, RFP announcements and stakeholder notices	$ 3,721
Computer Software	Software License Fees & Upgrades	$ 5,862
AV Equipment	Equipment to facilitate effective meetings and presentation for consumer, providers, and other stakeholders	$ 2,000
Telecommunications	Cost of local, cellular and long distance tele-communications (phone, fax and cell)	$ 7,080
Seminar/Conferences	Conference registration fees and appropriate professional training fees for admin staff development	$ 8,616
Fees and Services	Temporary Personnel as needed	$ 23,637
	Other Costs Total	**$ 85,479**

Total Direct Cost	
	$ 1,437,415

Indirect Cost			
Type of Indirect Cost *[Select from dropdown list]*	**Rate** *[Insert rate below]*	**Insert Base**	**Total [Insert Indirect]**
Provisional			$ 169,915

Part A Administrative Total	
	$ 1,607,329

PART A PLANNING COUNCIL BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$82,525	1.00	Victoria Williams, RWPC Director	Responsible for overall functioning of RW Planning Council, supervises all support staff	$ 82,525
$77,918	1.00	To be hired 12/21, Health Planner	Responsible for coordinating comprehensive planning and needs assessment activities, analyzing and presenting data	$ 77,918
$58,800	1.00	Diane Beck, RWPC Coordinator	Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mail outs, educational events, etc.)	$ 58,800
$48,139	1.00	Rodriga Avila, Assistant Coordinator	Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduleing of meetings, mail outs, reception duties, etc.)	$ 48,139
			Personnel Total	**$ 267,382**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
7.38%	Social Security	$ 19,733
	Health Insurance (4 x $14,900)	$ 59,600
15.10%	Retirement	$ 40,375
0.88%	Workers Comp	$ 2,353
0.32%	Unemplyment Insurance	$ 856
	Incentives/allowances	$ 2,937
	Fringe Benefit Total	**$ 125,853**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
.58/mile	86	Victoria Williams, Director	Local mileage and parking in the six county planning area to attend adminiatrative meetings with the CEO and other County representatives, coordinate educational efforts and administer the program	$ 50
.58/mile	86	To be hired 12/21, Health Planner	Local mileage and parking in the six county planning area to attend planning meetings, collect needs assessment data and coordinate educational efforts	$ 50
.58/mile	86	Diane Beck, RWPC Coordinator	Local mileage and parking in the six county planning area to attend planning meetings, collect needs assessment data and coordinate educational efforts	$ 50
.58/mile	86	Rodriga Avila, Assistant Coordinator	Local mileage and parking in the six county planning area to attend administrative meetings, coordinate educational efforts and administer the program	$ 50
			Local Travel Sub-Total	**$ 200**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
Out of EMA travel	Victoria Williams, Director	Mileage or airfare as applicable (2 trip up to $375 ea.), hotel (up to 7 total nights at $250 ea.), meals (up to 7 days of meals for $55 daily) and parking for Ryan White related meetings to coordinate efforts with other planning and educational groups and the national Ryan White Program	$ 2,900
Out of EMA travel	Health Planner	Mileage or airfare as applicable (4 trip up to $375 ea.), hotel (up to 10 total nights at $250 ea.), meals (up to 10 days of meals for $55 daily) and parking for Ryan White related meetings to coordinate efforts with other planning and educational groups and the national Ryan White Program	$ 5,000
Out of EMA travel	Ryan White Volunteer	Mileage or airfare as applicable (1 trip up to $375 ea.), hotel (up to 7 total nights at $250 ea.), meals (up to 7 days of meals for $55 daily) and parking for Ryan White related meetings to coordinate efforts with other planning and educational groups and the national Ryan White Program	$ 2,900
		Long Distance Travel Sub-Total	**$ 10,800**
		Travel Total	**$ 11,000**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note**: Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
General consumable office supplies	Includes pens, pencils, notepads, notebooks for public documents, toner, report folders and more, essential for completion of daily operation. No unit greater than $5,000.	$ 3,420
Office Supplies - Computers, tablets and other	Computers, Laptops, Printers to replace obsolete equipment	$ 500
	Supplies Total	**$ 3,920**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
		Contracts Total	**$ -**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
Planning	Reimbursement for travel and child care which allows volunteers to fulfill their mandated planning responsibilites; meals provided at meetings for 39+ member Planning Council that meets 80+ times annually for Council, Subcommittees and Workgroups.	$ 18,000
Education	Education for Council members, other Ryan White volunteers, consumers and others about the Ryan White Program, the Council's roles and responsibilities and the Greater Houston HIV care system. Includes development and printing of community HIV resouce guide.	$ 28,000
Communication	Advertising; technical assistance costs for the webpage and app; interpretation and translation services; postage machine rental; copier rental; and more	$ 55,000
	Other Costs Total	**$ 101,000**

Total Direct Cost

	$ 509,155

Indirect Cost

Type of Indirect Cost [*Select from dropdown list*]	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

Part A Planning Council Total

	$ 509,155

PART A CLINICAL QUALITY MANAGEMENT BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 72,164	1.00	Mauricia Chatman, Project Coordinator - Quality Management Development	Implements case management chart review, QI projects, and client satisfaction activities, oversees CM training program	$ 72,164
$ 97,388	0.90	Heather Kiezman, Project Coordinator - Clinical Quality Improvement	Implementation of standards of care and QI projects; conducts clinical chart reviews	$ 87,649
			Personnel Total	**$ 159,813**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
7.38%	Social Security	$ 11,794
	Group Health $15,000 per FTE	$ 30,000
15.10%	Retirement	$ 24,132
0.88%	Workers Comp	$ 1,406
0.32%	Unemployment	$ 511
	Fringe Benefit Total	**$ 67,844**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
0.575	609	Mauricia Chatman, Project Coordinator - Quality Management Development	Staff travel to CQM meetings, site visits, and community events throughout the EMA	$ 350
0.575	609	Heather Keizman, Project Coordinator - Clinical Quality Improvement	Staff travel to CQM meetings, site visits, and community events throughout the EMA	$ 350
			Local Travel Sub-Total	**$ 700**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
In and Out of State	Mauricia Chatman, Project Coordinator - Quality Management Development	2 trips for Texas HIV care coordination meetings and Quality related training, including mileage or airfare (2 trips up to $300 ea.), hotel (2 trips up to 4 total nights at $250 ea.), meals (2 trips up to 4 days of meals for $55 daily) and parking.	$ 3,000
In State	Heather Keizman, Project Coordinator - Clinical Quality Improvement	1 trips for Texas HIV care coordination meetings, including mileage or airfare as applicable (1 trip up to $300 ea.), hotel (up to 4 total nights at $250 ea.), meals (up to 4 days of meals for $55 daily) and parking.	$ 1,500
		Long Distance Travel Sub-Total	**$ 4,500**
		Travel Total	**$ 5,200**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note** : Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
Office Supplies	Supplies are essential for completion of daily operation and CQM tasks. Includes pens, pencils, notepads, notebooks for public documents, toner, report folders and more.	$ 1,000
Educational Supplies	Meeting supplies and materials such as branded totes, pens, notepads, refreshments, educational materials (i.e. fact sheets, QM training materials, books, etc.) to promote ongoing participation of consumers and providers in QM improvement activities and QM focused trainings. No unit greater than $5,000.	$ 7,582
Office Supplies - Mobile/laptop equipment	Laptops, mobile printers, etc. replace of equipment to facilitate more efficient completion of program tasks associated with clinical quality management site visits. No unit greater than $5,000.	$ 5,357
	Supplies Total	**$ 13,939**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
QM Computer consulting	CPCDMS maintenance and development	50% of enhancements and maintenance costs for the CPCDMS client-level data system targeted to EMA quality management activities (approximately 1,045 hrs x $170/hr.). CPCDMS QM support includes development and maintenance of client level data integration for client samples during QM site visits, provider and QM staff reports to track clinical outcomes; customized queries for data to support implementation of targeted interventions for Black MSM and unstably housed population, consumer and RWPC data requests for quality improvement and community education, and more.	$ 177,673
		Contracts Total	**$ 177,673**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
Subscriptions for staff profession association journals/memberships	Supports continuing education and knowledge for credentialed staff to promote high level of expertise in QM and HIV related skills	$ 1,000
HRSA approved supplies for QM initiative client incentives.	To ensure ongoing participation of consumers in QM improvement activities, such as client satisfaction and focus groups	$ 8,000
Training Registration Fees	Supports continuing education and knowledge for credentialed staff to promote high level of expertise in QM and HIV related skills. Improvement Advisor Professional Development Program facilitated by the Institute for Healthcare Improvement ($16,500 per participant)	$ 33,000
Contract Fees	Temporary Personnel/Consultant work to support feasibility study for Housing pilot to explore innovative approaches in improving retention to care and viral load suppression. Allocation to support consultant faciltated identification of recipient needs for HOPWA data integration, shared eligiblity system, consumer barriers, jurisdiction housing availablity, local government funding and services availalbity, and more.	$ 20,580
	Other Costs Total	**$ 62,580**

Total Direct Cost

	$ 487,049

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

Part A Clinical Quality Management Total

	$ 487,049

PART A HIV SERVICES BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
				$ -
			Personnel Total	**$ -**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
		$ -
	Fringe Benefit Total	**$ -**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	**$ -**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	**$ -**
		Travel Total	**$ -**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note:** Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	**$ -**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
Service providers obtained through County procurement process	HIV Direct Client Services	HIV Direct Client Services Contracts as Allocated by the RWPC. See Attachment 8a: Service Category Plan	$ 20,500,113
		Contracts Total	**$ 20,500,113**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 20,500,113

Indirect Cost			
Type of Indirect Cost *[Select from dropdown list]*	**Rate** *(Insert rate below)*	**Insert Base**	**Total [Insert Indirect]**
Part A HIV Services Total			
			$ 20,500,113

MAI ADMINISTRATIVE BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
				$ -
			Personnel Total	$ -

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
		$ -
	Fringe Benefit Total	$ -

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	$ -

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note:** Items such as laptops, tablets, and desktop computers are classified as a*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
		Contracts Total	$ -

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	$ -

Total Direct Cost

	$ -

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

MAI Administrative Total

$ -

MAI CLINICAL QUALITY MANAGEMENT BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
				$ -
			Personnel Total	$ -

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
		$ -
	Fringe Benefit Total	$ -

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	$ -

Supplies

[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
		Contracts Total	$ -

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	$ -

Total Direct Cost

$ -

Indirect Cost

Type of Indirect Cost *[Select from*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

MAI Clinical Quality Management Total

$ -

MAI HIV SERVICES BUDGET
APPLICANT: HOUSTON EMA
FISCAL YEAR: 2022

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
				$ -
			Personnel Total	**$ -**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
		$ -
	Fringe Benefit Total	**$ -**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	**$ -**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	**$ -**
		Travel Total	**$ -**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note:** Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	**$ -**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
Service providers obtained through County procurement process	HIV Direct Client Services	HIV Direct Client Services Contracts as Allocated by the RWPC. See Attachment 8b: Service Category Plan	$ 2,322,959
		Contracts Total	**$ 2,322,959**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 2,322,959

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

MAI HIV Services Total

	$ 2,322,959

TRENDS

2019 Houston HSDA Continuum of Care data overview

Ann Dills, MSW
HIV Systems Consultant
Texas DSHS HIV/STD Program
ann.dills@dshs.texas.gov

DATA

What populations are most impacted by HIV?

What health disparities exist?

What parts of our system are working well?

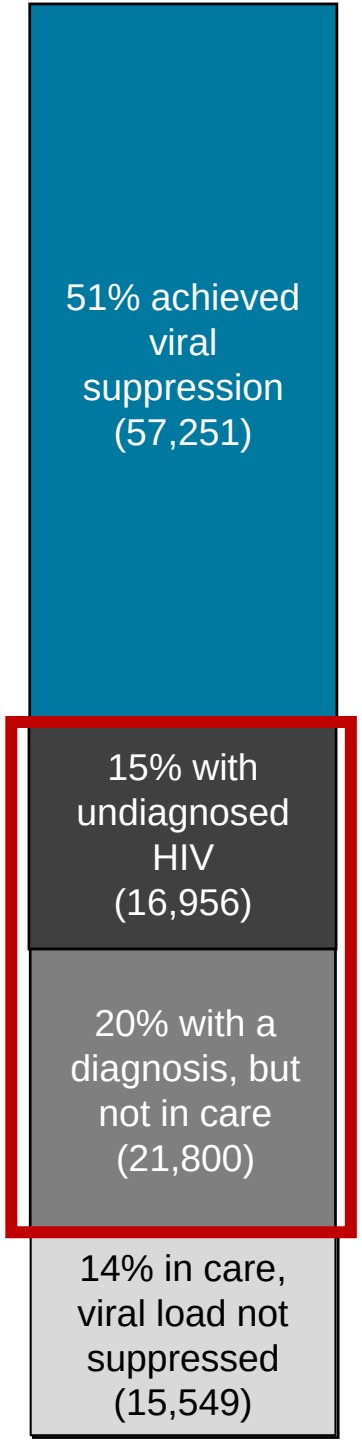
What parts of our system aren't meeting the needs of communities?

HIV Transmission Mapping – where do we disrupt?

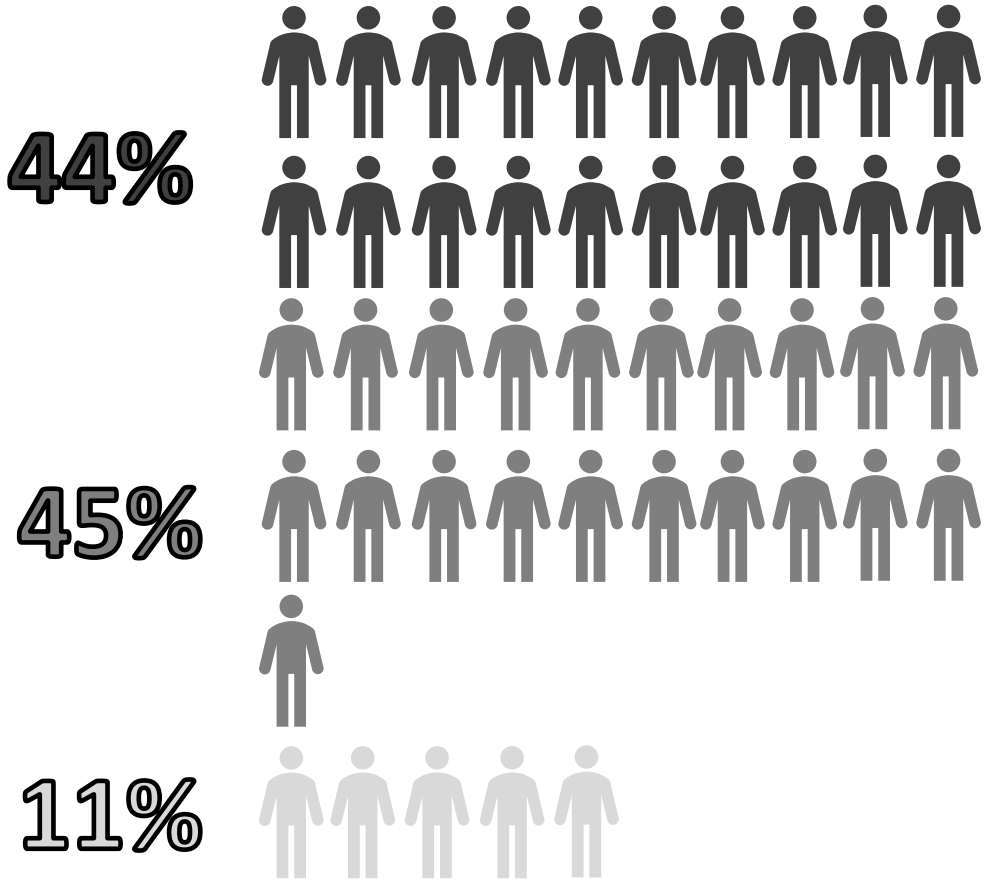
Estimated 111,062 PLWH in Texas in 2018

51% of PLWH achieved viral suppression

49% of PLWH *did not achieve* viral suppression



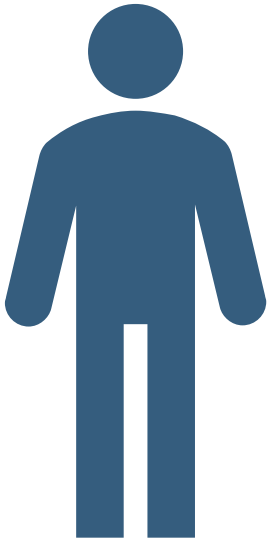
4,617 people with new HIV infections



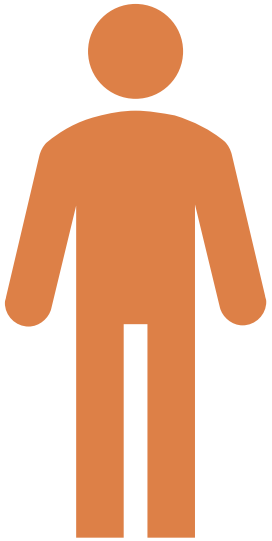
= 1,000 people

= 100 people

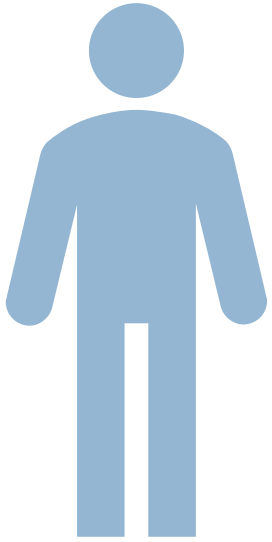
Texas Priority Populations



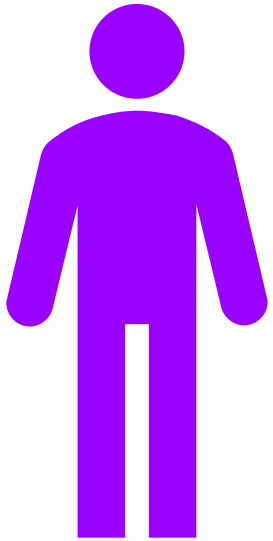
Latinx Gay, Bisexual and other Men who have Sex with Men (Latinx MSM)



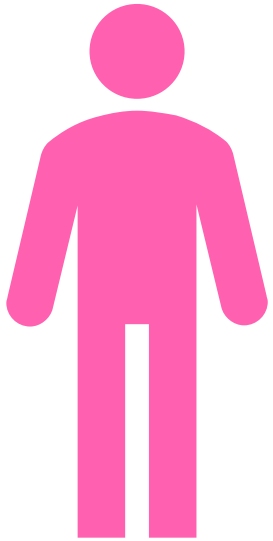
Black Gay, Bisexual and other Men who have Sex with Men (Black MSM)



White Gay, Bisexual and other Men who have Sex with Men (White MSM)

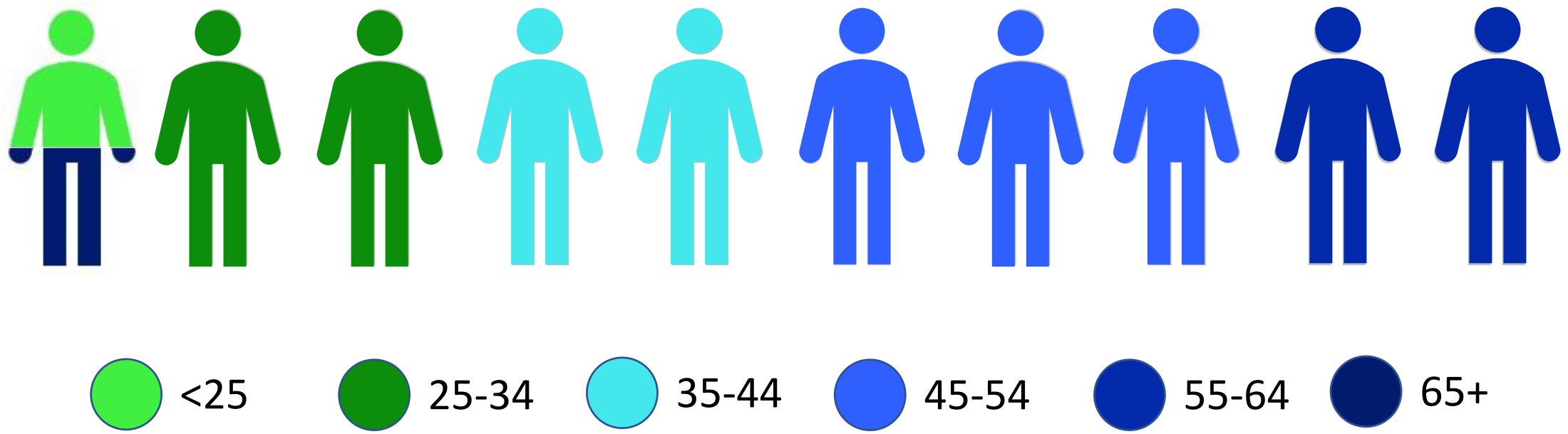


Black Women who have Sex with Men (Black Women)

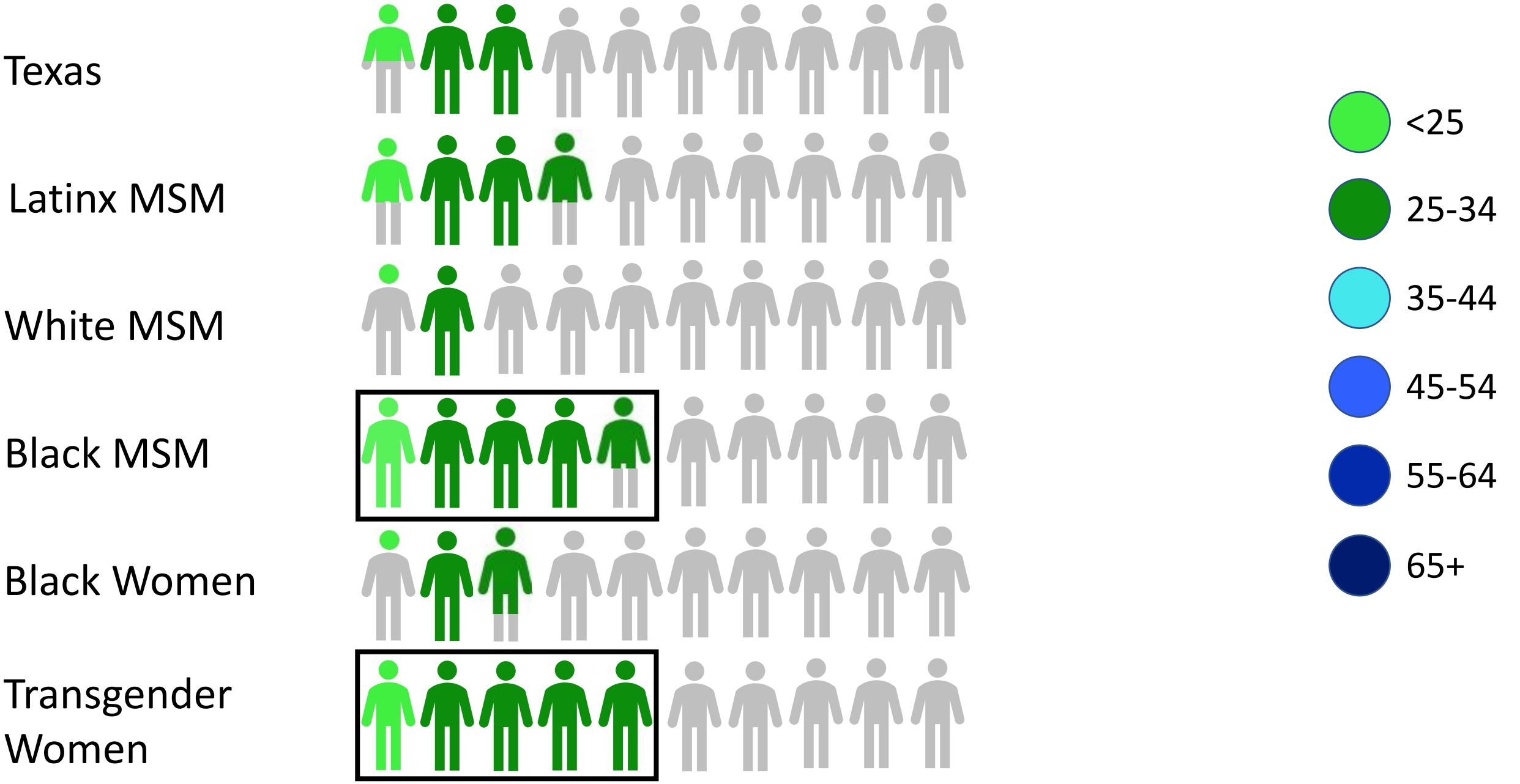


Transgender Women who have Sex with Men (Transgender Women)

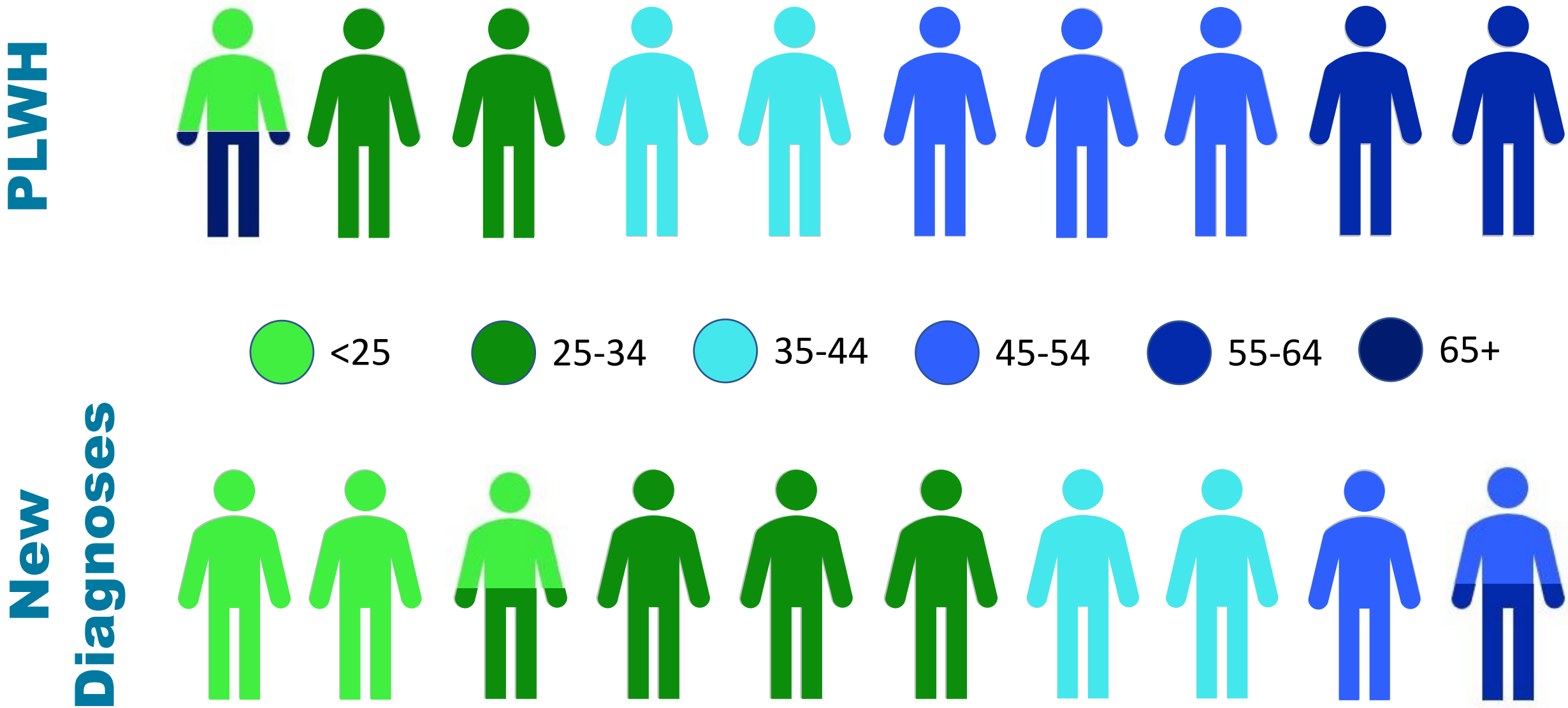
Texas PLWH, by Age, 2019



Texas PLWH, by Age, 2019



Texas PLWH and New Diagnoses, by Age, 2019



People Living With HIV (PLWH) know their status

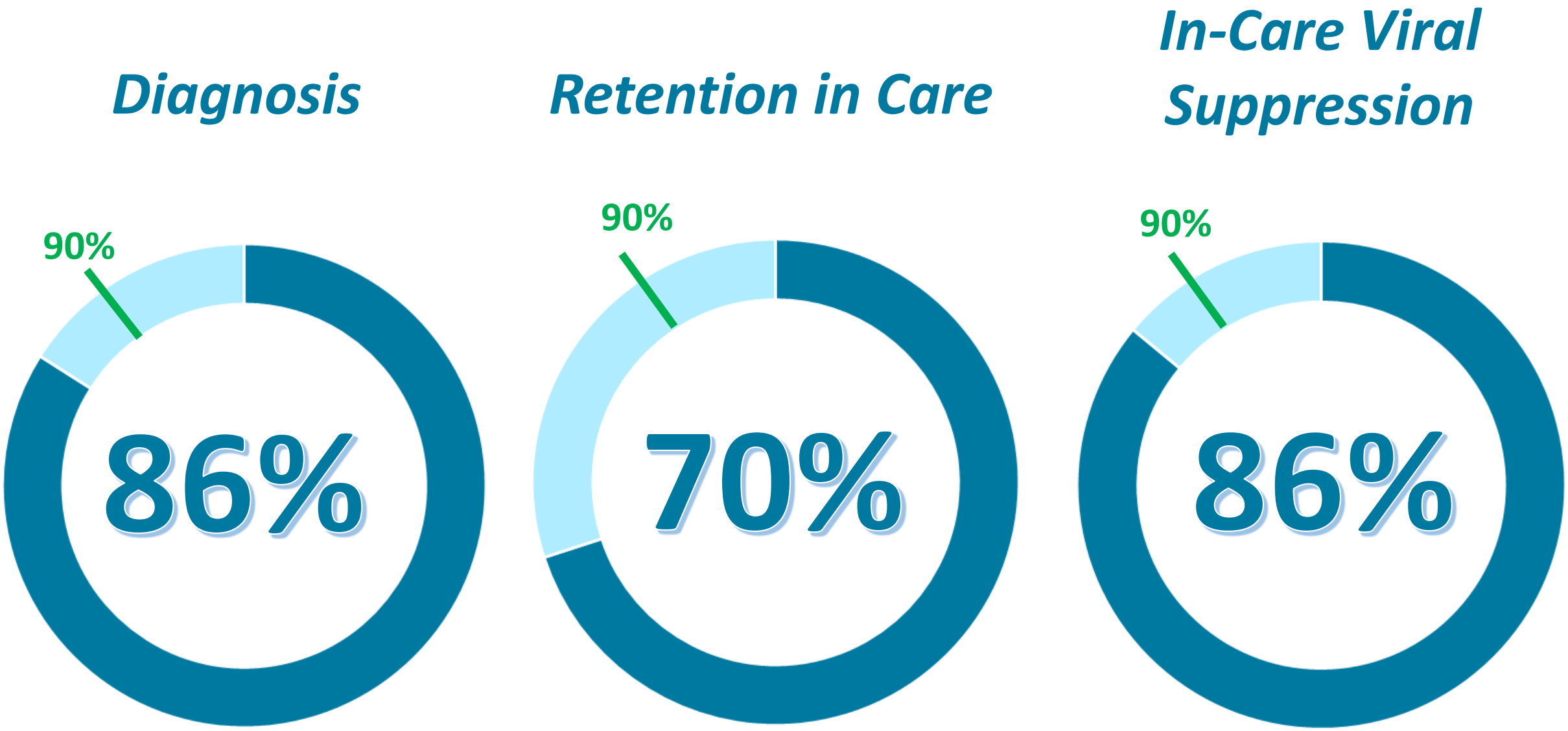
PLWH who know their status are on Antiretroviral Therapy

PLWH who are on ART achieve Viral Suppression

50%

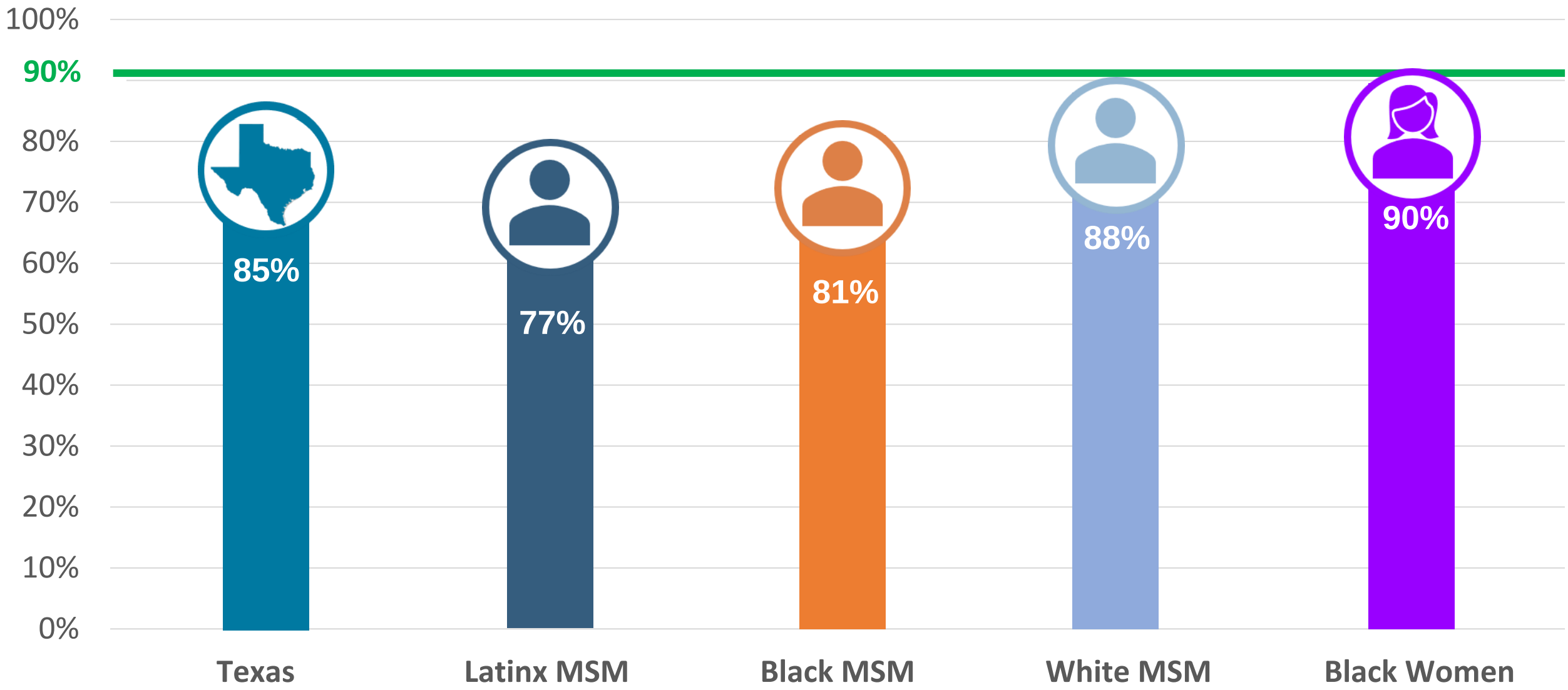
Decrease in the number of people who acquire HIV (Incidence)

Achieving Together: 90/90/90 – Texas 2019



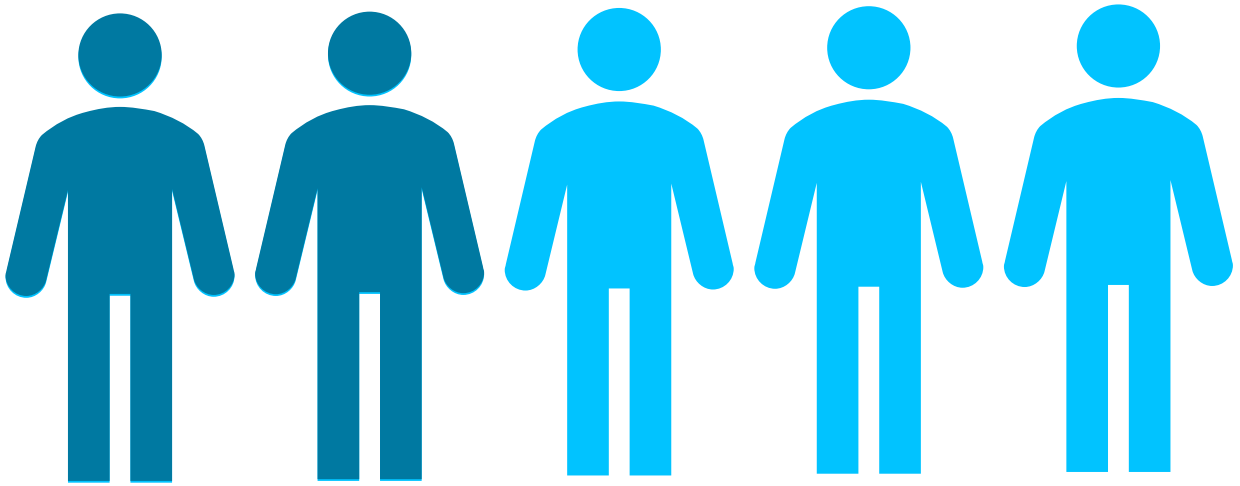
HIV Diagnosis in Texas – Priority Populations, 2018

Estimated proportion of PLWH who have diagnosed HIV in 2018



HIV incidence in Texas

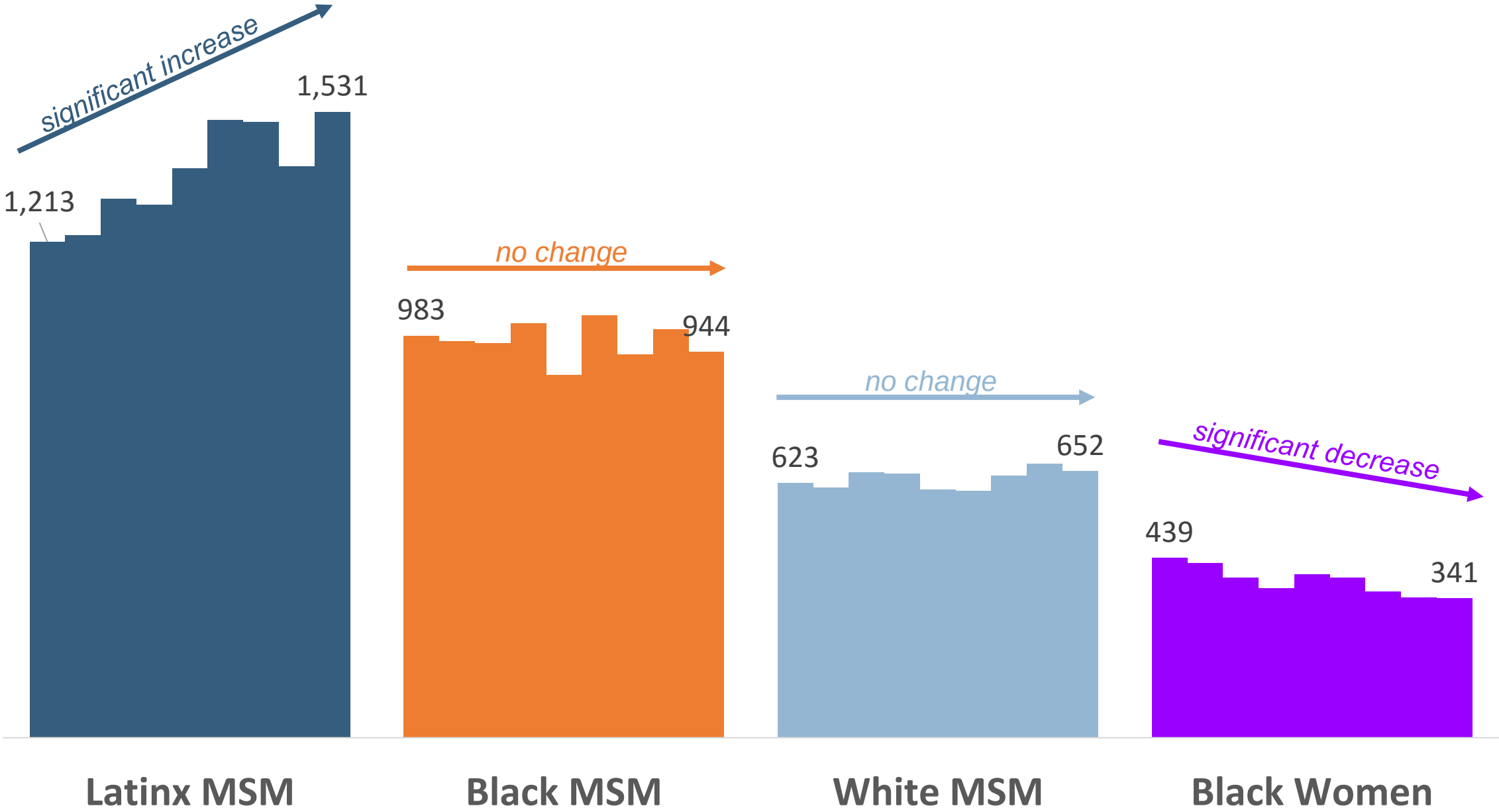
Of the **16,000 Texans** who are living with undiagnosed HIV



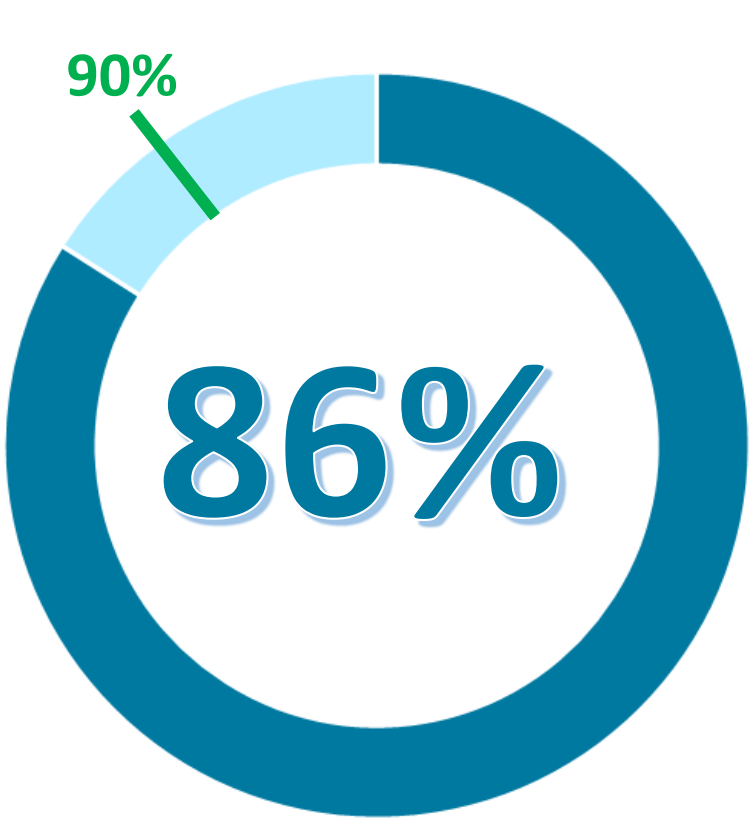
people with undiagnosed HIV

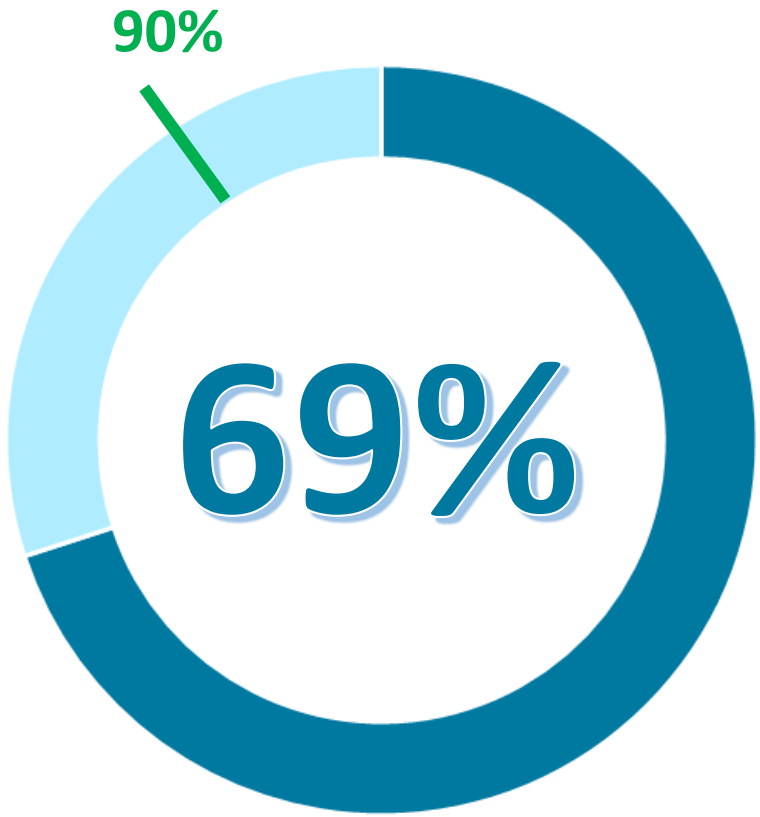
25-34

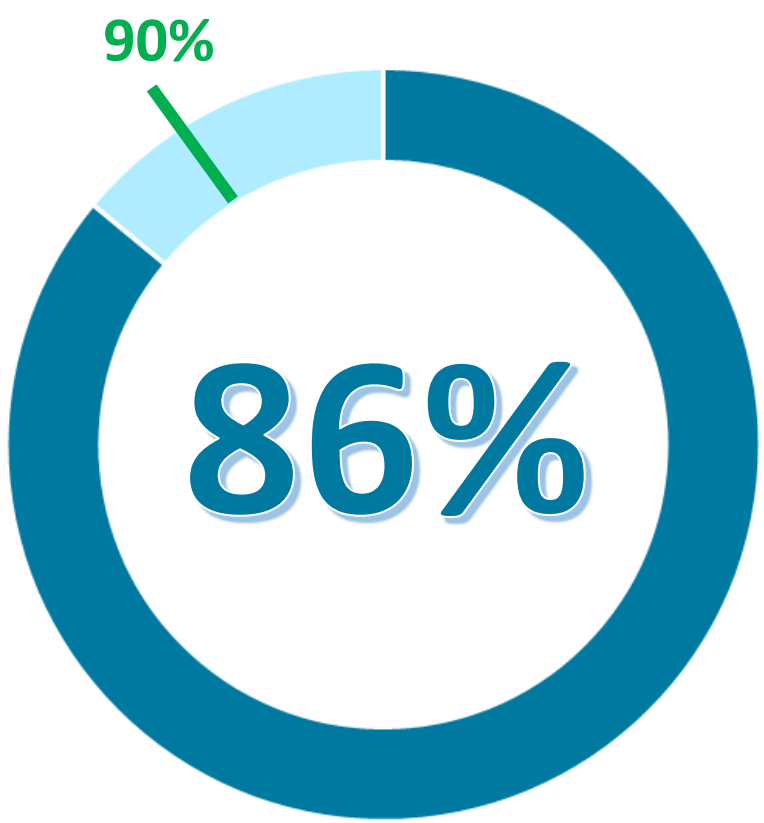
HIV incidence in Texas, 2010-2018



Achieving Together: 90/90/90 – Houston 2019

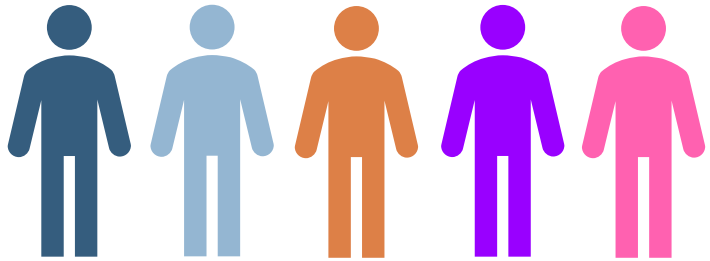




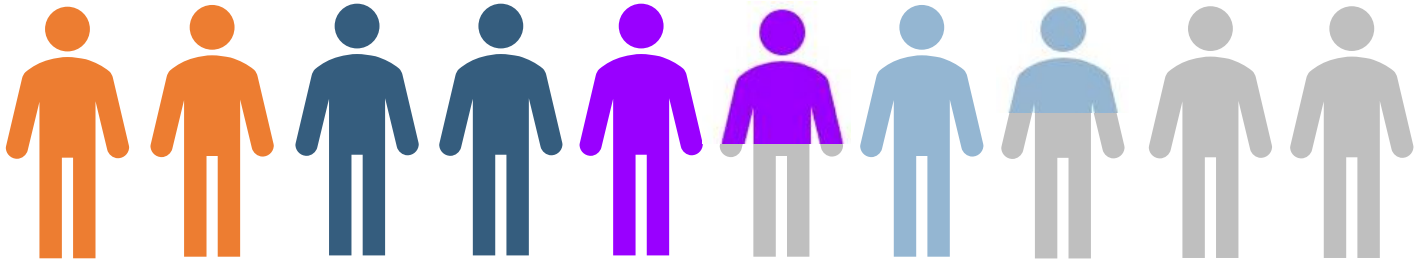


Priority Populations, Houston HSDA 2019

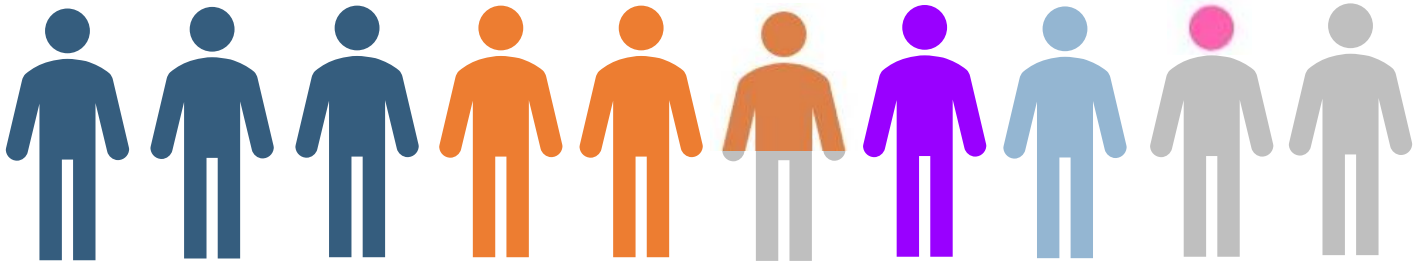
Locally Relevant Populations for Focused Prevention



PLWH
2019 – 30,490



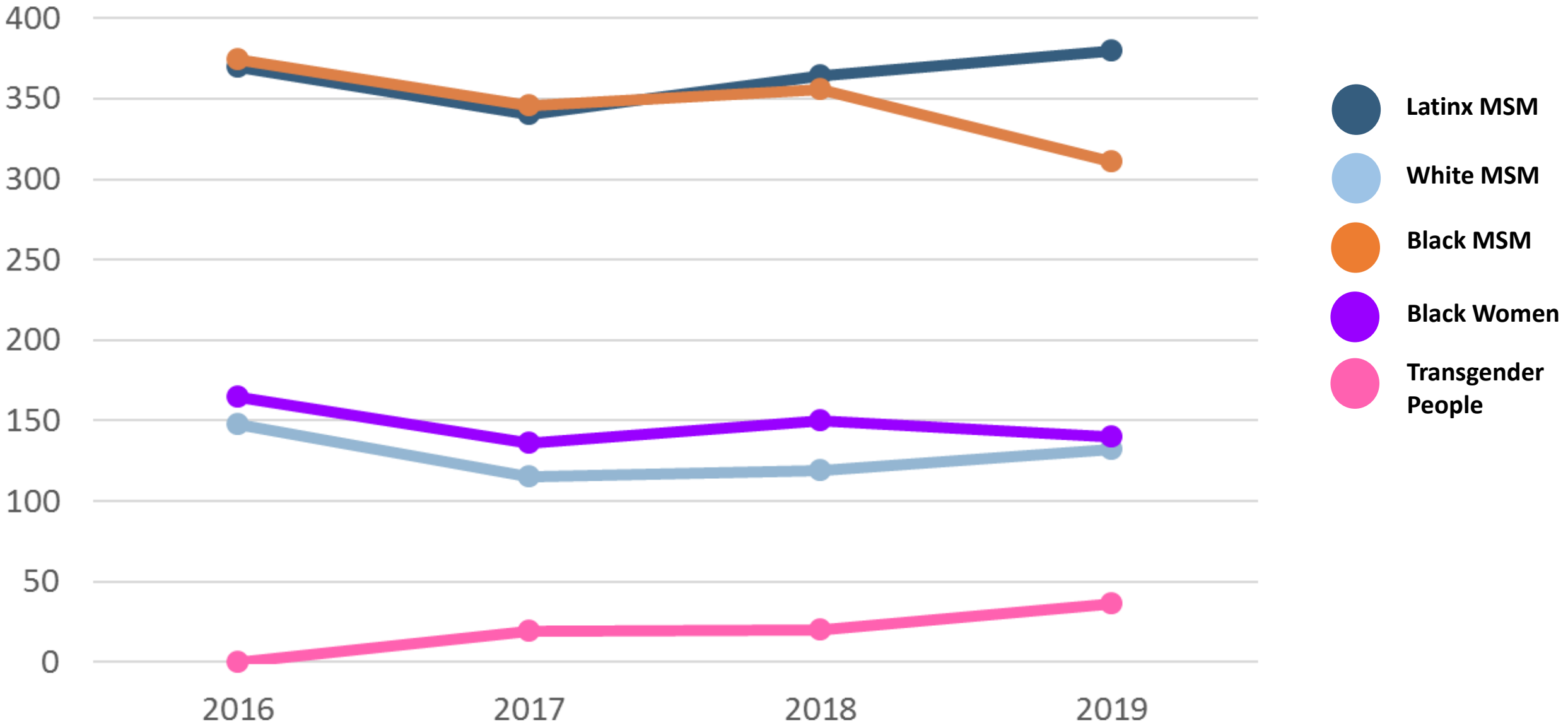
New Diagnoses
2019 – 1,290



- Latinx MSM
- White MSM
- Black MSM
- Black Women
- Transgender People

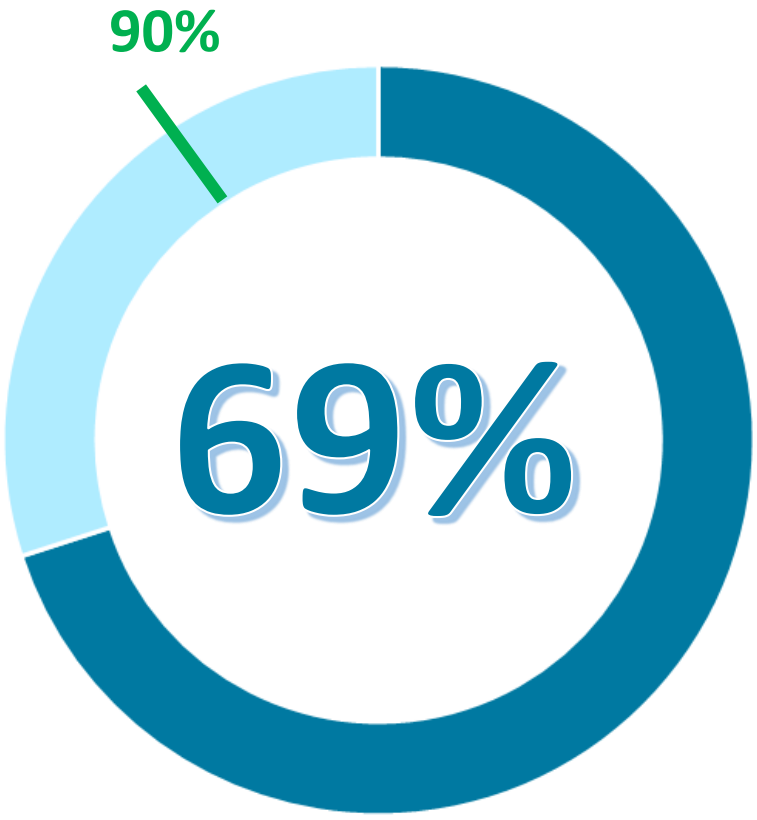
New HIV Diagnoses among Priority Populations

Houston HSDA, 2016-2019

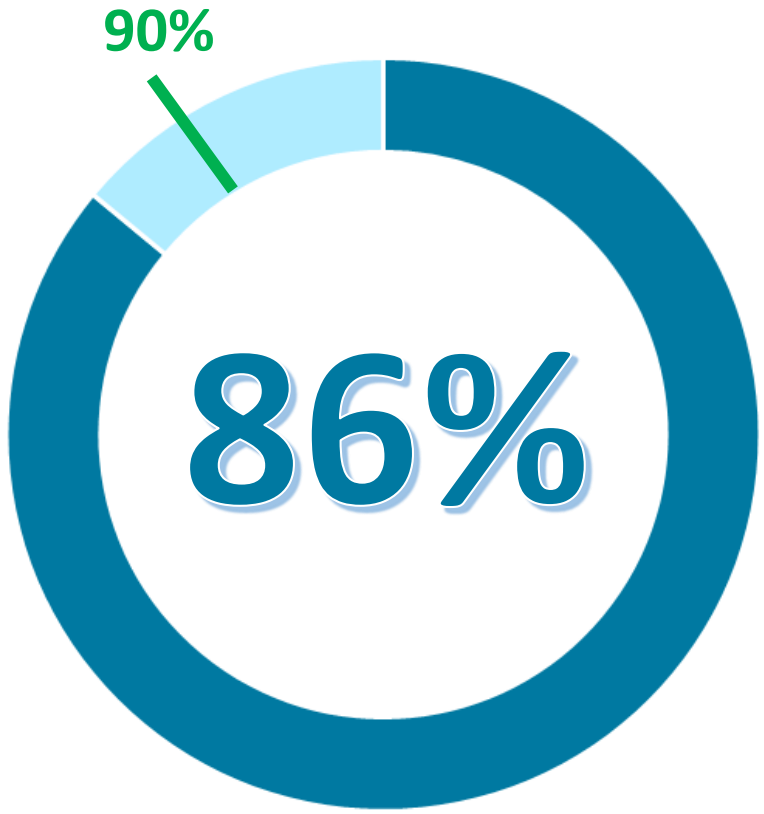


Achieving Together: 90/90/90 – Houston 2019

Retention in Care



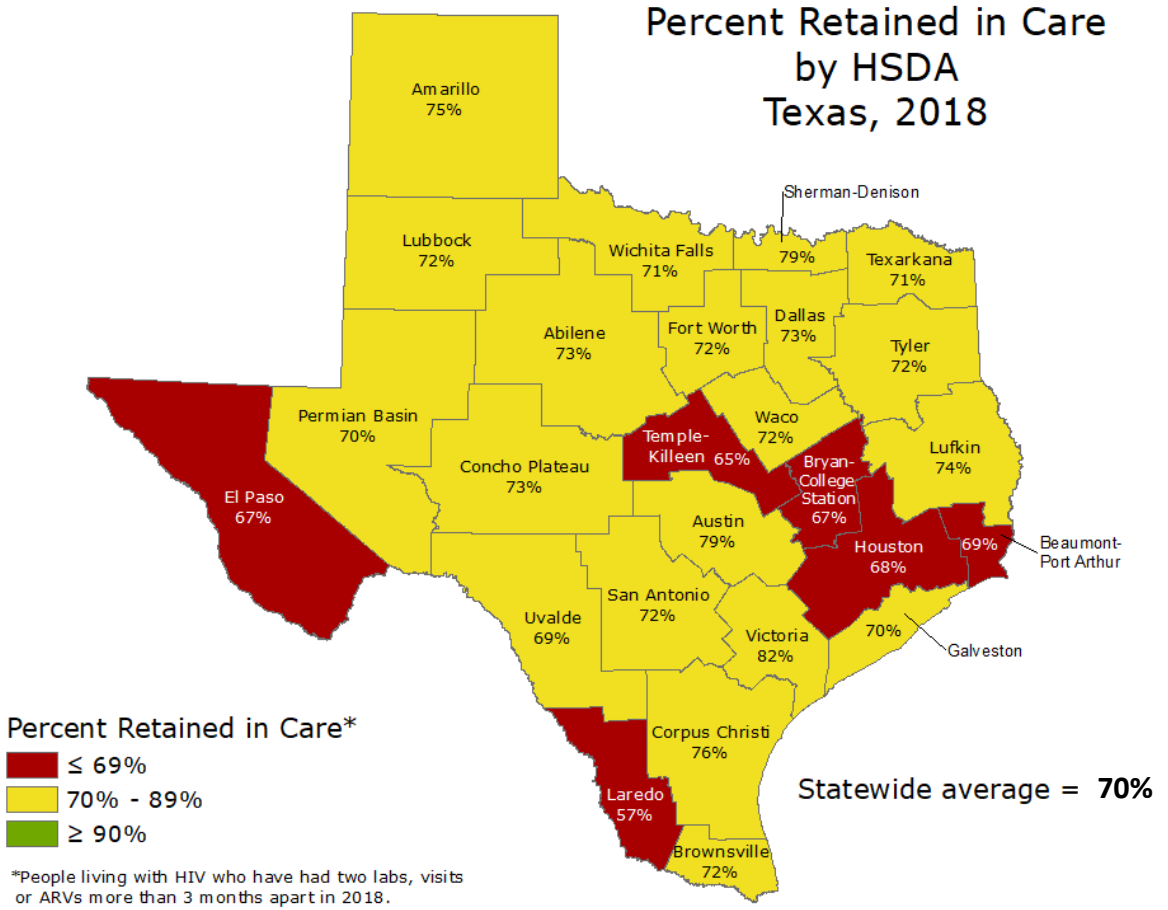
In-Care Viral Suppression



Treatment Cascade Stoplight System

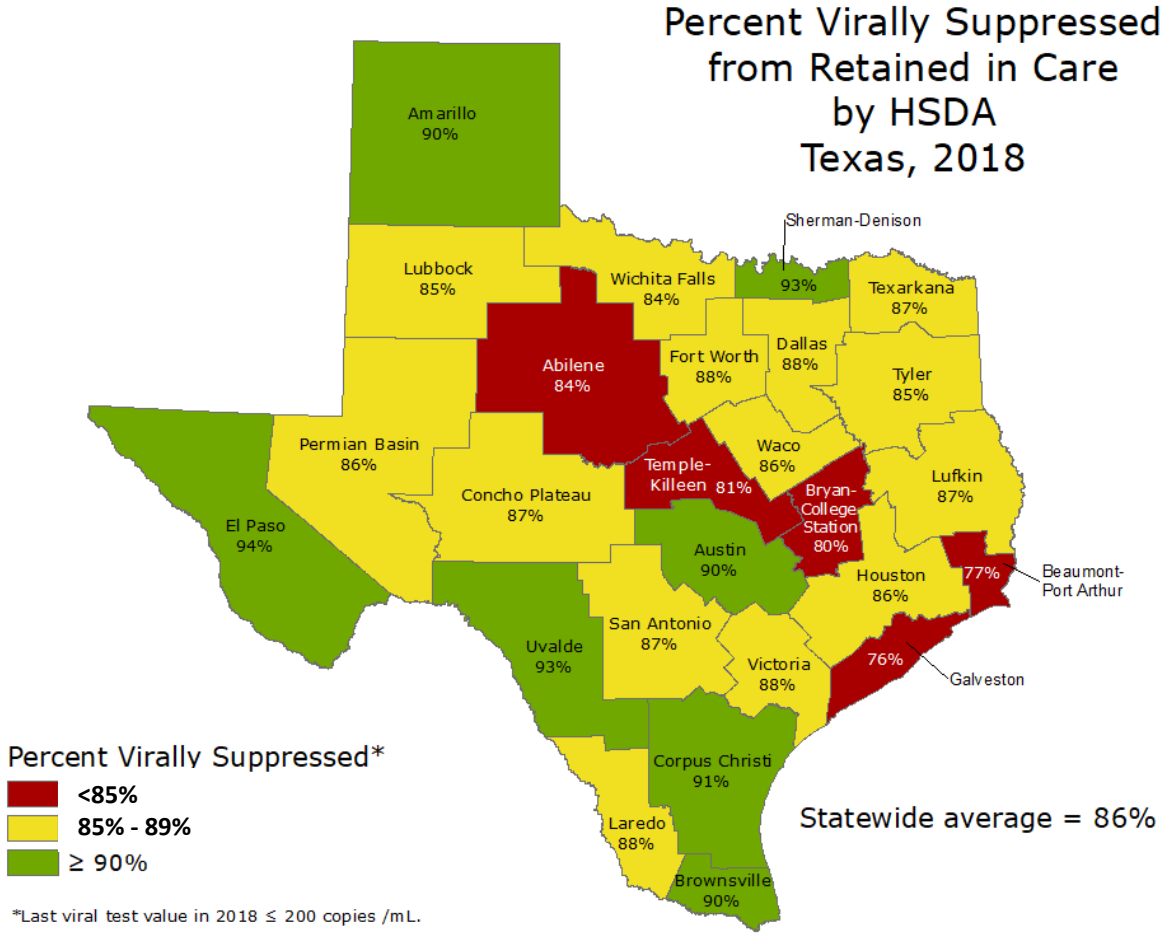
Retention In Care		In-Care Viral Suppression
< 69%	Stop and examine further, May be a priority	< 84%
70% - 89%	May need to examine further, May not be a priority	85% - 89%
90% <	Maintain Current Activities, Look for Promising Practices	90% <

Treatment Cascade Stoplight System – Texas 2018



*People living with HIV who have had two labs, visits or ARVs more than 3 months apart in 2018.

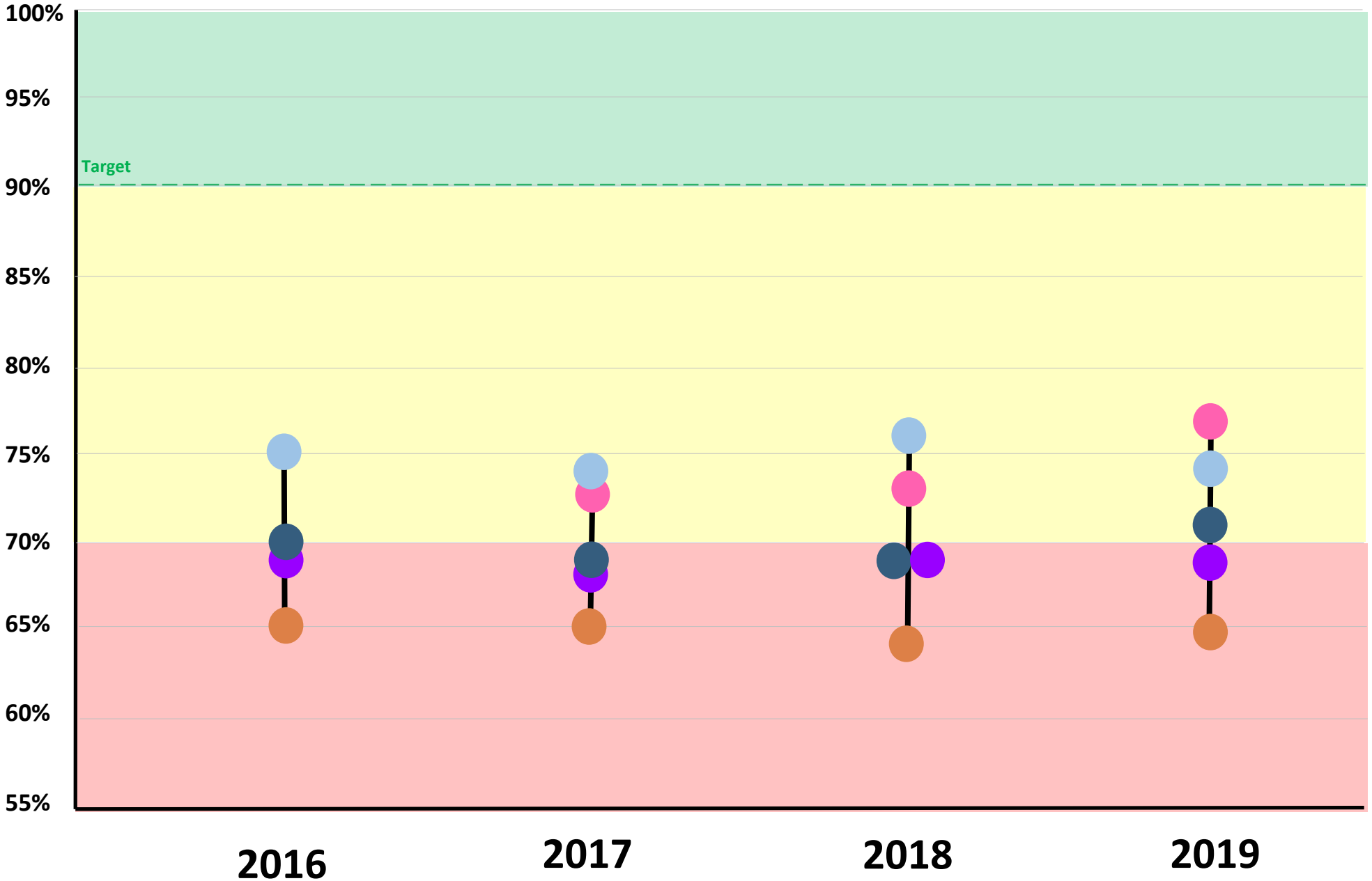
Source: Texas eHARS, 2019



*Last viral test value in 2018 ≤ 200 copies /mL.

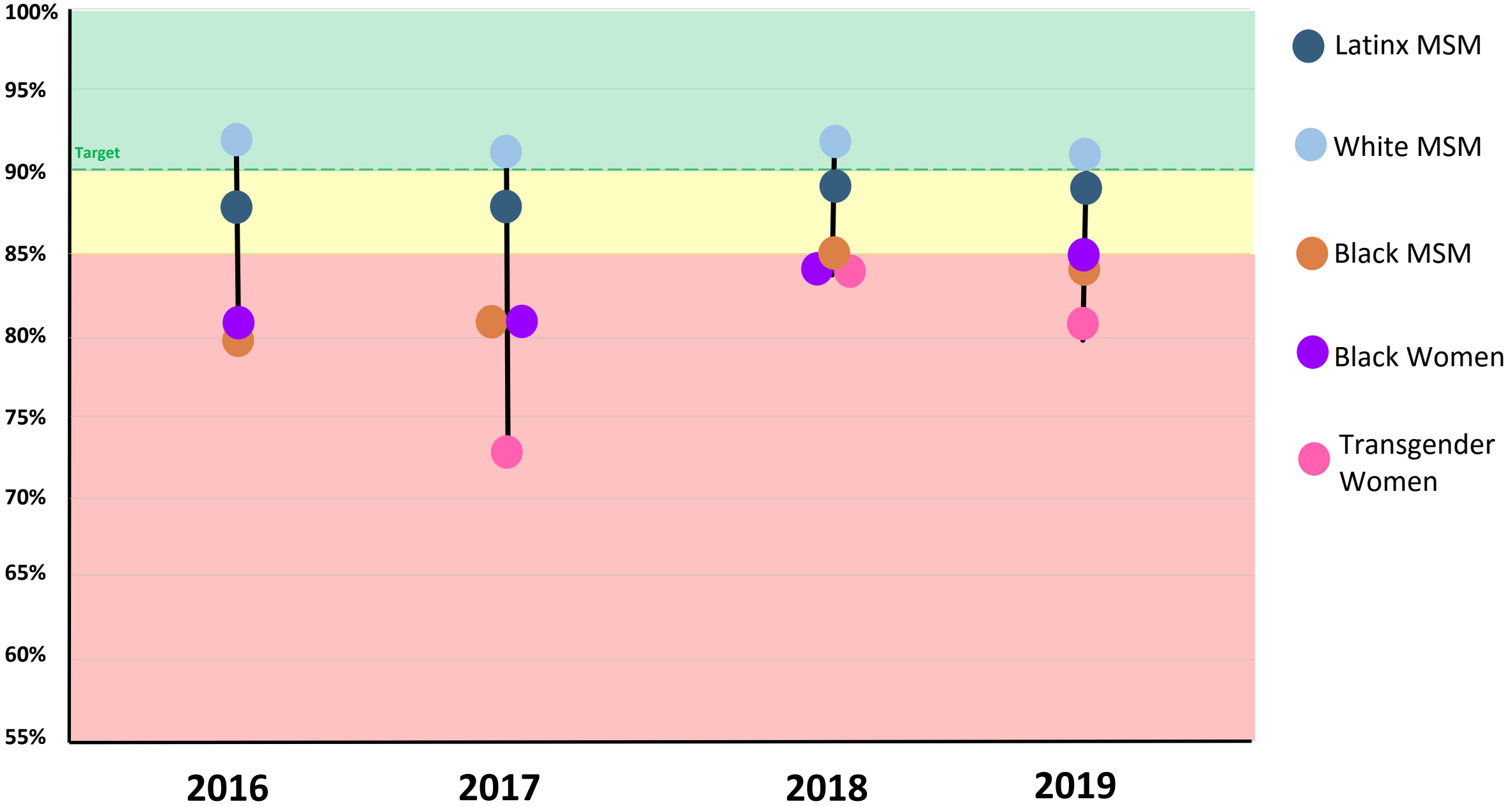
Source: Texas eHARS, 2019

Retention in Care, Priority Populations, 2019



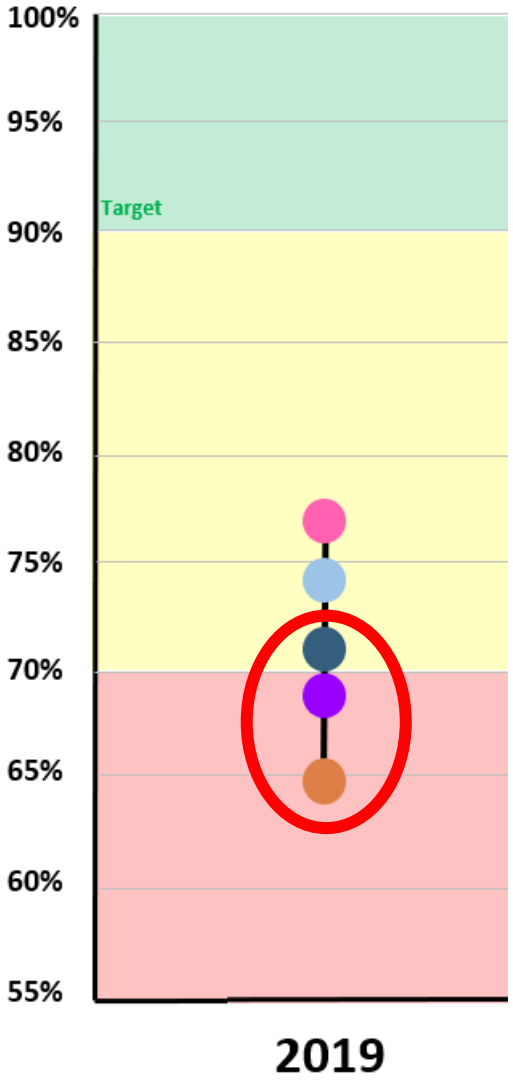
**Data sets representing PLWH who are in-care are most often used to confirm gender identity for transgender PLWH. Because of this, the % of transgender PLWH who have achieved retention in care may be over-represented.*

In-Care Viral Suppression, Priority Populations, 2019

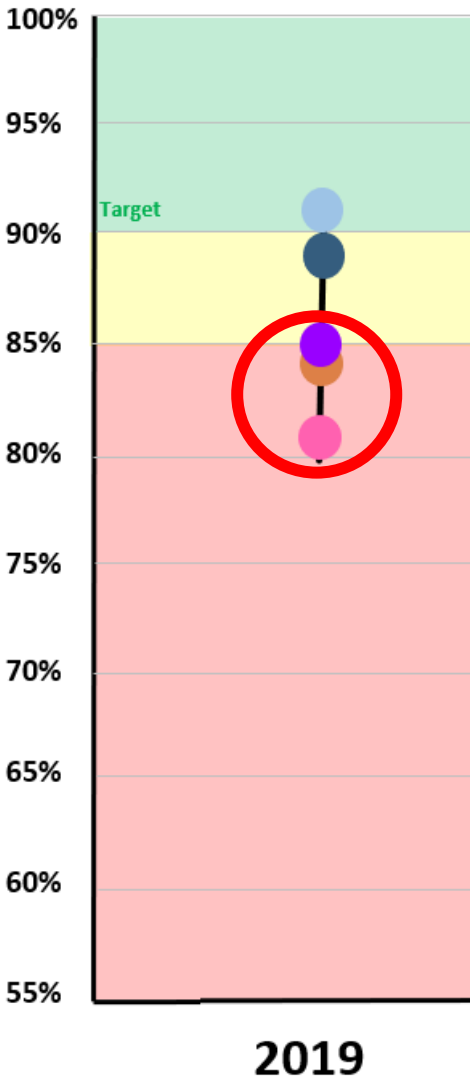


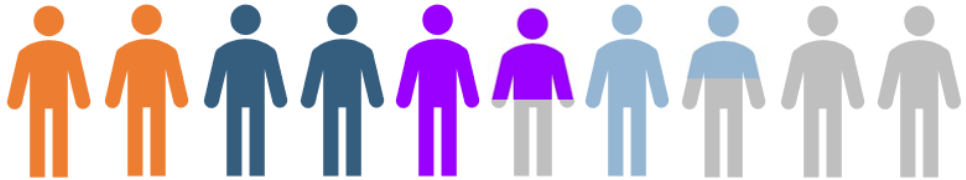
Priority Populations,2019

Retention in Care

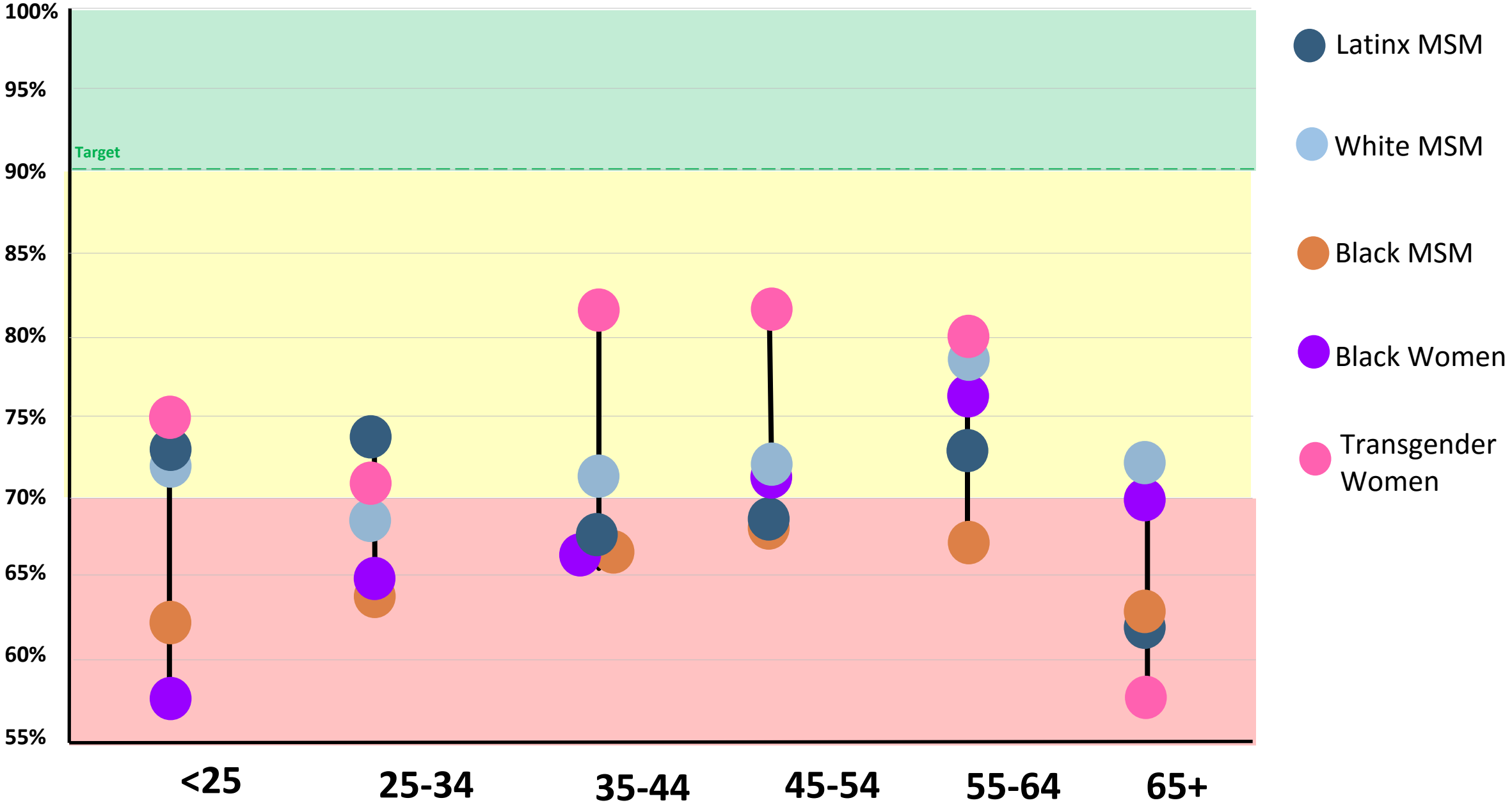


In-Care Viral Suppression

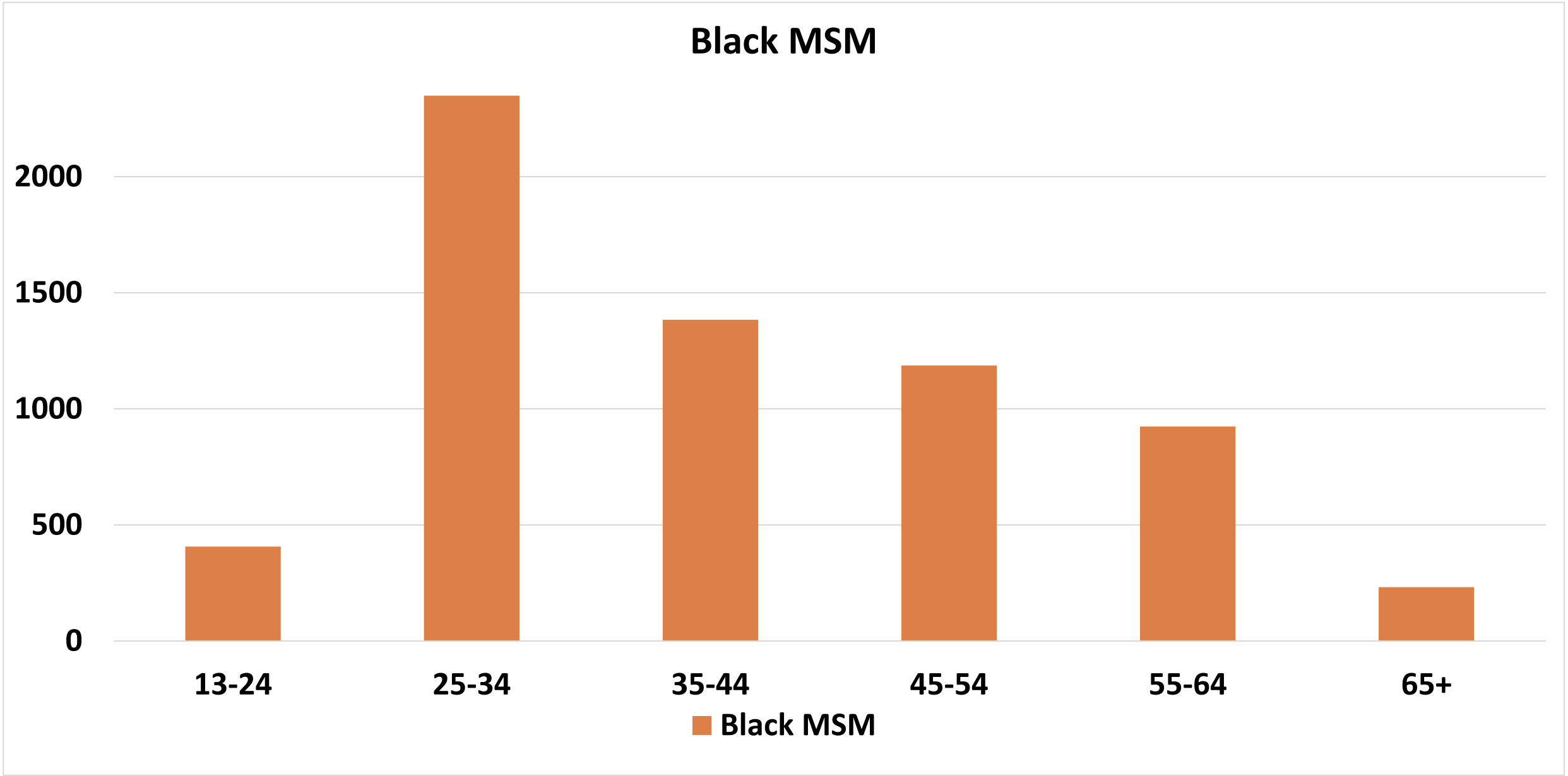




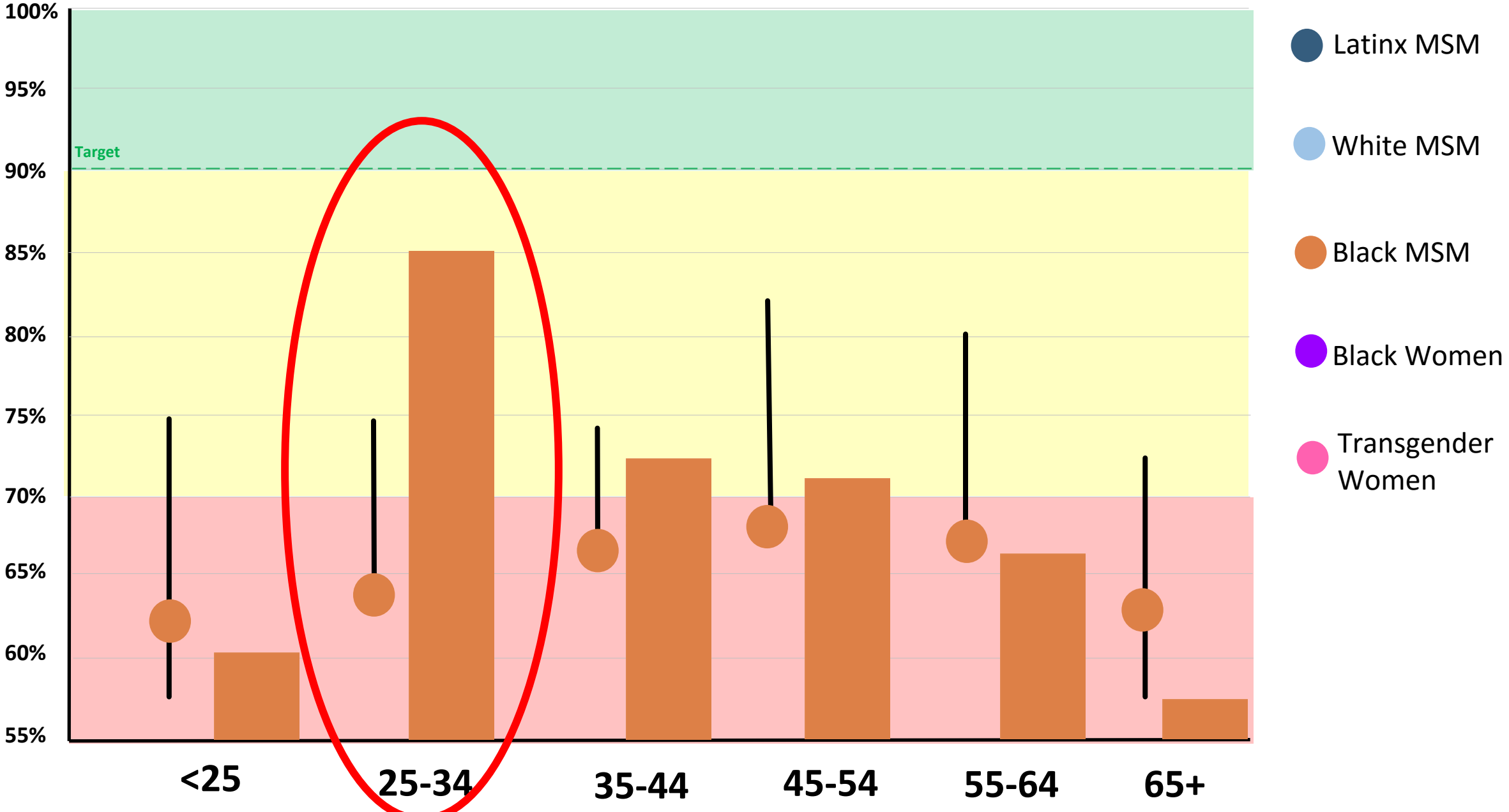
Retention in Care, Priority Populations, 2019



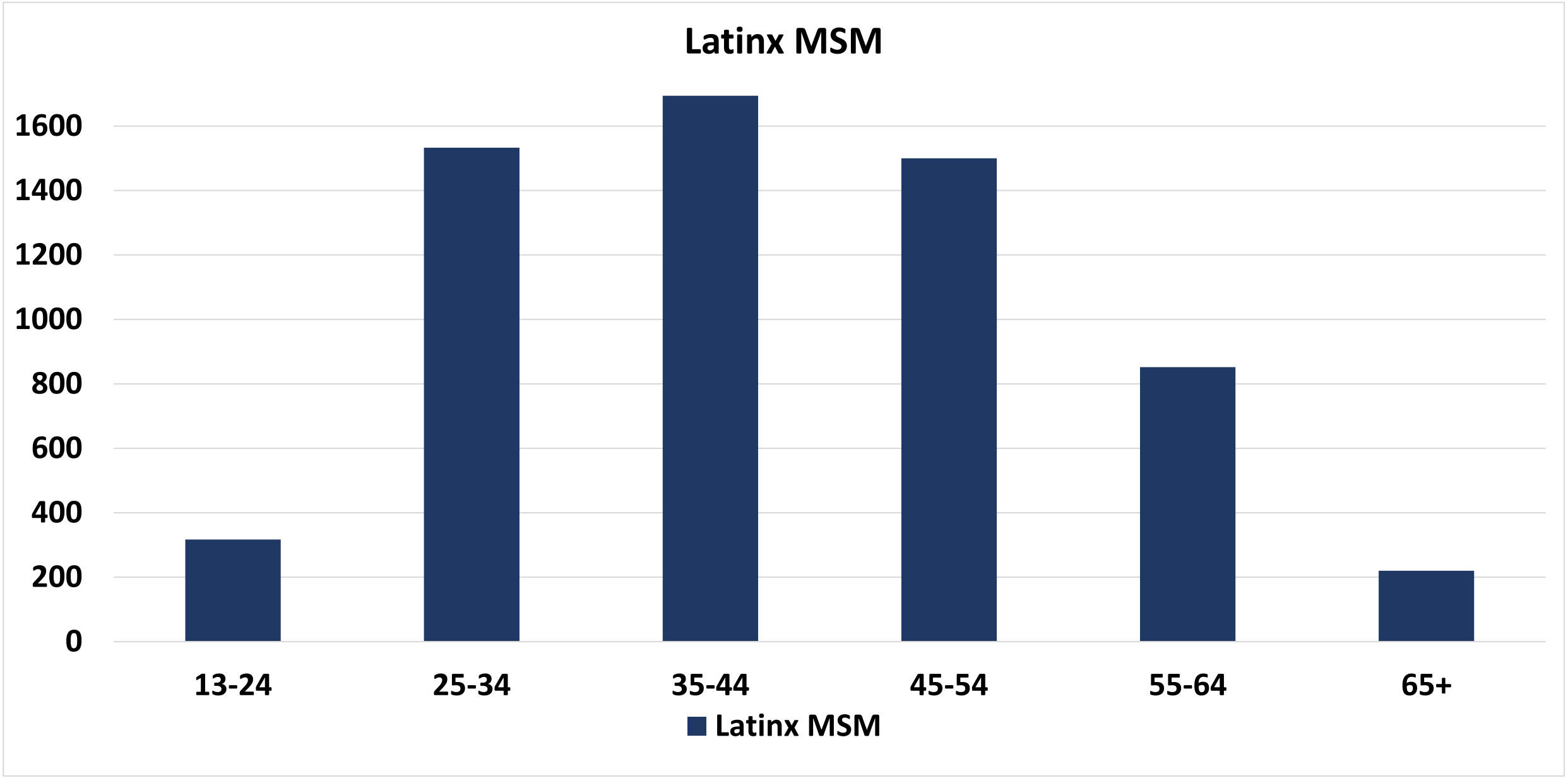
PLWH, by age, 2019 – Houston HSDA



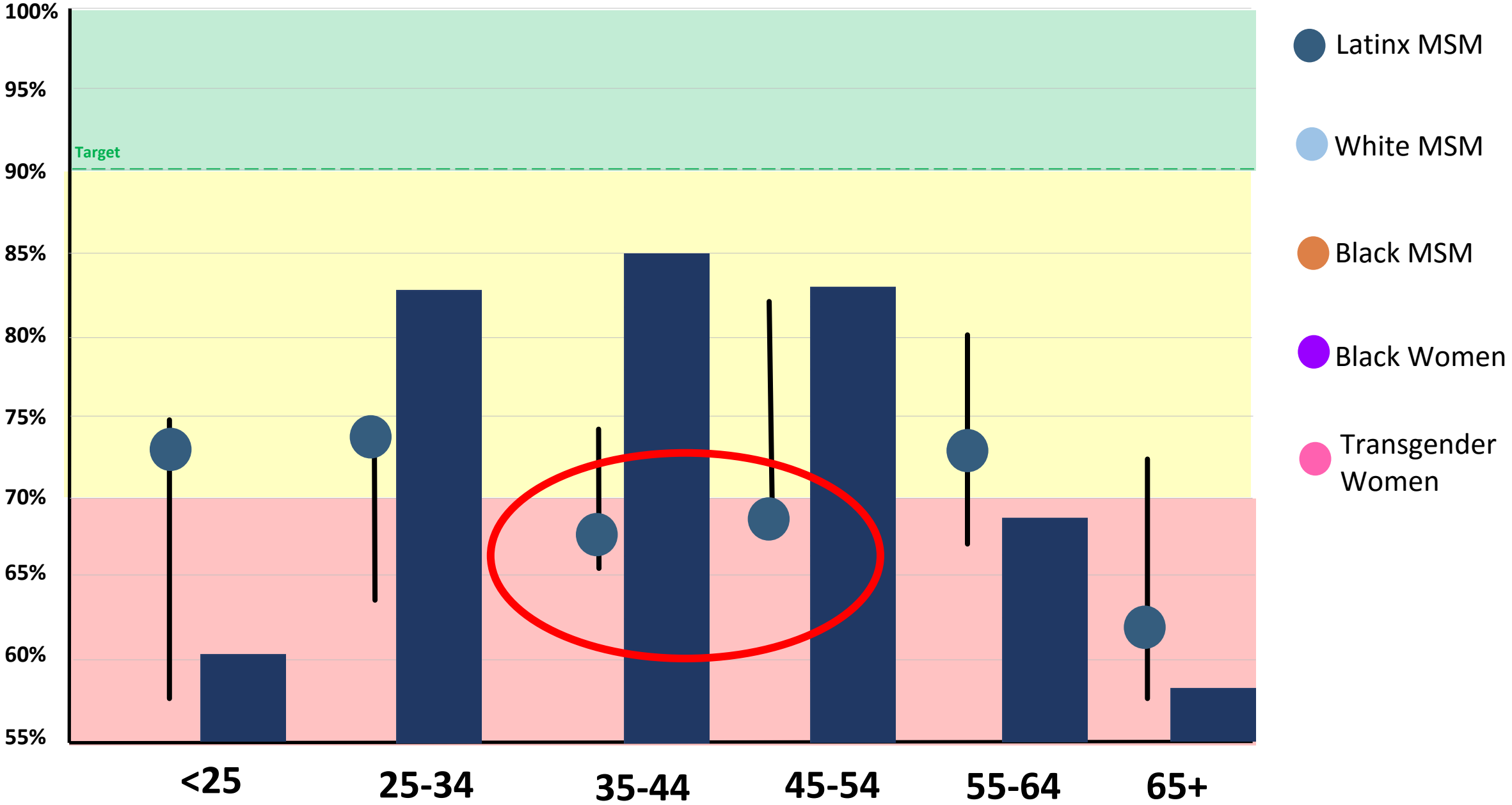
Retention in Care, Priority Populations, 2019



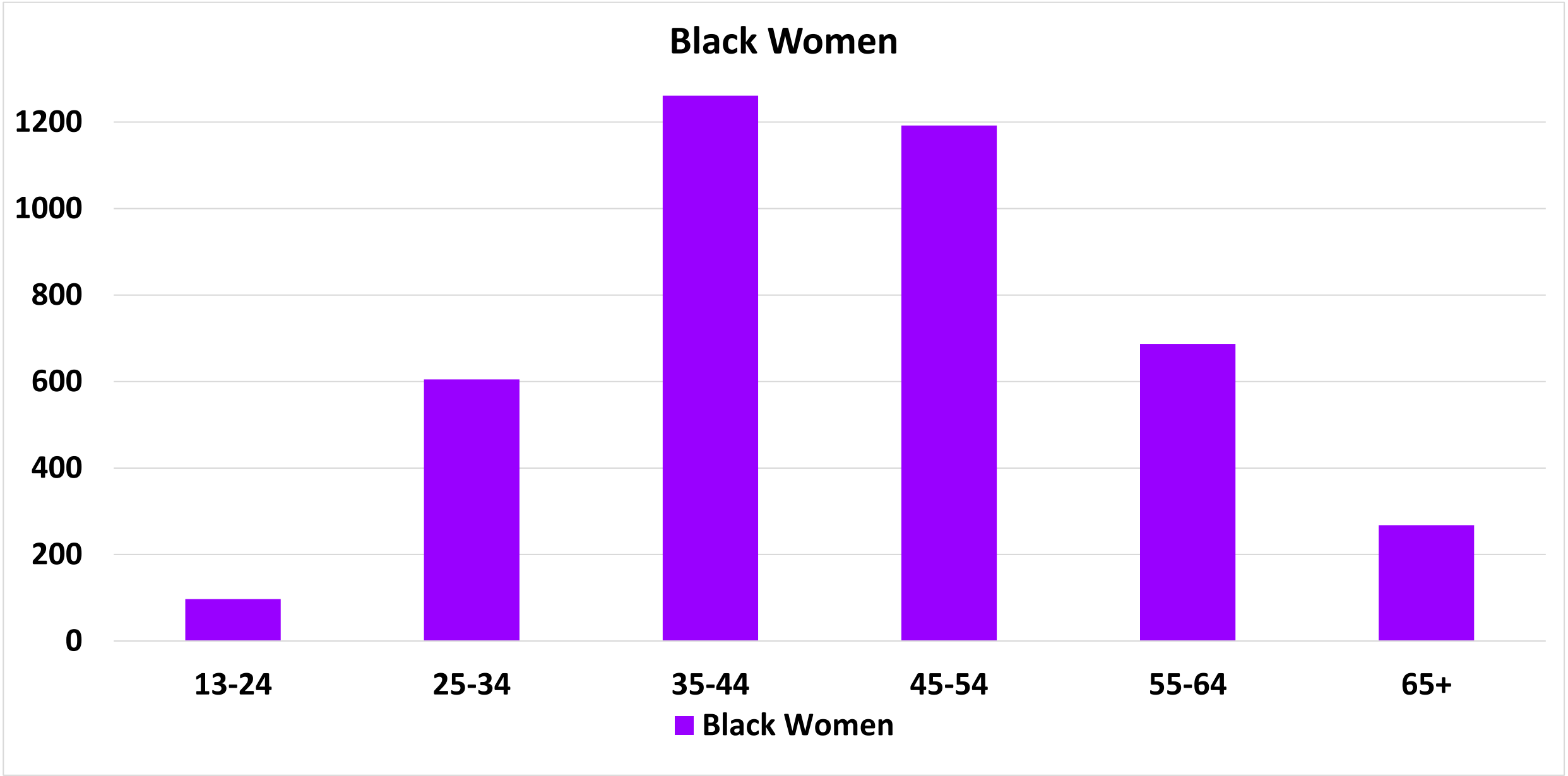
PLWH, by age, 2019 – Houston HSDA



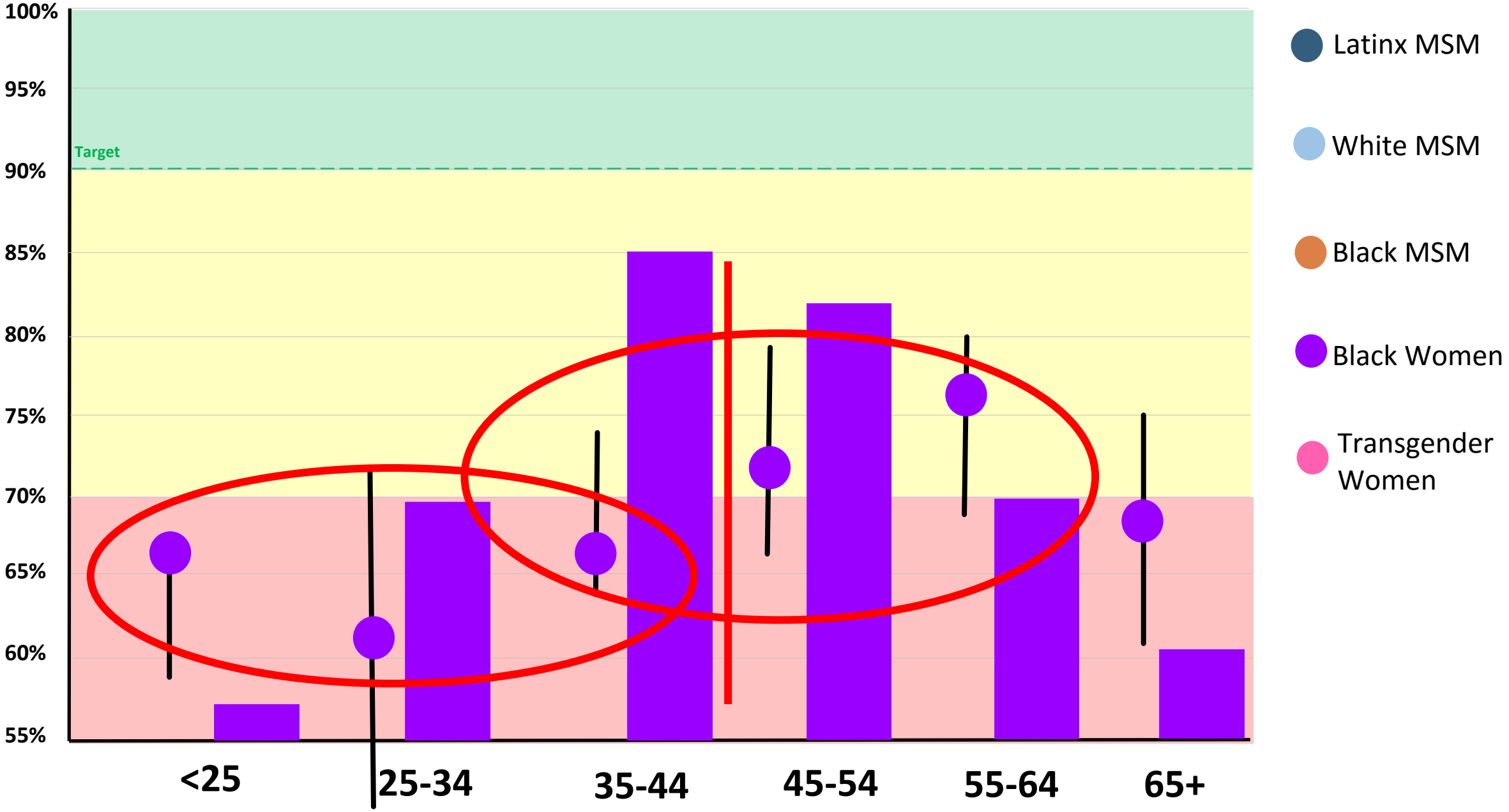
Retention in Care, Priority Populations, 2019



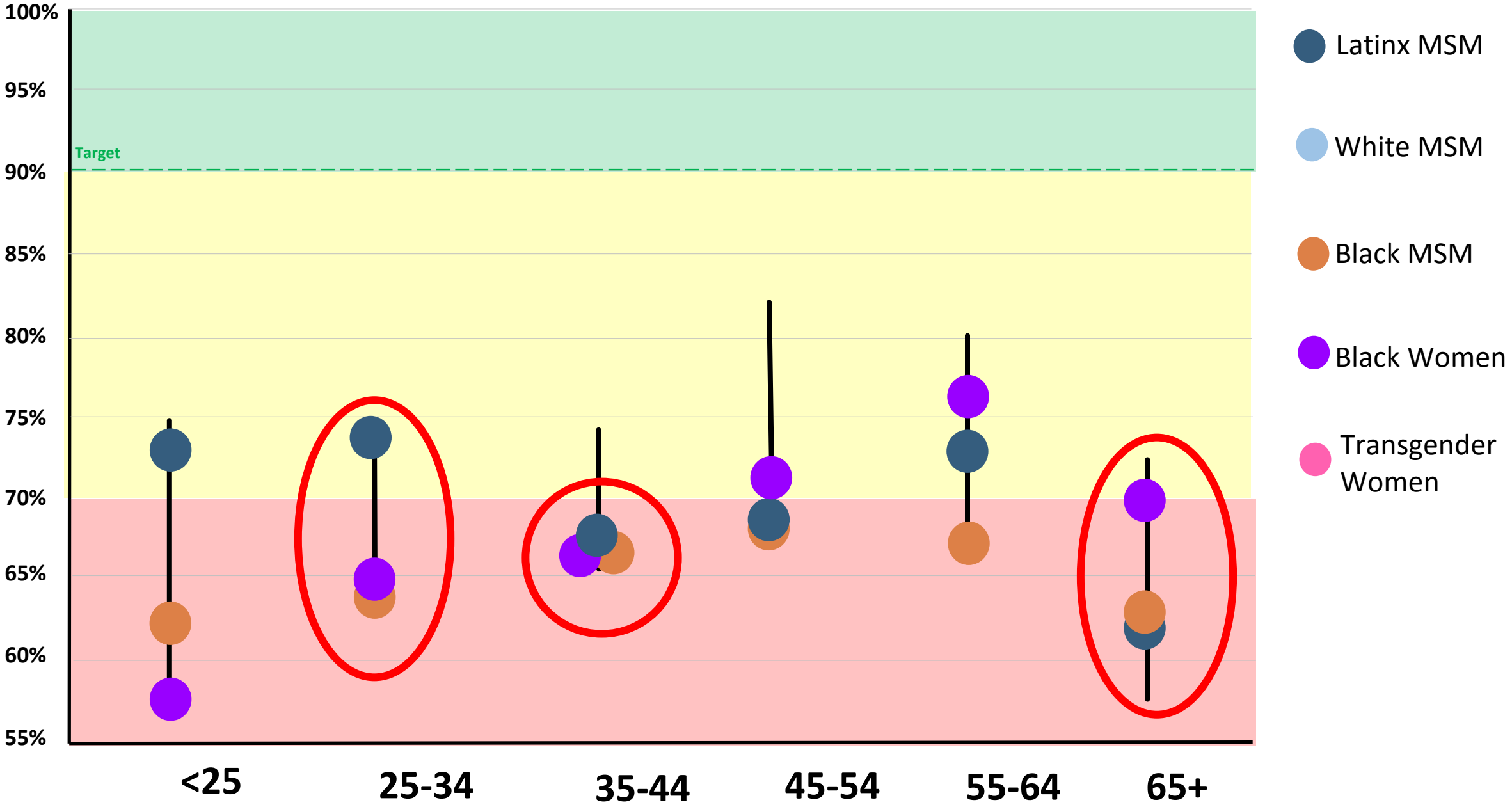
PLWH, by age, 2019 – Houston HSDA



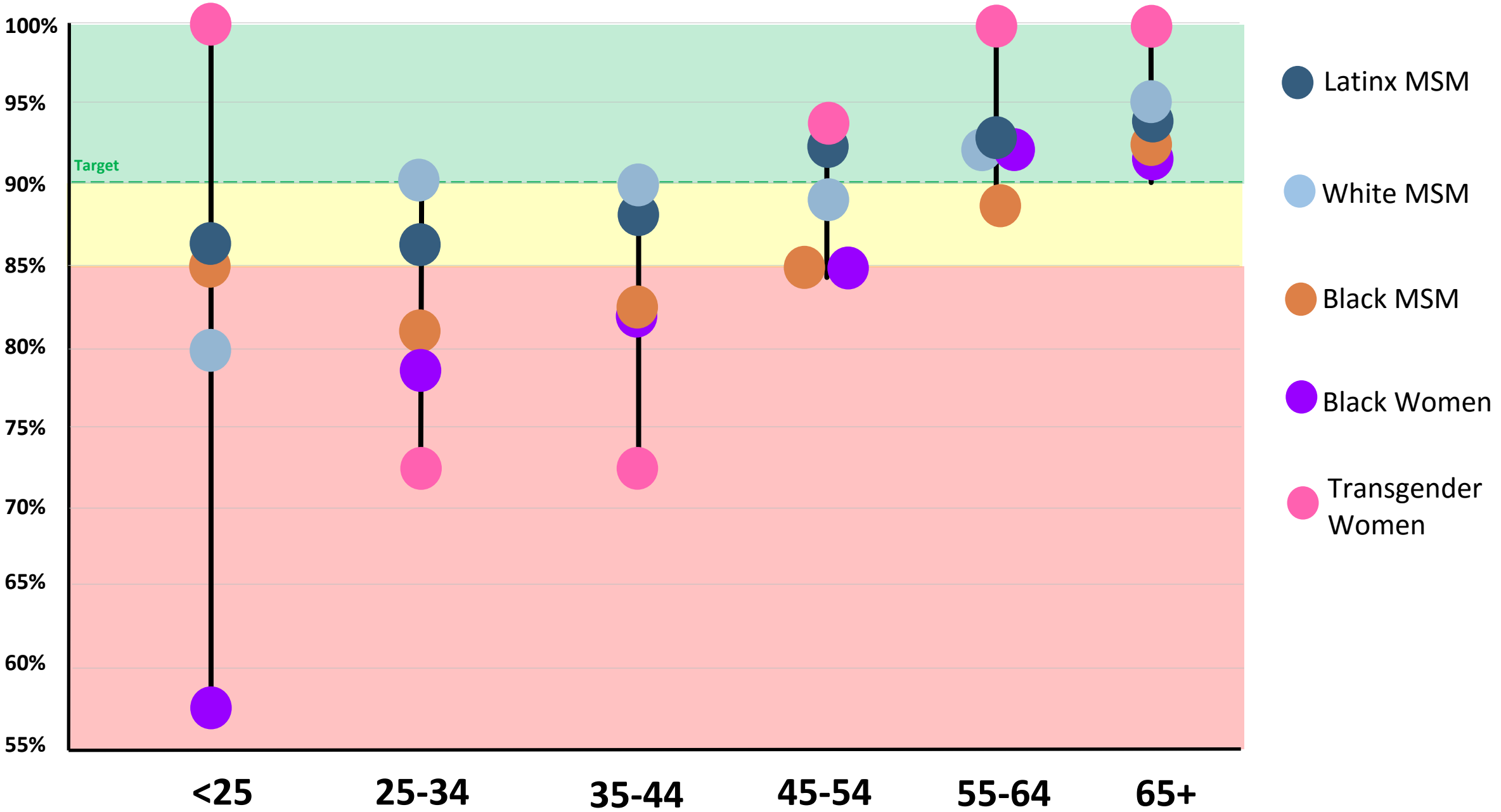
Retention in Care, Priority Populations, 2018



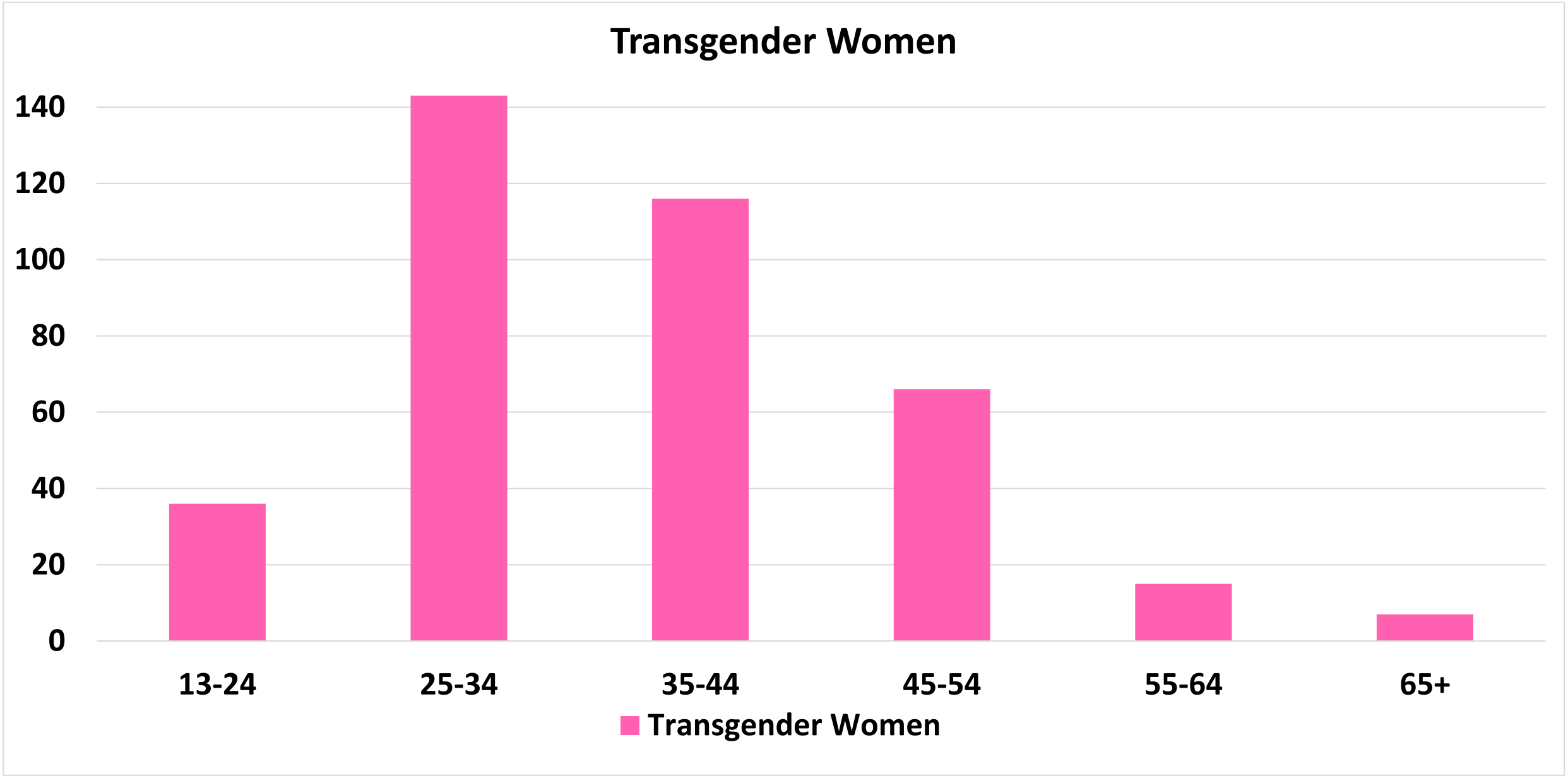
Retention in Care, Priority Populations, 2019



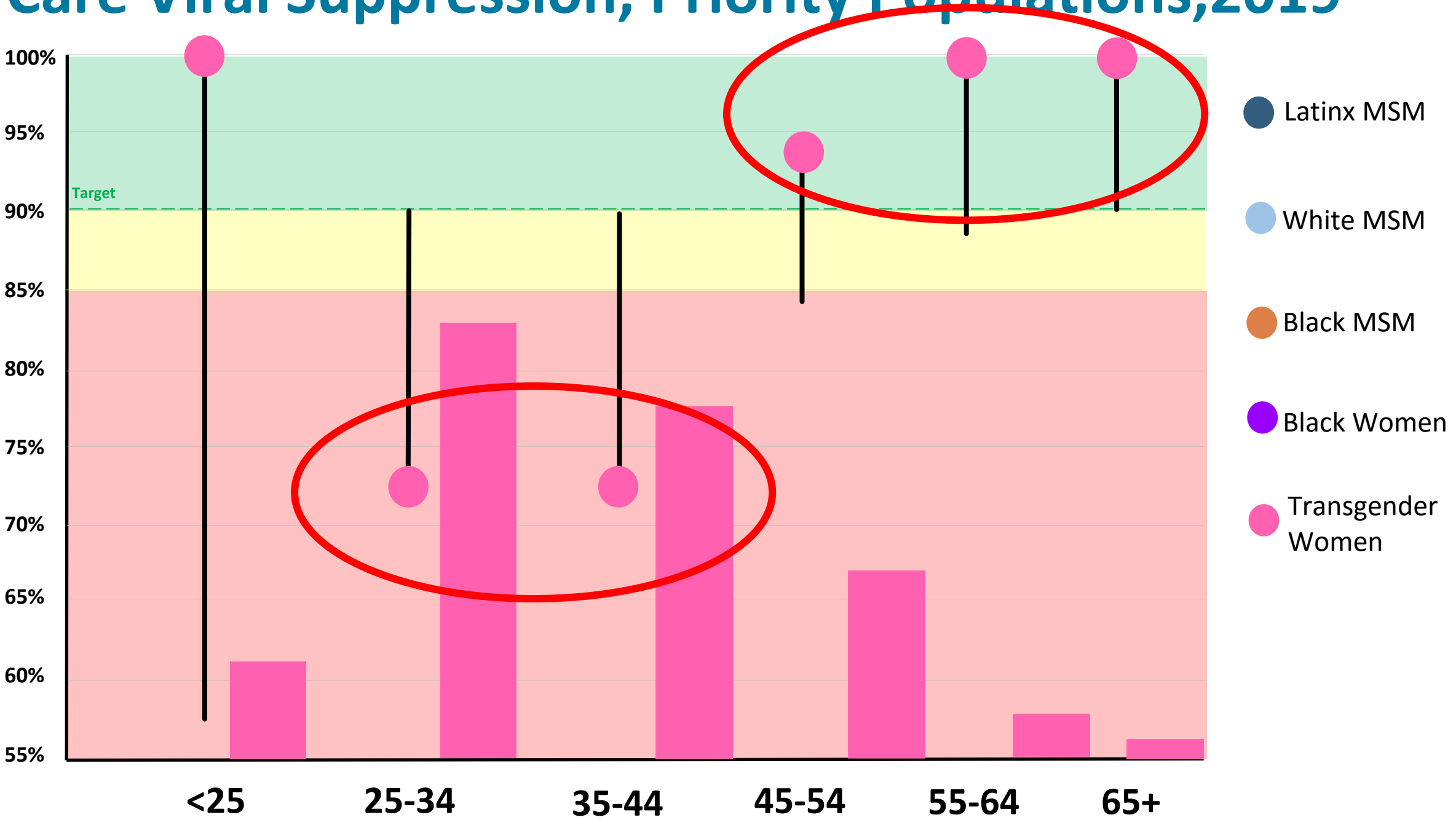
In-Care Viral Suppression, Priority Populations,2019



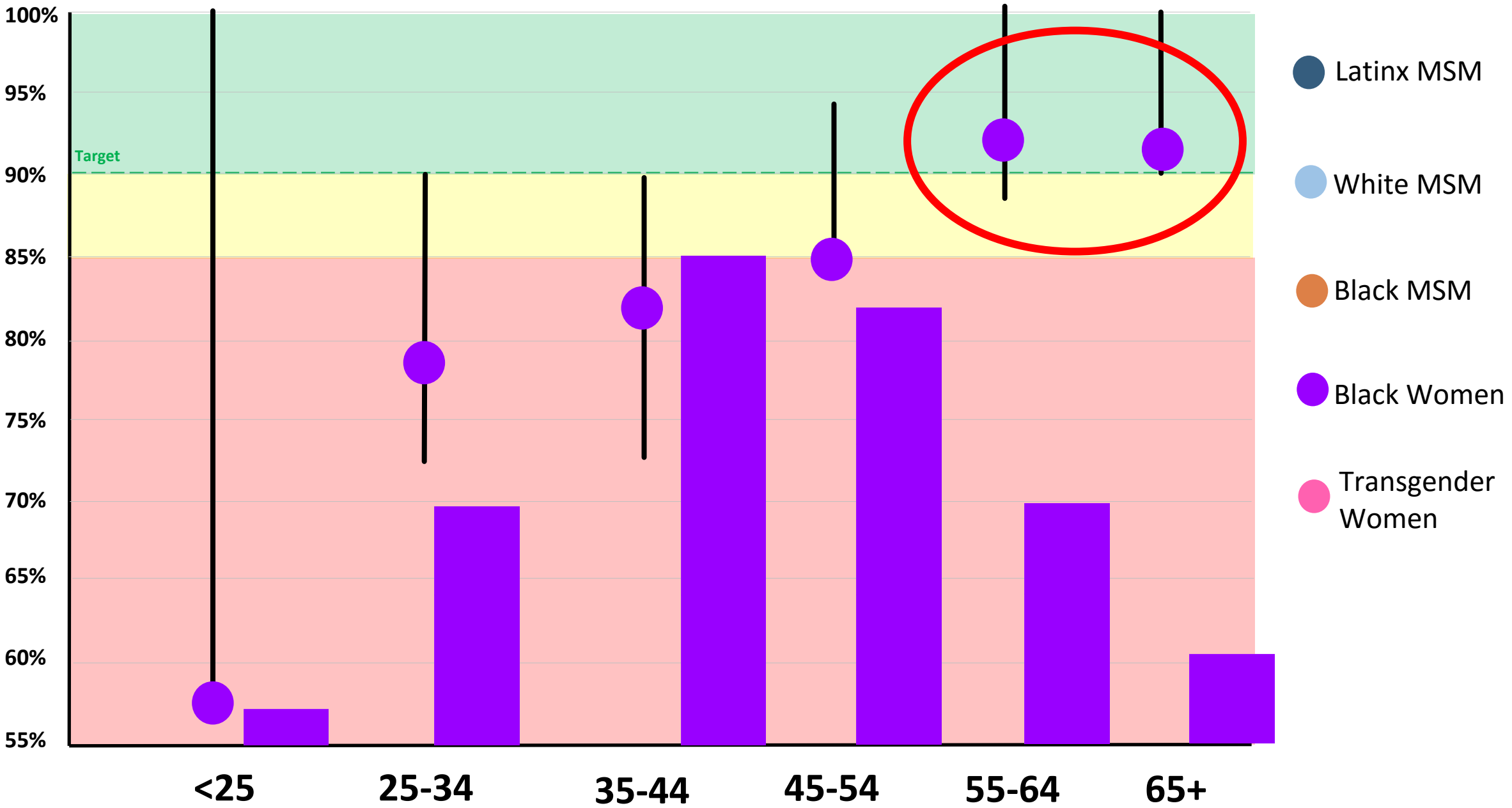
PLWH, by age, 2019 – Houston HSDA



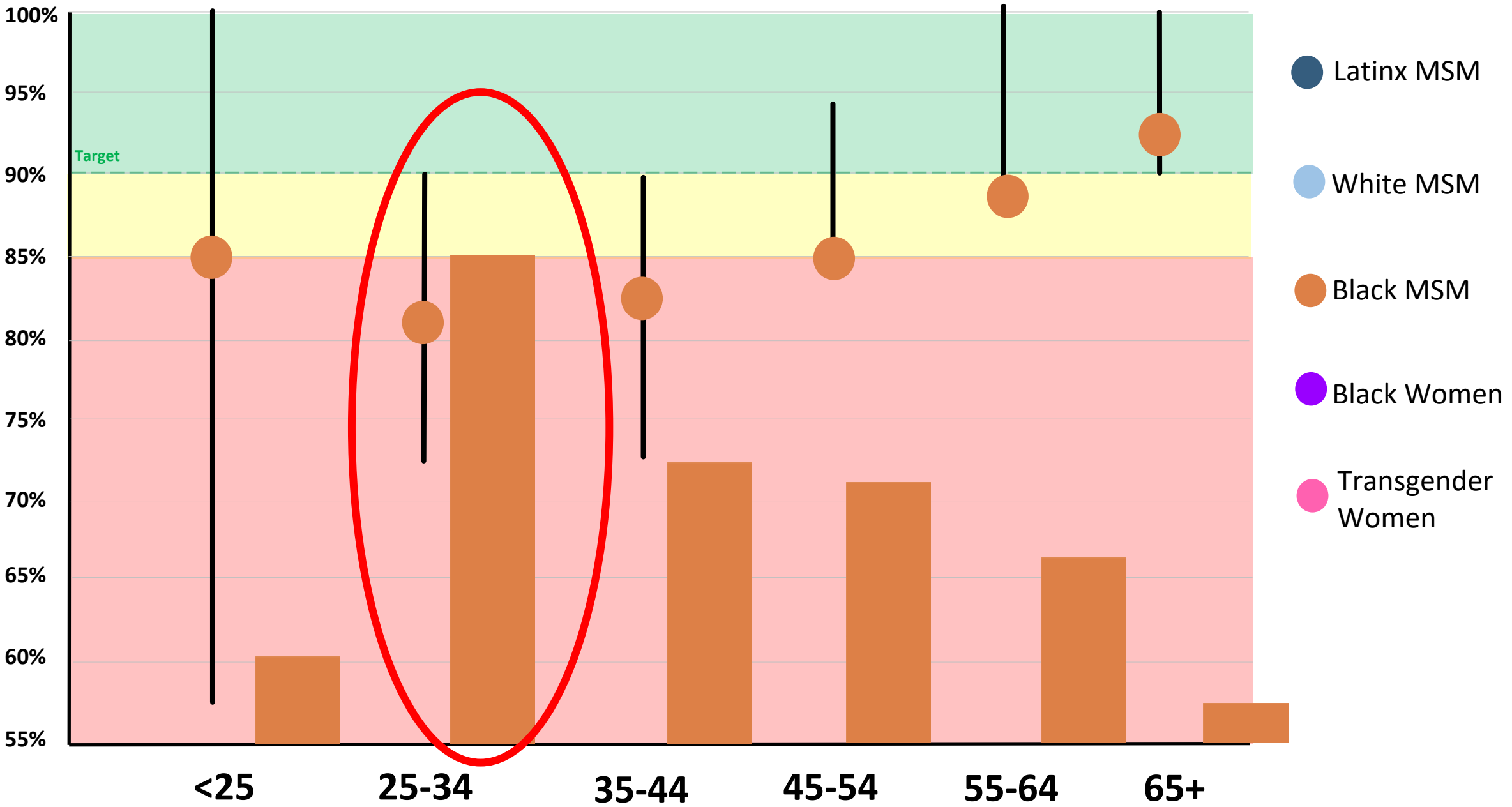
In-Care Viral Suppression, Priority Populations,2019



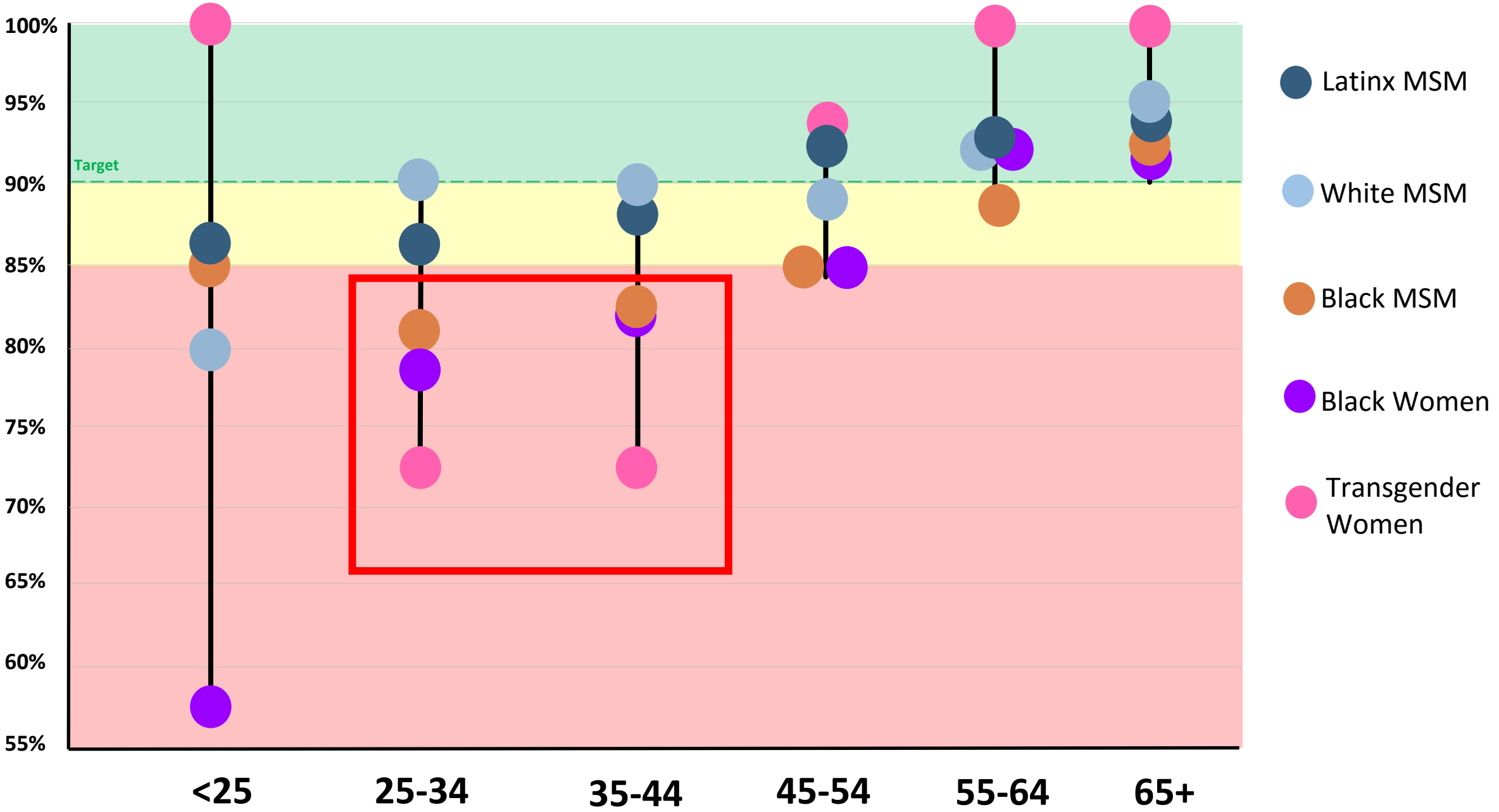
In-Care Viral Suppression, Priority Populations,2019



In-Care Viral Suppression, Priority Populations,2019



In-Care Viral Suppression, Priority Populations,2019

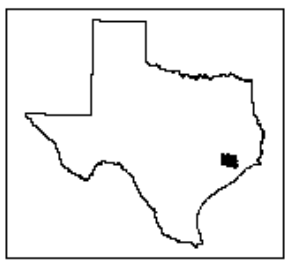


City of Houston Retained in Care 2018

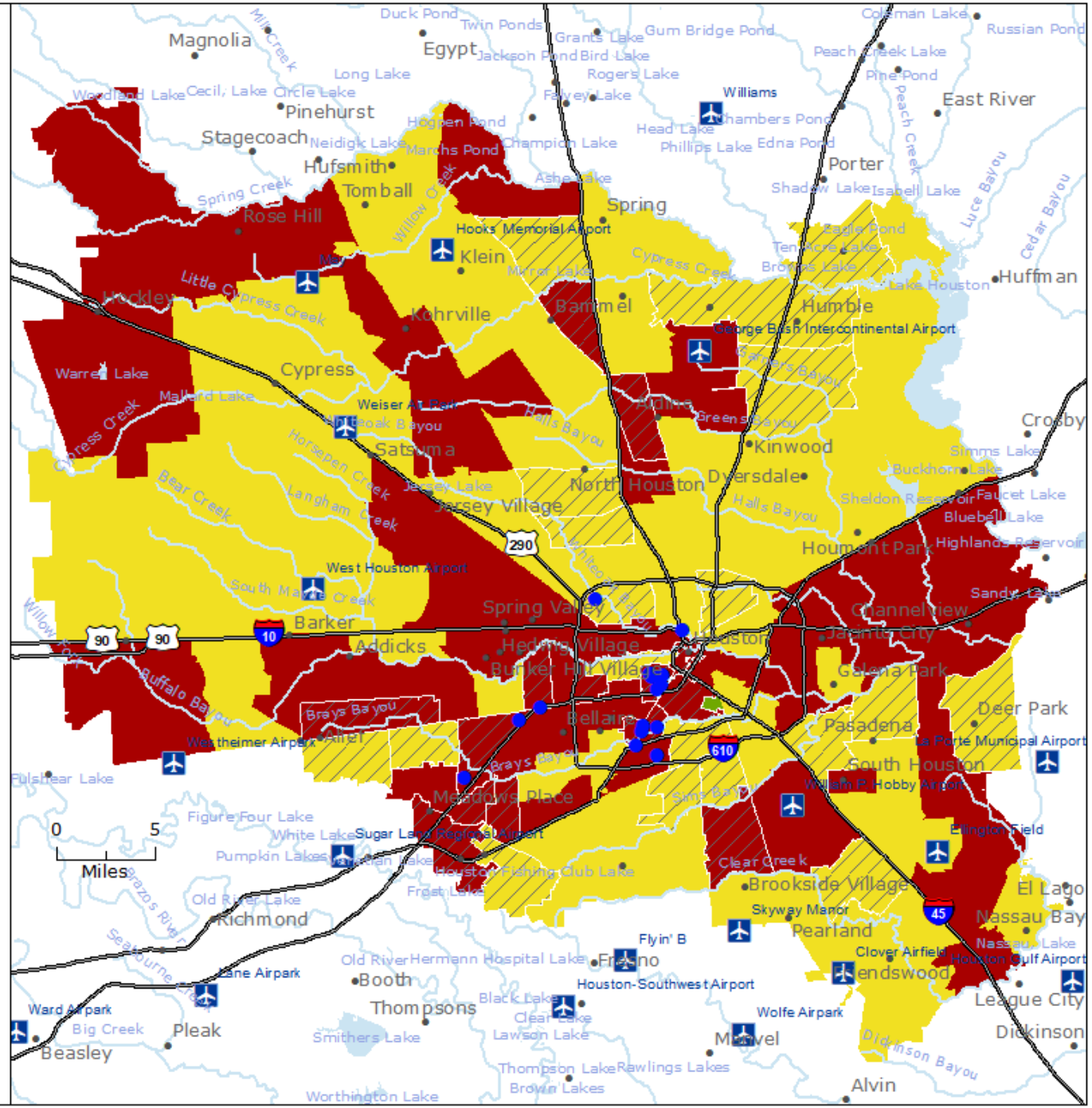
Statewide average = 67%

Percent Retained in Care by ZIP Code

- ≤ 69%
- 70% - 89%
- ≥ 90%
- No data/Not shown
- ≥ 1 HIV testing site
- Care facility
- City
- Airport
- Waterbody
- Highway



Source: Texas eHARS, 2019.

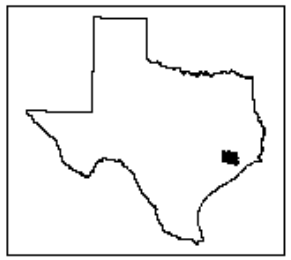


City of Houston Suppression Among Individuals Retained in Care 2018

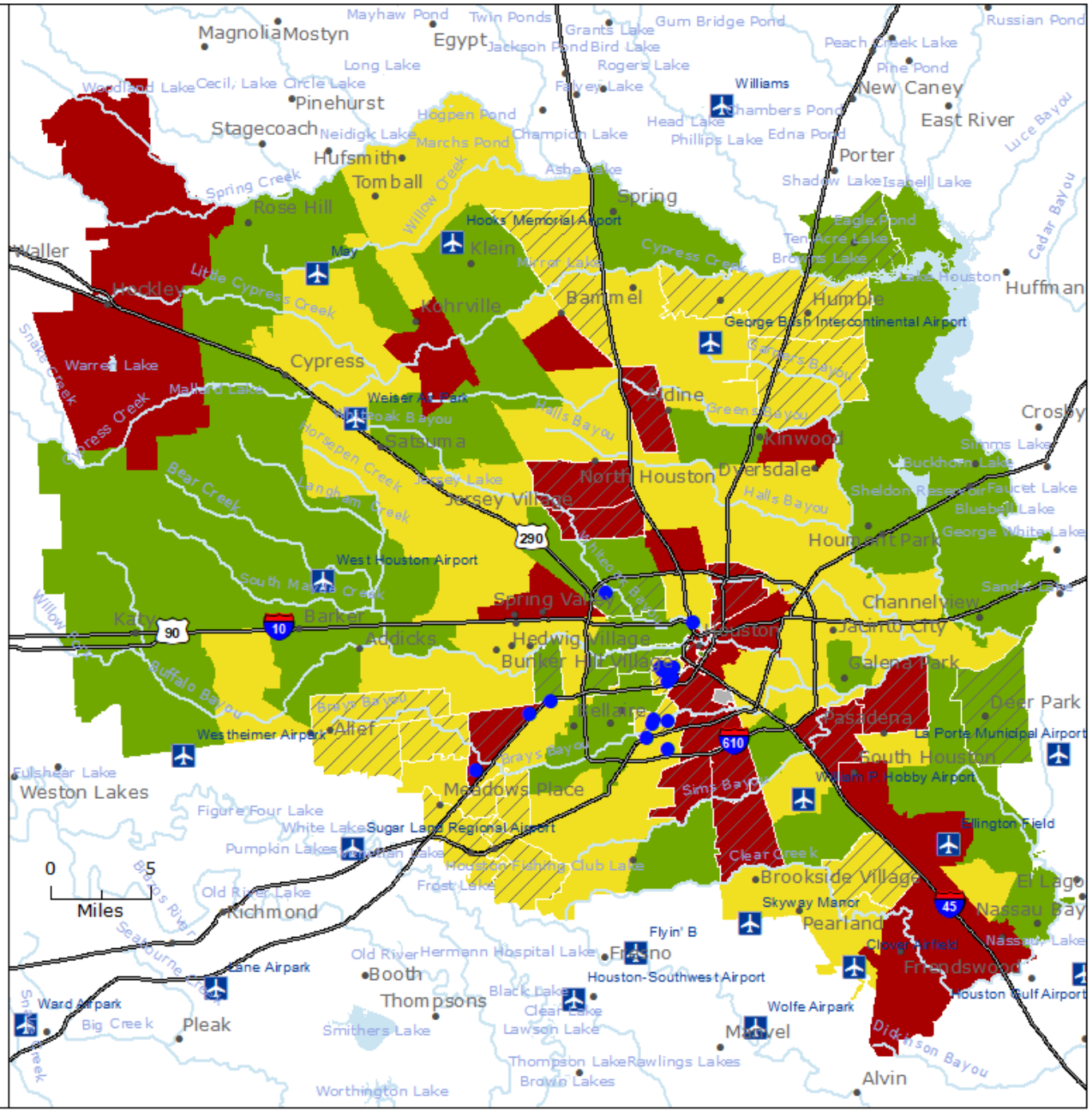
Statewide average = 84%

Percent Retained in Care by ZIP Code

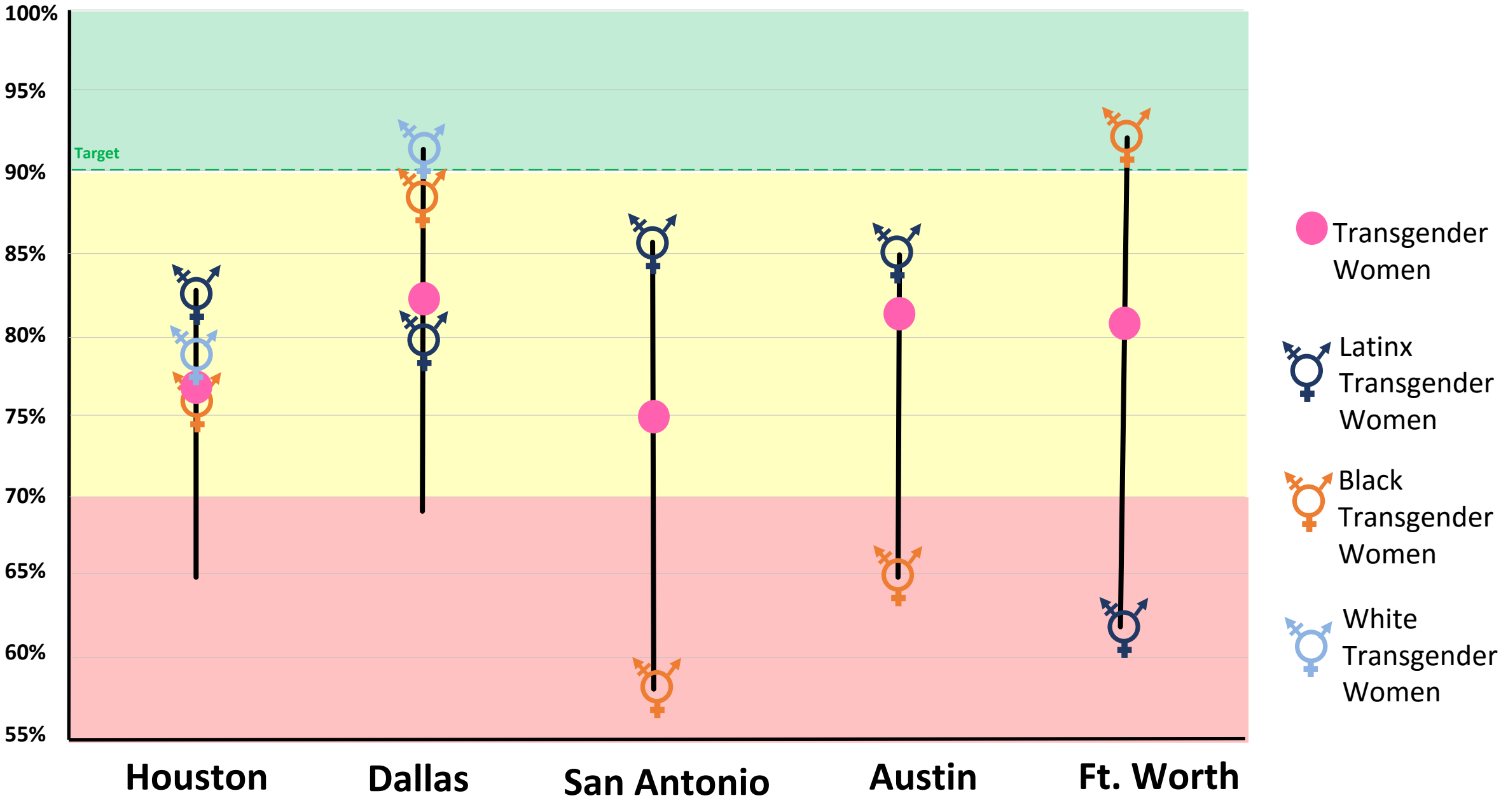
- ≤ 84%
- 85% - 89%
- ≥ 90%
- No data/Not shown
- ≥ 1 HIV testing site
- Care facility
- City
- Airport
- Waterbody
- Highway



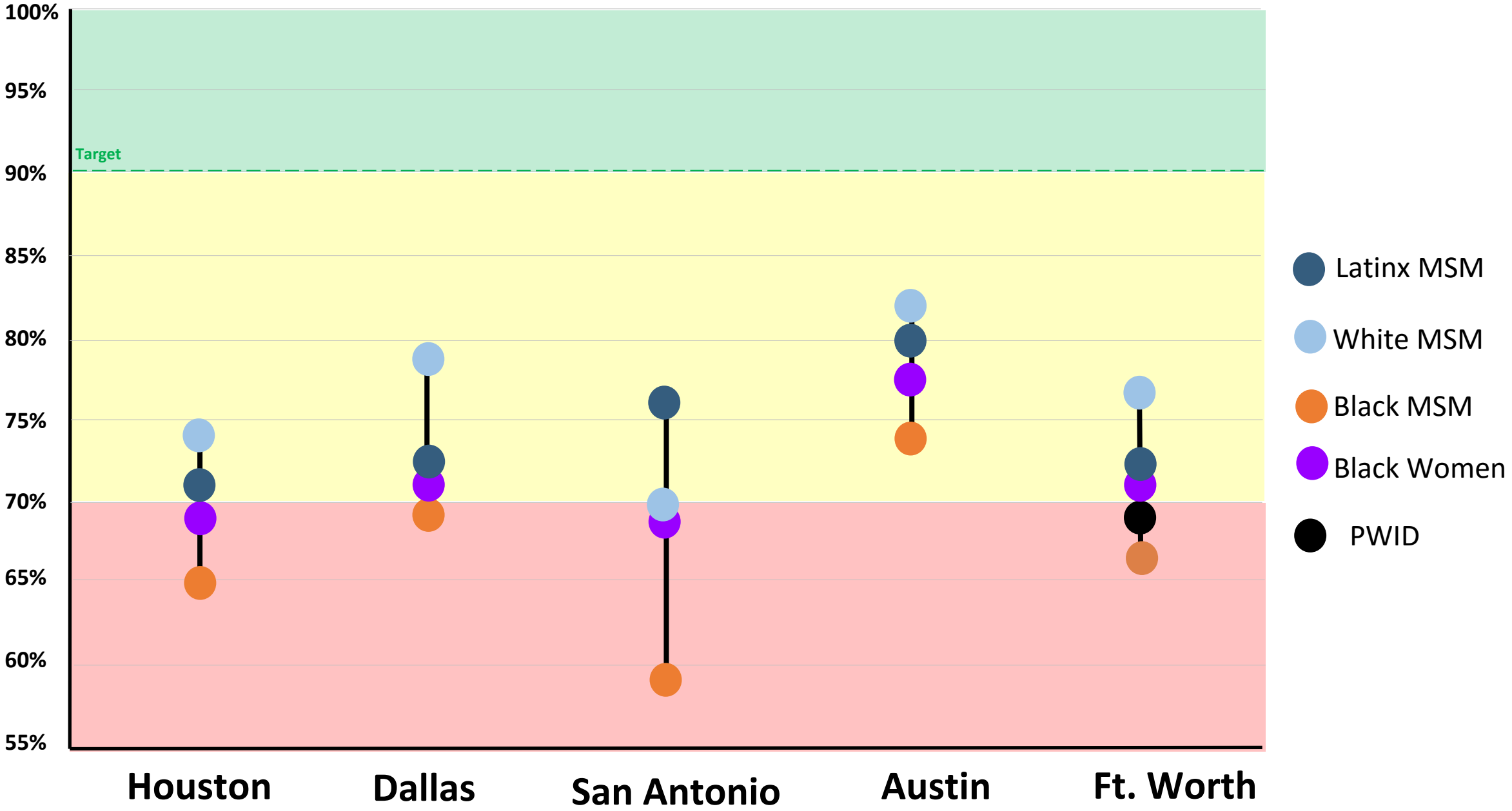
Source: Texas eHARS, 2019.



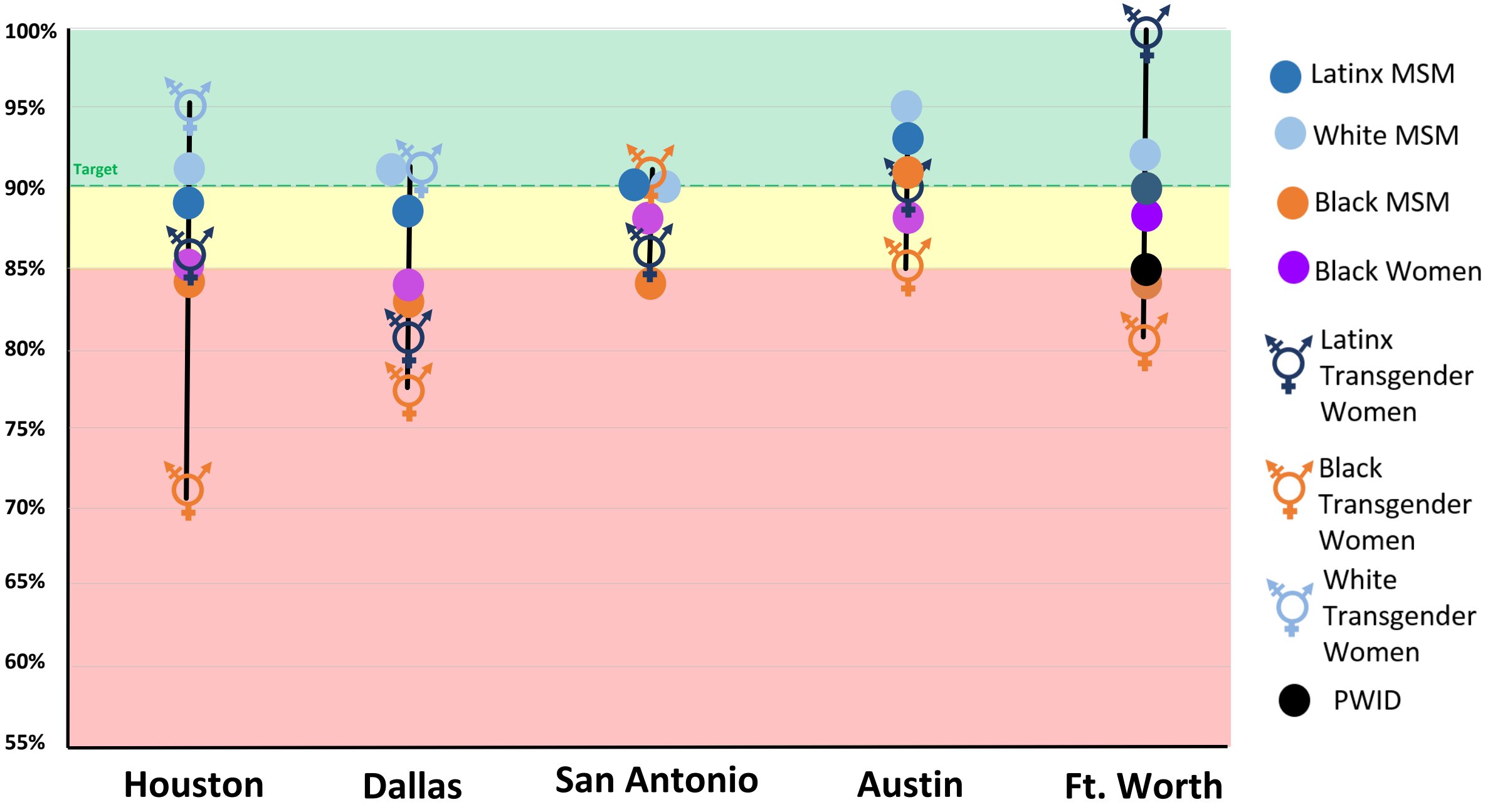
Retention in Care, Priority Populations, 2019



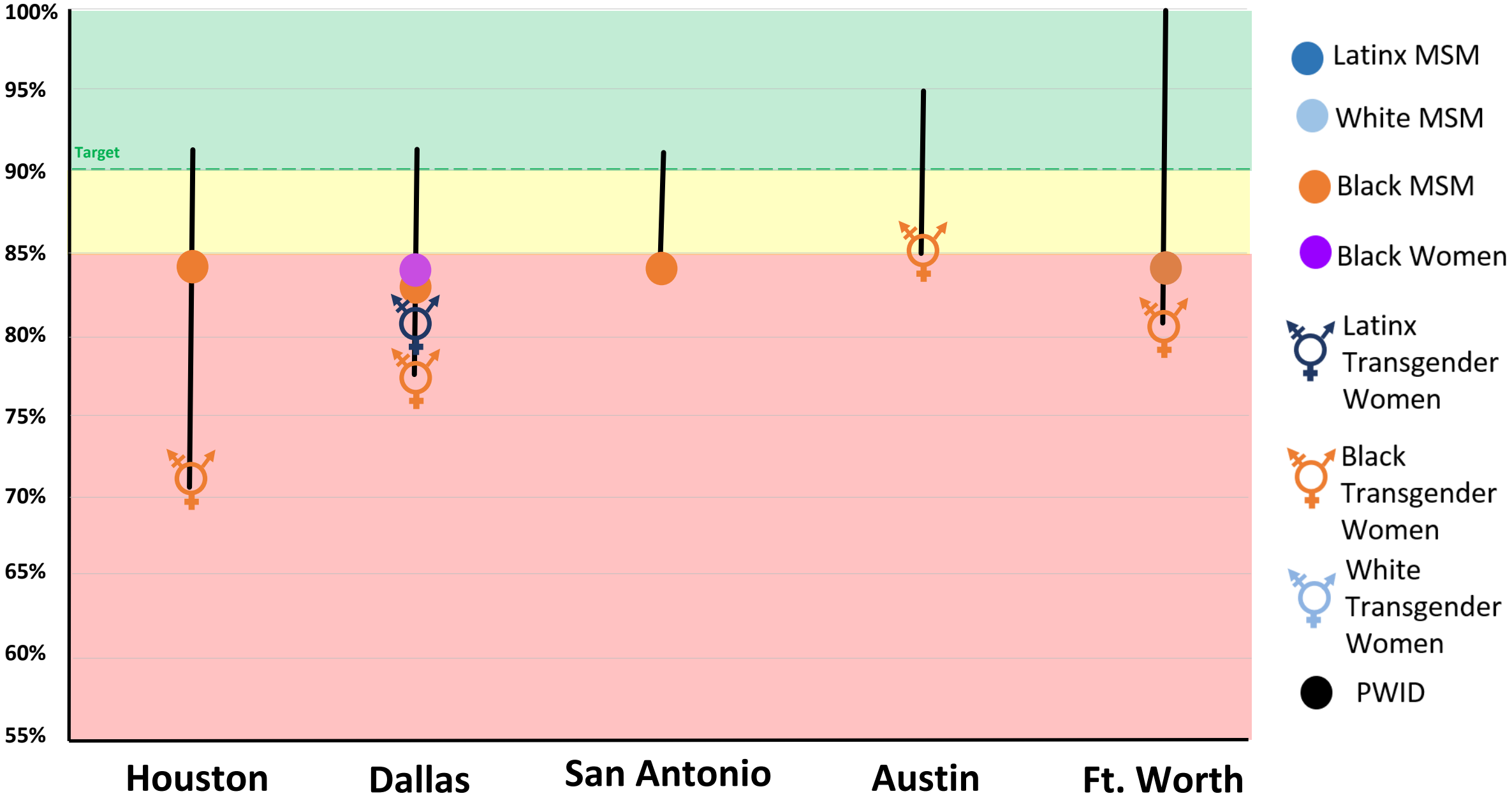
Retention in Care, Priority Populations, 2019



In-Care Viral Suppression, Priority Populations, 2019

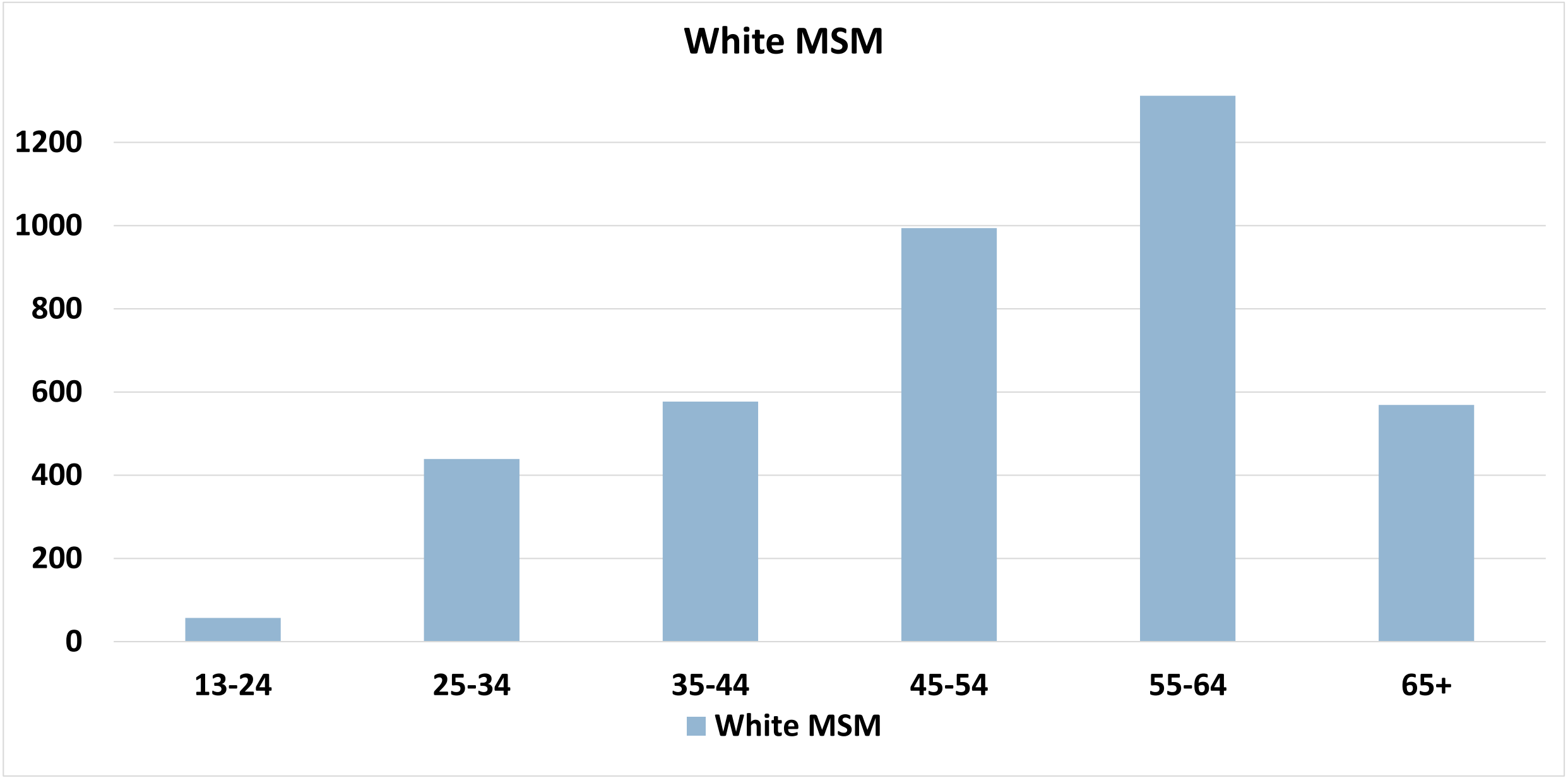


In-Care Viral Suppression, Priority Populations, 2019

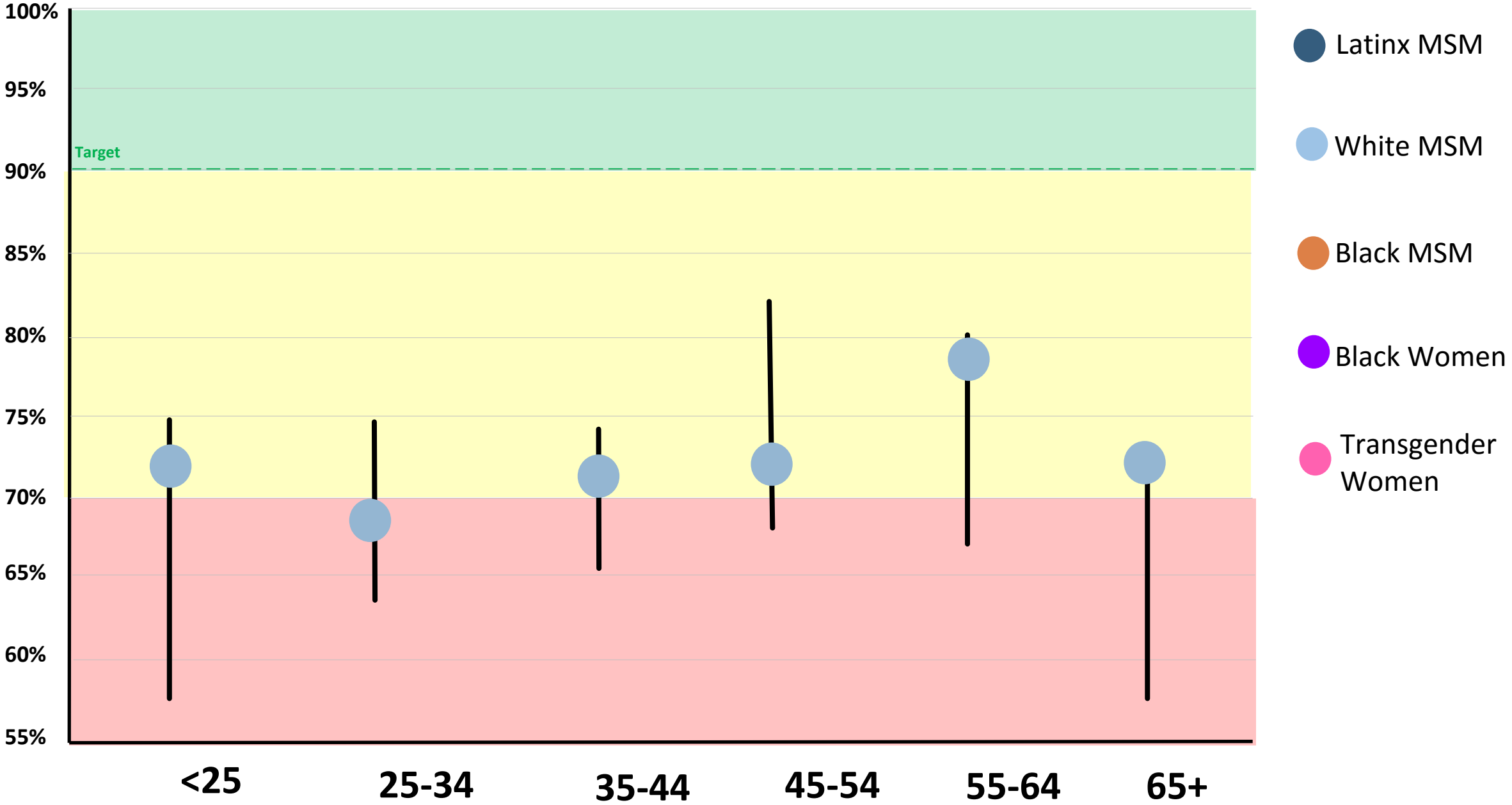


Supplemental slides

PLWH, by age, 2019 – Houston HSDA



Retention in Care, Priority Populations, 2019



HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV CAN BE TRANSMITTED BY

Sexual Contact

Sharing Needles to Inject Drugs

During Pregnancy, Birth, or Breast/Chestfeeding

HIV IS NOT TRANSMITTED BY

Air or Water

Saliva, Sweat, Tears, or Closed-Mouth Kissing

Insects or Pets

Sharing Toilets, Food, or Drinks

PROTECT YOURSELF FROM HIV

- Get tested at least once or more often if you have certain risk factors.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.

- If you engage in behaviors that may increase your chances of getting HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.

- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

KEEP YOURSELF HEALTHY AND PROTECT OTHERS IF YOU HAVE HIV

- Find HIV care and stay in HIV care.
- Take your HIV treatment as prescribed.
- Get and keep an undetectable viral load. This is the best way to stay healthy and protect others.
- If you have an undetectable viral load, you will not transmit HIV through sex.

- If your viral load is not undetectable—or does not stay undetectable—you can still protect your partners by using other HIV prevention options.
- Learn more at **www.cdc.gov/hiv/basics/livingwithhiv**.

For more information, please visit **www.cdc.gov/hiv.**

INFORMACIÓN BÁSICA SOBRE EL VIH

Sin tratamiento, el VIH (virus de la inmunodeficiencia humana) puede hacer que una persona esté muy enferma, e incluso causarle la muerte. Aprender lo básico sobre el VIH puede mantenerlo saludable y prevenir la transmisión de este virus.

EL VIH PUEDE SER TRANSMITIDO

Mediante el contacto sexual

Al compartir las agujas para inyectarse drogas

Durante el embarazo, el parto o el pecho/lactancia materna

EL VIH NO SE TRANSMITE

A través del aire o del agua

Mediante la saliva, el sudor, las lágrimas o los besos con la boca cerrada

Por los insectos o por las mascotas

Al compartir el inodoro, los alimentos o las bebidas

PROTÉJASE DEL VIH

- Hágase la prueba al menos una vez o con más frecuencia si tiene ciertos factores de riesgo.
- Use condones de la manera correcta cada vez que tenga relaciones sexuales anales o vaginales.

- Elija actividades que impliquen poco o nada de riesgo, como las relaciones sexuales orales.
- No se inyecte drogas, pero si lo hace, no comparta las agujas, jeringas, u otro equipo de inyección de drogas.
- Si tiene comportamientos que pueden aumentar sus posibilidades de contraer el VIH, pregúntele a su proveedor de atención médica si la profilaxis preexposicíon (PrEP) es adecuada para usted.

- Si cree que se ha expuesto al VIH dentro delos últimos 3 días, pregúntele de inmediato a un proveedor de atención médica acerca de la profilaxis posexposición (PEP). La PEP puede prevenir el VIH, pero debe comenzarse dentro de las 72 horas de la posible exposición.
- Hágase las pruebas de detección de otras ETS y reciba el tratamiento necesario.

SI TIENE EL VIH, MANTÉNGASE SALUDABLE Y PROTEJA A LOS DEMÁS

- Busque atención médica para el VIH y no deje de recibir la atención médica para el VIH.
- Tomar el tratamiento para el VIH según las indicaciones.

- Obtenga y mantenga una carga viral indetectable. Esta es la mejor manera de mantenerse saludable y proteger a los demás.
- Si tiene una carga viral indetectable, no transmitirá el VIH a su pareja sexual.
- Si su carga viral no es indetectable, o no permanece indetectable, aún puede proteger a sus parejas utilizando otras opciones de prevención del VIH.
- Obtenga más información en **www.cdc.gov/hiv/spanish/basics/livingwithhiv**.

Para obtener más información, visite la página **www.cdc.gov/hiv/spanish.**

MLS-280326_r

HIV Overview

HIV and AIDS: The Basics

Key Points

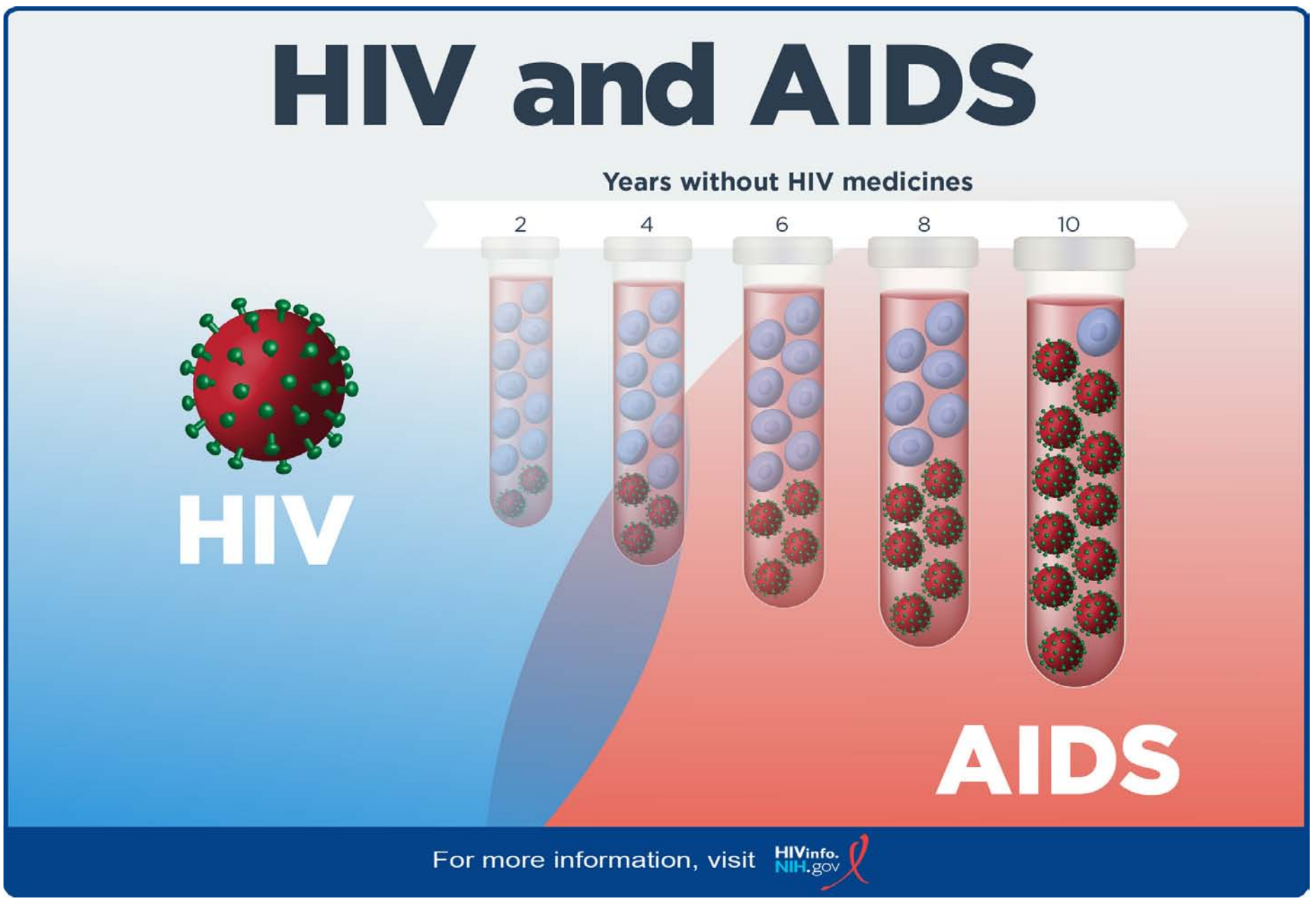
- The human immunodeficiency virus (HIV) is the virus that causes HIV infection. HIV causes acquired immunodeficiency syndrome (AIDS), the most advanced stage of HIV infection.
- HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the United States, HIV is spread mainly by having anal or vaginal sex or sharing injection drug equipment, such as syringes or needles, with a person who has HIV.
- Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV treatment regimen) every day.
- ART is recommended for everyone who has HIV. ART cannot cure HIV infection, but HIV medicines help people with HIV live longer, healthier lives. HIV medicines can also reduce the risk of HIV transmission.

What is HIV and AIDS?

HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection. The abbreviation "HIV" can refer to the virus or to HIV infection.

AIDS stands for acquired immunodeficiency syndrome. AIDS is the most advanced stage of HIV infection.

HIV attacks and destroys the infection-fighting CD4 cells (CD4 T lymphocyte) of the immune system. The loss of CD4 cells makes it difficult for the body to fight off infections and certain cancers. Without treatment, HIV can gradually destroy the immune system and HIV infection advances to AIDS.



How is HIV spread?

The spread of HIV from person to person is called HIV transmission. HIV is spread only through certain body fluids from a

person who has HIV. These body fluids include:

- Blood
- Semen
- Pre-seminal fluid
- Vaginal fluids
- Rectal fluids
- Breast milk

HIV transmission is only possible through contact with HIV-infected body fluids. In the United States, HIV is spread mainly by:

- Having anal or vaginal sex with someone who has HIV without using a condom or taking medicines to prevent or treat HIV
- Sharing injection drug equipment (works), such as needles or syringes, with someone who has HIV

The spread of HIV from a woman with HIV to her child during pregnancy, childbirth, or breastfeeding is called perinatal transmission of HIV. For more information, read the HIVinfo fact sheet on Preventing Perinatal Transmission of HIV.

You cannot get HIV by shaking hands or hugging a person who has HIV. You also cannot get HIV from contact with objects, such as dishes, toilet seats, or doorknobs, used by a person with HIV. HIV is not spread through the air or water or by mosquitoes, ticks, or other blood-sucking insects. Use the HIVinfo You Can Safely Share...With Someone With HIV infographic to spread this message.

How can a person reduce the risk of getting HIV?

To reduce your risk of HIV infection, use condoms correctly every time you have sex, limit your number of sexual partners, and never share injection drug equipment.

Also talk to your health care provider about pre-exposure prophylaxis (PrEP). PrEP is an HIV prevention option for people who do not have HIV but who are at high risk of becoming infected with HIV. PrEP involves taking a specific HIV medicine every day. For more information, read the HIVinfo fact sheet on Pre-exposure Prophylaxis (PrEP).

HIV medicines, given to women with HIV during pregnancy and childbirth and to their babies after birth, reduce the risk of perinatal transmission of HIV. In addition, because HIV can be transmitted through breast milk, women with HIV who live in the United States should not breastfeed their babies. Baby formula is a safe and healthy alternative to breast milk and is readily available in the United States.

What is the treatment for HIV?

Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV treatment regimen) every day.

ART is recommended for everyone who has HIV. ART prevents HIV from multiplying, which reduces the amount of HIV in the body (called the viral load). Having less HIV in the body protects the immune system and prevents HIV infection from advancing to AIDS. ART cannot cure HIV, but HIV medicines help people with HIV live longer, healthier lives.

ART also reduces the risk of HIV transmission. A main goal of ART is to reduce a person's viral load to an undetectable level. An undetectable viral load means that the level of HIV in the blood is too low to be detected by a viral load test. People with HIV who maintain an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative partner through sex.

What are the symptoms of HIV and AIDS?

Within 2 to 4 weeks after infection with HIV, some people may have flu-like symptoms, such as fever, chills, or rash. The symptoms may last for a few days to several weeks. Other possible symptoms of HIV include night sweats, muscle aches, sore throat, fatigue, swollen lymph nodes, and mouth ulcers. Having these symptoms do not mean you have HIV. Other illnesses can cause the same symptoms. Some people may not feel sick during early HIV infection (called acute HIV infection). During this earliest stage of HIV infection, the virus multiplies rapidly. After the initial stage of infection, HIV continues to multiply but at very low levels.

More severe symptoms of HIV infection, such as a badly damaged immune system and signs of opportunistic infections, generally do not appear for many years until HIV has advanced to AIDS. People with AIDS have badly damaged immune systems that make them prone to opportunistic infections. (Opportunistic infections are infections and infection-related cancers that occur more frequently or are more severe in people with weakened immune systems than in people with healthy immune systems.)

Without treatment with HIV medicines, HIV infection usually advances to AIDS in 10 years or longer, though it may advance faster in some people.

HIV transmission is possible at any stage of HIV infection—even if a person with HIV has no symptoms of HIV.

How is AIDS diagnosed?

Symptoms such as fever, weakness, and weight loss may be a sign that a person's HIV has advanced to AIDS. However, a diagnosis of AIDS is based on the following criteria:

- A drop in CD4 count to less than 200 cells/mm^3. A CD4 count measures the number of CD4 cells in a sample of blood.

  OR

- The presence of certain opportunistic infections.

Although an AIDS diagnosis indicates severe damage to the immune system, HIV medicines can still help people at this stage of HIV infection.

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

From Centers for Disease Control and Prevention:

- HIV Basics
- About HIV
- AIDS and Opportunistic Infections

From the Department of Health and Human Services (HHS):

- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection:
  - Introduction

From the National Institute of Allergy and Infectious Diseases (NIAID):

- HIV/AIDS

Also see the HIV Source collection of HIV links and resources.

The HIV Life Cycle

Key Points

- HIV attacks and destroys the CD4 cells (CD4 T lymphocyte) of the immune system. CD4 cells play a major role in protecting the body from infection.
- HIV uses the machinery of the CD4 cells to multiply and spread throughout the body. This process, which is carried out in seven steps or stages, is called the HIV life cycle. HIV medicines protect the immune system by blocking HIV at different stages of the HIV life cycle.
- Antiretroviral therapy (ART) is the use of a combination of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines from at least two different HIV drug classes every day. Because each class of drugs is designed to target a specific step in the HIV life cycle, ART is very effective at preventing HIV from multiplying.

What is the HIV life cycle?

HIV attacks and destroys the CD4 cells (CD4 T lymphocyte) of the immune system. CD4 cells are a type of white blood cell that play a major role in protecting the body from infection. HIV uses the machinery of the CD4 cells to multiply and spread throughout the body. This process, which is carried out in seven steps or stages, is called the HIV life cycle.

What is the connection between the HIV life cycle and HIV medicines?

Antiretroviral therapy (ART) is the use of a combination of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV treatment regimen) every day. HIV medicines protect the immune system by blocking HIV at different stages of the HIV life cycle. HIV medicines are grouped into different drug classes according to how they fight HIV. Each class of drugs is designed to target a specific step in the HIV life cycle.

Because an HIV treatment regimen includes HIV medicines from at least two different HIV drug classes, ART is very effective at preventing HIV from multiplying. Having less HIV in the body protects the immune system and prevents HIV from advancing to acquired immunodeficiency syndrome (AIDS).

ART cannot cure HIV, but HIV medicines help people with HIV live longer, healthier lives. HIV medicines also reduce the risk of HIV transmission (the spread of HIV to others).

What are the seven stages of the HIV life cycle?

The seven stages of the HIV life cycle are: 1) binding, 2) fusion, 3) reverse transcription, 4) integration, 5) replication, 6) assembly, and 7) budding.

To understand each stage in the HIV life cycle, it helps to first imagine what HIV looks like.

Now, follow each stage in the HIV life cycle as HIV attacks a CD4 cell and uses the machinery of the cell to multiply.

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

From the National Institute of Allergy and Infectious Diseases:

- HIV Replication Cycle
- Antiretroviral Drug Discovery and Development

Also see the HIV Source collection of HIV links and resources.

The Stages of HIV Infection

Key Points

- Without treatment with HIV medicines, HIV infection advances in stages, getting worse over time.
- The three stages of HIV infection are (1) acute HIV infection, (2) chronic HIV infection, and (3) acquired immunodeficiency syndrome (AIDS).
- There is no cure for HIV, but treatment with HIV medicines (called antiretroviral therapy or ART) can slow or prevent HIV from advancing from one stage to the next. HIV medicines help people with HIV live longer, healthier lives.

HIV Infection

Without treatment, HIV infection advances in stages, getting worse over time. HIV gradually destroys the immune system and eventually causes acquired immunodeficiency syndrome (AIDS).

There is no cure for HIV, but treatment with HIV medicines (called antiretroviral therapy or ART) can slow or prevent HIV from

advancing from one stage to the next. HIV medicines help people with HIV live longer, healthier lives. One of the main goals of ART is to reduce a person's viral load to an undetectable level. An undetectable viral load means that the level of HIV in the blood is too low to be detected by a viral load test. People with HIV who maintain an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative partner through sex.

HIV Progression

There are three stages of HIV infection:

1. Acute HIV Infection

Acute HIV infection is the earliest stage of HIV infection, and it generally develops within 2 to 4 weeks after infection with HIV. During this time, some people have flu-like symptoms, such as fever, headache, and rash. In the acute stage of infection, HIV multiplies rapidly and spreads throughout the body. The virus attacks and destroys the infection-fighting CD4 cells (CD4 T lymphocyte) of the immune system. During the acute HIV infection stage, the level of HIV in the blood is very high, which greatly increases the risk of HIV transmission. A person may experience significant health benefits if they start ART during this stage.

2. Chronic HIV Infection

The second stage of HIV infection is chronic HIV infection (also called asymptomatic HIV infection or clinical latency). During this stage, HIV continues to multiply in the body but at very low levels. People with chronic HIV infection may not have any HIV-related symptoms. Without ART, chronic HIV infection usually advances to AIDS in 10 years or longer, though in some people it may advance faster. People who are taking ART may be in this stage for several decades. While it is still possible to transmit HIV to others during this stage, people who take ART exactly as prescribed and maintain an undetectable viral load have effectively no risk of transmitting HIV to an HIV-negative partner through sex.

3. AIDS

AIDS is the final, most severe stage of HIV infection. Because HIV has severely damaged the immune system, the body cannot fight off opportunistic infections. (Opportunistic infections are infections and infection-related cancers that occur more frequently or are more severe in people with weakened immune systems than in people with healthy immune systems.) People with HIV are diagnosed with AIDS if they have a CD4 count of less than 200 cells/mm3 or if they have certain opportunistic infections. Once a person is diagnosed with AIDS, they can have a high viral load and are able to transmit HIV to others very easily. Without treatment, people with AIDS typically survive about 3 years.

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

From HIV.gov:

- What Are HIV and AIDS?

From the Centers for Disease Control and Prevention (CDC):

- About HIV

Also see the HIV Source collection of HIV links and resources.

What is a Latent HIV Reservoir?

Key Points

- A latent HIV reservoir is a group of immune system cells in the body that are infected with HIV but are not actively producing new HIV.
- Finding ways to target and destroy latent reservoirs is a major challenge facing HIV researchers who are exploring different strategies for clearing out reservoirs.

What is a latent HIV reservoir?

A latent HIV reservoir is a group of immune system cells in the body that are infected with HIV but are not actively producing

new virus.

HIV attacks immune system cells in the body and uses the cells' own machinery to make copies of itself. However, some HIV-infected immune cells go into a resting or latent state. While in this resting state, the infected cells do not produce new virus. HIV can hide inside these cells for years, forming a latent HIV reservoir but, at any time, cells in the latent reservoir can become active again and start making more virus.

To find out more about how HIV attacks cells, read the HIV Life Cycle fact sheet from HIVinfo.

Do HIV medicines work against latent HIV reservoirs?

HIV medicines prevent HIV from multiplying, which reduces the amount of the virus in the body (called the viral load). Because the HIV-infected cells in a latent reservoir are not producing new copies of the virus, HIV medicines have no effect on them.

People with HIV must take a daily combination of HIV medicines (called an HIV treatment regimen) to keep their viral loads low. If a person stops taking their HIV medicines, the infected cells of the latent reservoir can begin making HIV again and the person's viral load will increase. That is why it is important to continue taking HIV medicines every day as prescribed, even when viral load levels are low.

Are researchers studying ways to target latent HIV reservoirs?

Finding ways to target and destroy latent reservoirs is a major challenge facing HIV researchers. Researchers are exploring different strategies for clearing out reservoirs, including:

- Using gene therapy (manipulating genes to treat or prevent disease) to cut out certain HIV genes and inactivate the virus in HIV-infected immune cells.
- Developing drugs or other methods to reactivate latent HIV so that the HIV can be destroyed by the immune system or new HIV therapies. This means of eliminating latent HIV reservoirs is sometimes known as the "shock and kill" or "kick and kill" strategy.

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

From the National Institute of Allergy and Infectious Diseases:

- HIV/AIDS Treatment
- HIV Viral Eradication
- Sustained ART-Free HIV Remission

Also see the HIV Source collection of HIV links and resources.

HIV Testing

Key Points

- HIV testing determines if a person is infected with HIV. The human immunodeficiency virus (HIV) is the virus that causes acquired immunodeficiency syndrome (AIDS). AIDS is the most advanced stage of HIV infection.
- The Centers for Disease Control and Prevention (CDC) recommends that everyone 13 to 64 years of age get tested for HIV at least once as part of routine health care and that people at higher risk for HIV get tested more often. If you are over 64 years of age and at risk for HIV, your health care provider may recommend HIV testing.
- Risk factors for HIV include having vaginal or anal sex with someone who is HIV positive or whose HIV status you do not know; having sex with many partners; and injecting drugs and sharing needles, syringes, or other drug equipment with others.
- CDC recommends that all pregnant women get tested for HIV so that they can begin taking HIV medicines if they are HIV positive.

What is HIV testing?

HIV testing determines if a person is infected with HIV. The human immunodeficiency virus (HIV) is the virus that causes acquired immunodeficiency syndrome (AIDS). AIDS is the most advanced stage of HIV infection.

HIV testing can detect HIV infection, but it cannot tell how long a person has had HIV or if the person has AIDS.

Why is HIV testing important?

Knowing your HIV status can help keep you—and others—safe.

If you are HIV negative:

A negative HIV test result shows that you do not have HIV. Continue taking steps to avoid getting HIV, such as using condoms during sex and, if you are at high risk of getting HIV, taking medicines to prevent HIV (called pre-exposure prophylaxis or PrEP). For more information, read the HIVinfo fact sheet on The Basics of HIV Prevention.

If you are HIV positive:

A positive HIV test result shows that you have HIV, but you can still take steps to protect your health. Begin by talking to your health care provider about antiretroviral therapy (ART). People on ART take a combination of HIV medicines every day to treat HIV infection. ART is recommended for everyone who has HIV, and people with HIV should start ART as soon as possible. ART cannot cure HIV, but HIV medicines help people with HIV live longer, healthier lives.

A main goal of ART is to reduce a person's viral load to an undetectable level. An undetectable viral load means that the level of HIV in the blood is too low to be detected by a viral load test. People with HIV who maintain an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative partner through sex.

Who should get tested for HIV?

The Centers for Disease Control and Prevention (CDC) recommends that everyone 13 to 64 years of age get tested for HIV at least once as part of routine health care. As a general rule, people at higher risk for HIV should get tested each year. Sexually active gay and bisexual men may benefit from getting tested more often, such as every 3 to 6 months. If you are over 64 years of age and at risk, your health care provider may recommend HIV testing.

Factors that increase the risk of HIV include:

- Having vaginal or anal sex with someone who is HIV positive or whose HIV status you do not know
- Injecting drugs and sharing needles, syringes, or other drug equipment with others
- Exchanging sex for money or drugs
- Having a sexually transmitted disease (STD), such as syphilis
- Having sex with anyone who has any of the HIV risk factors listed above

Talk to your health care provider about your risk for HIV and how often you should get tested for HIV.

Should pregnant women get tested for HIV?

CDC recommends that all pregnant women get tested for HIV so that they can begin taking HIV medicines if they are HIV positive. Women with HIV take HIV medicines during pregnancy and childbirth to reduce the risk of perinatal transmission of HIV and to protect their own health. For more information, read the HIVinfo fact sheet on Preventing Perinatal Transmission of HIV.

What are the types of HIV tests?

There are three types of tests used to diagnose HIV infection: antibody tests, antigen/antibody tests, and nucleic acid tests (NATs). Your health care provider can determine the appropriate HIV test for you. How soon each test can detect HIV infection differs, because each test has a different window period. The window period is the time between when a person may have been exposed to HIV and when a test can accurately detect HIV infection.

- **Antibody tests** check for HIV antibodies in blood or oral fluid. HIV antibodies are disease-fighting proteins that the body produces in response to HIV infection. Most rapid tests and home use tests are antibody tests.
- **Antigen/antibody tests** can detect both HIV antibodies and HIV antigens (a part of the virus) in the blood.
- **NATs** look for HIV in the blood.

A person's initial HIV test will usually be either an antibody test or an antigen/antibody test. NATs are very expensive and not routinely used for HIV screening unless the person had a high-risk exposure or a possible exposure with early symptoms of HIV infection.

When an HIV test is positive, a follow-up test will be conducted. Sometimes people will need to visit a health care provider to take a follow-up test. Other times, the follow-up test may be performed in a lab using the same blood sample that was provided for the first test. A positive follow-up test confirms that a person has HIV.

Talk to your health care provider about your HIV risk factors and the best type of HIV test for you.

Is HIV testing confidential?

HIV testing can be confidential or anonymous.

Confidential testing means that your HIV test results will include your name and other identifying information, and the results will be included in your medical record. HIV-positive test results will be reported to local or state health departments to be counted in statistical reports. Health departments remove all personal information (including names and addresses) from HIV test results before sharing the information with CDC. CDC uses this information for reporting purposes and does not share this information with any other organizations, including insurance companies.

Anonymous testing means you do not have to give your name when you take an HIV test. When you take the test, you receive a number. To get your HIV test results, you give the number instead of your name.

Where can someone get tested for HIV?

Your health care provider can give you an HIV test. HIV testing is also available at many hospitals, medical clinics, substance use programs, and community health centers. Use CDC's GetTested treatment locator to find an HIV testing location near you. Getting tested through a professional health care provider is recommended; however, there are HIV self-testing kits available. Rapid self-test and mail-in self-test are the two types of HIV self-tests, but state laws regarding self-testing may limit their availability in a location.

A rapid self-test is an oral fluid test done entirely at home or in private. There is currently one U.S. Food and Drug Administration (FDA)-approved rapid self-test called OraQuick In-Home HIV test. A mail-in self-test requires a person to provide a blood sample from a fingerstick, which is then sent to a lab for testing.

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

From CDC:

- Getting Tested
- HIV Basics: Testing
- HIV Testing
- Self-Testing
- Self-Testing: A Convenient and Private Option

From FDA:

- OraQuick In-Home HIV Test

Also see the HIV Source collection of HIV links and resources.

FDA-Approved HIV Medicines

Treatment with HIV medicines is called antiretroviral therapy (ART). ART is recommended for everyone with HIV, and people with HIV should start ART as soon as possible. People on ART take a combination of HIV medicines (called an HIV treatment regimen) every day. A person's initial HIV treatment regimen generally includes three HIV medicines from at least two different HIV drug classes.

The following table lists HIV medicines recommended for the treatment of HIV infection in the United States, based on the U.S. Department of Health and Human Services (HHS) HIV/AIDS medical practice guidelines. All of these drugs are approved by the U.S. Food and Drug Administration (FDA). The HIV medicines are listed according to drug class

are approved by the U.S. Food and Drug Administration (FDA). The HIV medicines are listed according to drug class and identified by generic and brand names. Click on a drug name to view information on the drug from the Clinicalinfo Drug Database.

To see a timeline of all FDA approval dates for HIV medicines, view the HIVinfo FDA Approval of HIV Medicines infographic.

FDA-Approved HIV Medicines

Drug Class	Generic Name (Other names and acronyms)	Brand Name	FDA Approval Date
Nucleoside Reverse Transcriptase Inhibitors (NRTIs)			
NRTIs block reverse transcriptase, an enzyme HIV needs to make copies of itself.	abacavir (abacavir sulfate, ABC)	Ziagen	December 17, 1998
	emtricitabine (FTC)	Emtriva	July 2, 2003
	lamivudine (3TC)	Epivir	November 17, 1995
	tenofovir disoproxil fumarate (tenofovir DF, TDF)	Viread	October 26, 2001
	zidovudine (azidothymidine, AZT, ZDV)	Retrovir	March 19, 1987
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)			
NNRTIs bind to and later alter reverse transcriptase, an enzyme HIV needs to make copies of itself.	doravirine (DOR)	Pifeltro	August 30, 2018
	efavirenz (EFV)	Sustiva	September 17, 1998
	etravirine (ETR)	Intelence	January 18, 2008
	nevirapine (extended-release nevirapine, NVP)	Viramune	June 21, 1996
		Viramune XR (extended release)	March 25, 2011
	rilpivirine (rilpivirine hydrochloride, RPV)	Edurant	May 20, 2011
Protease Inhibitors (PIs)			
PIs block HIV protease, an enzyme HIV needs to make copies of itself.	atazanavir (atazanavir sulfate, ATV)	Reyataz	June 20, 2003
	darunavir (darunavir ethanolate, DRV)	Prezista	June 23, 2006
	fosamprenavir (fosamprenavir calcium, FOS-APV, FPV)	Lexiva	October 20, 2003
	ritonavir (RTV) *Although ritonavir is a PI, it is generally used as a pharmacokinetic enhancer as recommended in the Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV and the Guidelines for the Use of Antiretroviral Agents in Pediatric	Norvir	March 1, 1996

Drug Class	Generic Name (Other names and acronyms)	Brand Name	FDA Approval Date
	tipranavir (TPV)	Aptivus	June 22, 2005
Fusion Inhibitors			
Fusion inhibitors block HIV from entering the CD4 T lymphocyte (CD4 cells) of the immune system.	enfuvirtide (T-20)	Fuzeon	March 13, 2003
CCR5 Antagonists			
CCR5 antagonists block CCR5 coreceptors on the surface of certain immune cells that HIV needs to enter the cells.	maraviroc (MVC)	Selzentry	August 6, 2007
Integrase Strand Transfer Inhibitor (INSTIs)			
Integrase inhibitors block HIV integrase, an enzyme HIV needs to make copies of itself.	cabotegravir (cabotegravir sodium, CAB)	Vocabria	January 22, 2021
	dolutegravir (dolutegravir sodium, DTG)	Tivicay	August 12, 2013
		Tivicay PD	June 12, 2020
	raltegravir (raltegravir potassium, RAL)	Isentress	October 12, 2007
		Isentress HD	May 26, 2017
Attachment Inhibitors			
Attachment inhibitors bind to the gp120 protein on the outer surface of HIV, preventing HIV from entering CD4 cells.	fostemsavir (fostemsavir tromethamine, FTR)	Rukobia	July 2, 2020
Post-Attachment Inhibitors			
Post-attachment inhibitors block CD4 receptors on the surface of certain immune cells that HIV needs to enter the cells.	ibalizumab-uiyk (Hu5A8, IBA, Ibalizumab, TMB-355, TNX-355)	Trogarzo	March 6, 2018
Pharmacokinetic Enhancers			
Pharmacokinetic enhancers are used in HIV treatment to increase the effectiveness of an HIV medicine included in an HIV treatment regimen.	cobicistat (COBI, c)	Tybost	September 24, 2014
Combination HIV Medicines			
Combination HIV medicines contain two or more HIV medicines from one or more drug classes.	abacavir and lamivudine (abacavir sulfate / lamivudine, ABC / 3TC)	Epzicom	August 2, 2004
	abacavir, dolutegravir, and lamivudine (abacavir sulfate / dolutegravir sodium / lamivudine, ABC / DTG / 3TC)	Triumeq	August 22, 2014
		Triumeq PD	March 30, 2022
	abacavir, lamivudine, and zidovudine (abacavir sulfate / lamivudine / zidovudine, ABC / 3TC / ZDV)	Trizivir	November 14, 2000
	atazanavir and cobicistat (atazanavir sulfate / cobicistat, ATV / COBI)	Evotaz	January 29, 2015
	bictegravir, emtricitabine, and tenofovir alafenamide (bictegravir sodium / emtricitabine /	Biktarvy	February 7, 2018

Drug Class	Generic Name (Other names and acronyms)	Brand Name	FDA Approval Date
	tenofovir alafenamide fumarate, BIC / FTC / TAF)		
	cabotegravir and rilpivirine (CAB and RPV, CAB plus RPV, Cabenuva kit, cabotegravir extended-release injectable suspension and rilpivirine extended-release injectable suspension)	Cabenuva	January 22, 2021
	darunavir and cobicistat (darunavir ethanolate / cobicistat, DRV / COBI)	Prezcobix	January 29, 2015
	darunavir, cobicistat, emtricitabine, and tenofovir alafenamide (darunavir ethanolate / cobicistat / emtricitabine / tenofovir AF, darunavir ethanolate / cobicistat / emtricitabine / tenofovir alafenamide, darunavir / cobicistat / emtricitabine / tenofovir AF, darunavir / cobicistat / emtricitabine / tenofovir alafenamide fumarate, DRV / COBI / FTC / TAF)	Symtuza	July 17, 2018
	dolutegravir and lamivudine (dolutegravir sodium / lamivudine, DTG / 3TC)	Dovato	April 8, 2019
	dolutegravir and rilpivirine (dolutegravir sodium / rilpivirine hydrochloride, DTG / RPV)	Juluca	November 21, 2017
	doravirine, lamivudine, and tenofovir disoproxil fumarate (doravirine / lamivudine / TDF, doravirine / lamivudine / tenofovir DF, DOR / 3TC / TDF)	Delstrigo	August 30, 2018
	efavirenz, emtricitabine, and tenofovir disoproxil fumarate (efavirenz / emtricitabine / tenofovir DF, EFV / FTC / TDF)	Atripla	July 12, 2006
	efavirenz, lamivudine, and tenofovir disoproxil fumarate (EFV / 3TC / TDF)	Symfi	March 22, 2018
	efavirenz, lamivudine, and tenofovir disoproxil fumarate (EFV / 3TC / TDF)	Symfi Lo	February 5, 2018
	elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide (elvitegravir / cobicistat / emtricitabine / tenofovir alafenamide fumarate, EVG / COBI / FTC / TAF)	Genvoya	November 5, 2015
	elvitegravir, cobicistat, emtricitabine, and tenofovir disoproxil fumarate (QUAD, EVG / COBI / FTC / TDF)	Stribild	August 27, 2012
	emtricitabine, rilpivirine, and tenofovir alafenamide (emtricitabine / rilpivirine / tenofovir AF, emtricitabine / rilpivirine / tenofovir alafenamide fumarate, emtricitabine / rilpivirine hydrochloride / tenofovir AF,	Odefsey	March 1, 2016

Drug Class	Generic Name (Other Names)	Brand Name	FDA Approval Date
	emtricitabine / rilpivirine hydrochloride / tenofovir alafenamide fumarate (FTC / RPV / TAF)		
	emtricitabine, rilpivirine, and tenofovir disoproxil fumarate (emtricitabine / rilpivirine hydrochloride / tenofovir disoproxil fumarate, emtricitabine / rilpivirine / tenofovir, FTC / RPV / TDF)	Complera	August 10, 2011
	emtricitabine and tenofovir alafenamide (emtricitabine / tenofovir AF, emtricitabine / tenofovir alafenamide fumarate, FTC / TAF)	Descovy	April 4, 2016
	emtricitabine and tenofovir disoproxil fumarate (emtricitabine / tenofovir DF, FTC / TDF)	Truvada	August 2, 2004
	lamivudine and tenofovir disoproxil fumarate (3TC / TDF)	Cimduo	February 28, 2018
	lamivudine and zidovudine (3TC / ZDV)	Combivir	September 27, 1997
	lopinavir and ritonavir (ritonavir-boosted lopinavir, LPV/r, LPV / RTV)	Kaletra	September 15, 2000

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

From FDA:

- HIV and AIDS: Medicines to Help You

From the National Library of Medicine:

- Drug information from the DailyMed website

Also see the HIV Source collection of HIV links and resources.

FDA-Approved HIV Medicines

Treatment with HIV medicines is called antiretroviral therapy (ART). ART is recommended for everyone with HIV, and people with HIV should start ART as soon as possible. People on ART take a combination of HIV medicines (called an HIV treatment regimen) every day. A person's initial HIV treatment regimen generally includes three HIV medicines from at least two different HIV drug classes.

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	etravirine (ETR)	Intelence	January 18, 2008
	nevirapine (extended-release nevirapine, NVP)	Viramune	June 21, 1996
		Viramune XR (extended release)	March 25, 2011
	rilpivirine (rilpivirine hydrochloride, RPV)	Edurant	May 20, 2011
Protease Inhibitors (PIs)			
PIs block HIV protease, an enzyme HIV needs to make copies of itself.	atazanavir (atazanavir sulfate, ATV)	Reyataz	June 20, 2003
	darunavir (darunavir ethanolate, DRV)	Prezista	June 23, 2006
	fosamprenavir (fosamprenavir calcium, FOS-APV, FPV)	Lexiva	October 20, 2003
	ritonavir (RTV) *Although ritonavir is a PI, it is generally used as a pharmacokinetic enhancer as recommended in the Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV and the Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection.	Norvir	March 1, 1996
	tipranavir (TPV)	Aptivus	June 22, 2005
Fusion Inhibitors			

Drug Class	Generic Name (Other names and acronyms)	Brand Name	FDA Approved Date
Fusion inhibitors block HIV from entering the CD4 T lymphocyte (CD4 cells) of the immune system.	enfuvirtide (T-20)	Fuzeon	March 13, 2003
CCR5 Antagonists			
CCR5 antagonists block CCR5 coreceptors on the surface of certain immune cells that HIV needs to enter the cells.	maraviroc (MVC)	Selzentry	August 6, 2007
Integrase Strand Transfer Inhibitor (INSTIs)			
Integrase inhibitors block HIV integrase, an enzyme HIV needs to make copies of itself.	cabotegravir (cabotegravir sodium, CAB)	Vocabria	January 22, 2021
	dolutegravir (dolutegravir sodium, DTG)	Tivicay	August 12, 2013
		Tivicay PD	June 12, 2020
	raltegravir (raltegravir potassium, RAL)	Isentress	October 12, 2007
		Isentress HD	May 26, 2017
Attachment Inhibitors			
Attachment inhibitors bind to the gp120 protein on the outer surface of HIV, preventing HIV from entering CD4 cells.	fostemsavir (fostemsavir tromethamine, FTR)	Rukobia	July 2, 2020
Post-Attachment Inhibitors			
Post-attachment inhibitors block CD4 receptors on the surface of certain immune cells that HIV needs to enter the cells.	ibalizumab-uiyk (Hu5A8, IBA, Ibalizumab, TMB-355, TNX-355)	Trogarzo	March 6, 2018
Pharmacokinetic Enhancers			
Pharmacokinetic enhancers are used in HIV treatment to increase the effectiveness of an HIV medicine included in an HIV treatment regimen.	cobicistat (COBI, c)	Tybost	September 24, 2014
Combination HIV Medicines			
Combination HIV medicines contain two or more HIV medicines from one or more drug classes.	abacavir and lamivudine (abacavir sulfate / lamivudine, ABC / 3TC)	Epzicom	August 2, 2004
	abacavir, dolutegravir, and lamivudine (abacavir sulfate / dolutegravir sodium / lamivudine, ABC / DTG / 3TC)	Triumeq	August 22, 2014
		Triumeq PD	March 30, 2022
	abacavir, lamivudine, and zidovudine (abacavir sulfate / lamivudine / zidovudine, ABC / 3TC / ZDV)	Trizivir	November 14, 2000
	atazanavir and cobicistat (atazanavir sulfate / cobicistat, ATV / COBI)	Evotaz	January 29, 2015
	bictegravir, emtricitabine, and tenofovir alafenamide (bictegravir sodium / emtricitabine / tenofovir alafenamide fumarate, BIC / FTC / TAF)	Biktarvy	February 7, 2018
	cabotegravir and rilpivirine (CAB and RPV, CAB plus RPV, Cabenuva kit, cabotegravir extended-release injectable suspension and	Cabenuva	January 22, 2021

Drug Class	Generic Name (Select names and acronyms)	Brand Name	FDA Approval Date
	rilpivirine extended-release injectable suspension)		
	darunavir and cobicistat (darunavir ethanolate / cobicistat, DRV / COBI)	Prezcobix	January 29, 2015
	darunavir, cobicistat, emtricitabine, and tenofovir alafenamide (darunavir ethanolate / cobicistat / emtricitabine / tenofovir AF, darunavir ethanolate / cobicistat / emtricitabine / tenofovir alafenamide, darunavir / cobicistat / emtricitabine / tenofovir AF, darunavir / cobicistat / emtricitabine / tenofovir alafenamide fumarate, DRV / COBI / FTC / TAF)	Symtuza	July 17, 2018
	dolutegravir and lamivudine (dolutegravir sodium / lamivudine, DTG / 3TC)	Dovato	April 8, 2019
	dolutegravir and rilpivirine (dolutegravir sodium / rilpivirine hydrochloride, DTG / RPV)	Juluca	November 21, 2017
	doravirine, lamivudine, and tenofovir disoproxil fumarate (doravirine / lamivudine / TDF, doravirine / lamivudine / tenofovir DF, DOR / 3TC / TDF)	Delstrigo	August 30, 2018
	efavirenz, emtricitabine, and tenofovir disoproxil fumarate (efavirenz / emtricitabine / tenofovir DF, EFV / FTC / TDF)	Atripla	July 12, 2006
	efavirenz, lamivudine, and tenofovir disoproxil fumarate (EFV / 3TC / TDF)	Symfi	March 22, 2018
	efavirenz, lamivudine, and tenofovir disoproxil fumarate (EFV / 3TC / TDF)	Symfi Lo	February 5, 2018
	elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide (elvitegravir / cobicistat / emtricitabine / tenofovir alafenamide fumarate, EVG / COBI / FTC / TAF)	Genvoya	November 5, 2015
	elvitegravir, cobicistat, emtricitabine, and tenofovir disoproxil fumarate (QUAD, EVG / COBI / FTC / TDF)	Stribild	August 27, 2012
	emtricitabine, rilpivirine, and tenofovir alafenamide (emtricitabine / rilpivirine / tenofovir AF, emtricitabine / rilpivirine / tenofovir alafenamide fumarate, emtricitabine / rilpivirine hydrochloride / tenofovir AF, emtricitabine / rilpivirine hydrochloride / tenofovir alafenamide, emtricitabine / rilpivirine hydrochloride / tenofovir alafenamide fumarate, FTC / RPV / TAF)	Odefsey	March 1, 2016

Drug Class	Generic Name (Other names and acronyms)	Brand Name	FDA Approval Date
	emtricitabine, rilpivirine, and tenofovir disoproxil fumarate (emtricitabine / rilpivirine hydrochloride / tenofovir disoproxil fumarate, emtricitabine / rilpivirine / tenofovir, FTC / RPV / TDF)	Complera	August 10, 2011
	emtricitabine and tenofovir alafenamide (emtricitabine / tenofovir AF, emtricitabine / tenofovir alafenamide fumarate, FTC / TAF)	Descovy	April 4, 2016
	emtricitabine and tenofovir disoproxil fumarate (emtricitabine / tenofovir DF, FTC / TDF)	Truvada	August 2, 2004
	lamivudine and tenofovir disoproxil fumarate (3TC / TDF)	Cimduo	February 28, 2018
	lamivudine and zidovudine (3TC / ZDV)	Combivir	September 27, 1997
	lopinavir and ritonavir (ritonavir-boosted lopinavir, LPV/r, LPV / RTV)	Kaletra	September 15, 2000

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

From FDA:

- HIV and AIDS: Medicines to Help You

From the National Library of Medicine:

- Drug information from the DailyMed website

Also see the HIV Source collection of HIV links and resources.

What is an Investigational HIV Drug?

Key Points

- An investigational drug is an experimental drug that is being studied to see whether it is safe and effective.
- Investigational HIV drugs are studied in medical research studies called clinical trials. Once an investigational HIV drug has been proven safe and effective in a clinical trial, the U.S. Food and Drug Administration (FDA) may approve the drug for general use or sale in the United States.
- Investigational HIV drugs being studied include drugs to treat or prevent HIV and vaccines to treat or prevent HIV.
- Investigational HIV drugs can only be accessed through clinical trials and expanded access programs.

What is an investigational HIV drug?

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What types of investigational HIV drugs are being studied?

Investigational HIV drugs being studied include drugs to treat HIV and prevent HIV. Some types of investigational HIV drugs being studied include microbicides, immune modulators, latency-reversing agents, gp120 attachment inhibitors, and rev inhibitors.

HIV researchers are also studying investigational vaccines to prevent HIV and treat HIV. The goal of a preventive HIV vaccine is to prevent HIV in people who do not have HIV but who may be exposed to the virus. A safe and effective HIV treatment vaccine (also called a therapeutic HIV vaccine) could prevent HIV from advancing to acquired immunodeficiency syndrome (AIDS), replace the daily use of HIV medicines, and help prevent HIV transmission.

To learn more, read the HIVinfo What is a Preventive HIV Vaccine? and What is a Therapeutic HIV Vaccine? fact sheets.

How are clinical trials of investigational drugs conducted?

Clinical trials are conducted in phases. Each phase has a different purpose and helps researchers answer different questions about the investigational drug.

- **Phase 1 trial**: Initial testing in a small group of people (20–80) to evaluate the drug's safety and to identify side effects.
- **Phase 2 trial**: Testing in a larger group of people (100–300) to determine the drug's effectiveness and to further evaluate its safety.
- **Phase 3 trial**: Continued testing in large groups of people (1,000–3,000) to confirm the drug's effectiveness, monitor side effects, compare it with standard or equivalent treatments, and collect information to ensure that the investigational drug can be used safely.

  In most cases, an investigational drug must be proven effective and must show continued safety in a Phase 3 clinical trial to be considered for approval by the FDA for sale in the United States. (However, some drugs go through the FDA's accelerated approval process and are approved before a Phase 3 clinical trial is complete.)
- **Phase 4 trial**: Ongoing tracking that occurs after a drug is approved by the FDA for sale in the United States. The purpose of the tracking is to seek more information about the drug's risks, benefits, and optimal use.

For more information, read the HIVinfo HIV and AIDS Clinical Trials fact sheet.

The four phases of a clinical trial.

How can a person find a clinical trial that is studying an investigational HIV drug?

To find an HIV and AIDS clinical trial that is studying an investigational HIV drug, use the find a study search feature on ClinicalTrials.gov.

For help with your search, call a Clinicalinfo health information specialist at 1-800-448-0440 or email ContactUs@HIVinfo.NIH.gov.

You can also join ResearchMatch, which is a free, secure online tool that makes it easier for the public to become involved in clinical trials.

Are investigational HIV drugs available for use outside of a clinical trial?

In some cases, an investigational HIV drug may be available through an expanded access program. Expanded access allows for the use of an investigational drug outside of a clinical trial to treat a person who has a serious or immediate life-threatening disease and who has no FDA-approved treatment options. Drug companies must have permission from the FDA to make an investigational drug available for expanded access.

People seeking expanded access to an investigational HIV drug should talk to their health care provider to see if they may qualify to take part in an expanded access program.

Is it safe to use an investigational HIV drug?

One goal of HIV research is to identify safer, more effective HIV medicines. Researchers try to make clinical trials as safe as possible. However, taking an investigational HIV drug can involve both benefits and risks. Risks may include unexpected side effects from the drug, which can be unpleasant, serious, or even life-threatening.

The benefits and possible risks of participating in a clinical trial or an expanded access program are explained to people before they decide whether to participate.

How can a person find more information on investigational HIV drugs?

To find more information on investigational HIV drugs, use the Clinicalinfo Drug Database, which includes up-to-date information on many investigational HIV drugs.

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

From the National Institutes of Health (NIH):

- NIH Clinical Research Trials and You: The Basics
- NIH Clinical Research Trials and You: Finding a Clinical Trial

From the National Institute of Allergy and Infectious Diseases:

- HIV/AIDS

From the U.S. Food and Drug Administration (FDA):

- Expanded Access | Information for Patients

Also see the HIV Source collection of HIV links and resources.

What is a Therapeutic HIV Vaccine?

Key Points

- A therapeutic HIV vaccine is a vaccine that is designed to improve the body's immune response to HIV in a person who already has HIV.
- Currently, no therapeutic HIV vaccines have been approved by the U.S. Food and Drug Administration (FDA), but research is underway. You must be enrolled in a clinical trial to receive a therapeutic HIV vaccine.
- Researchers are exploring therapeutic HIV vaccines to slow down the progression of HIV infection and to eliminate the need for antiretroviral therapy (ART) while keeping undetectable levels of HIV.

What is a therapeutic HIV vaccine?

A therapeutic HIV vaccine is a vaccine that is designed to improve the body's immune response to HIV in a person who already has HIV.

Researchers are developing and testing therapeutic HIV vaccines to slow down the progression of HIV to acquired immunodeficiency syndrome (AIDS). The hope is that treating people with these vaccines would ideally keep HIV at undetectable levels (known as undetectable viral load) without the need for regular antiretroviral therapy (ART). ART is the recommended treatment for HIV infection and involves using a combination of different HIV medicines to prevent HIV from multiplying. Currently, a person with HIV must remain on ART to keep HIV at undetectable levels.

A therapeutic HIV vaccine may also make it less likely that a person could transmit HIV to others.

Are there any FDA-approved therapeutic HIV vaccines?

There are currently no U.S. Food and Drug Administration (FDA)-approved therapeutic HIV vaccines, but research is underway. You must be enrolled in a clinical trial to receive a therapeutic HIV vaccine.

How is a therapeutic HIV vaccine different from a preventive HIV vaccine?

A preventive HIV vaccine is given to people who do **not** have HIV, with the goal of preventing HIV infection in the future. The vaccine teaches the person's immune system to recognize and effectively fight HIV in case the virus ever enters the person's body. To learn more, read the HIVinfo What is a Preventive HIV Vaccine? fact sheet.

A therapeutic HIV vaccine is given to people who **already** have HIV. The goal of a therapeutic HIV vaccine is to strengthen a person's immune response to the HIV that is already in the person's body.

Where can a person get more information about clinical trials studying therapeutic HIV vaccines?

A list of clinical trials on therapeutic HIV vaccines is available from the database of ClinicalTrials.gov study summaries. Click on the title of any trial in the list to see more information about the study.

If you are interested in participating in a vaccine study, you can also contact the National Institutes of Health Vaccine Research Center by calling 866-833-LIFE (5433) or by emailing vaccines@nih.gov. To learn more, read the HIVinfo fact sheet on HIV and AIDS Clinical Trials.

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

From the National Institute of Allergy and Infectious Diseases:

- HIV Vaccine Development
- Sustained ART-Free HIV Remission

From the HIV Vaccine Trials Network:

- How Vaccines Work

Also see the HIV Source collection of HIV links and resources.

What is a Preventive HIV Vaccine?

Key Points

- A preventive HIV vaccine is given to people who do not have HIV, with the goal of preventing HIV infection in the future.
- Currently, no preventive HIV vaccines have been approved by the U.S. Food and Drug Administration (FDA), but research is underway. You must be enrolled in a clinical trial to receive a preventive HIV vaccine.

What is a preventive HIV vaccine?

A preventive HIV vaccine is given to people who do not have HIV, with the goal of preventing HIV infection in the future. The vaccine teaches the person's immune system to recognize and effectively fight HIV in case the person is ever exposed to HIV.

Are there any FDA-approved preventive HIV vaccines?

Currently, no preventive HIV vaccines have been approved by the U.S. Food and Drug Administration (FDA), but research is underway. You must be enrolled in a clinical trial to receive a preventive HIV vaccine.

How is a preventive HIV vaccine different from a therapeutic HIV vaccine?

While a preventive HIV vaccine is given to people who do **not** have HIV, a therapeutic HIV vaccine is given to people who **already** have HIV. The goal of a therapeutic HIV vaccine is to strengthen a person's immune response to the HIV that is already in the person's body. Researchers are exploring the use of therapeutic HIV vaccines:

- To slow down the progression of HIV infection
- To eliminate the need for antiretroviral therapy (ART) while keeping undetectable levels of HIV

To learn more, read the HIVinfo What is a Therapeutic HIV Vaccine? fact sheet.

Can a person get HIV from a preventive HIV vaccine?

No, a person cannot get HIV from a preventive HIV vaccine. The preventive HIV vaccines being studied in clinical trials do not contain HIV. Of the approximately 30,000 people who have participated in HIV vaccine studies around the world in the last 25 years, no one has gotten HIV from any of the vaccines tested.

Why is a preventive HIV vaccine important?

Treatment options for HIV have improved a lot over the last 30 years. But HIV medicines can have side effects, can be expensive, and can be hard to access in some countries. Also, some people may develop drug resistance to certain HIV medicines and then must change medicines.

Using condoms correctly and taking pre-exposure prophylaxis (PrEP) can help prevent HIV transmission. But researchers believe a preventive HIV vaccine will be the most effective way to completely end new HIV infections.

What research is being done on preventive HIV vaccines?

Some of the areas of interest being studied in clinical trials include:

- The safety of preventive vaccines.
- Whether a preventive vaccine protects against HIV infection.
- Whether a preventive vaccine controls HIV if a person gets HIV while enrolled in a study. (It is possible for someone to get HIV through sexual contact or from sharing drug injection equipment while they are participating in a clinical trial. But a person cannot get HIV from the HIV vaccine being tested.)
- The immune responses that occur in people who receive a preventive vaccine.
- Different ways of giving preventive vaccines, such as using a needle and syringe versus a needle-free device.

Where can a person get more information about clinical trials studying preventive HIV vaccines?

A list of clinical trials on preventive HIV vaccines is available from the database of ClinicalTrials.gov study summaries. Click on the title of any trial in the list to see more information about the study.

If you are interested in participating in a vaccine study, you can also contact the National Institutes of Health Vaccine Research Center by calling 866-833-LIFE (5433) or by emailing vaccines@nih.gov.

To learn more, read the HIVinfo fact sheet on HIV and AIDS Clinical Trials.

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

From the National Institute of Allergy and Infectious Diseases:

- HIV Vaccine Development

From the HIV Vaccine Trials Network (HVTN):

- How Vaccines Work
- HIV Vaccine Myths and Facts
- HVTN Trials

Also see the HIV Source collection of HIV links and resources.

HIV and AIDS Clinical Trials

Key Points

- A clinical trial is a research study done to evaluate new medical approaches in people. HIV and AIDS clinical trials help researchers find better ways to prevent, detect, or treat HIV and AIDS.
- Examples of HIV and AIDS clinical trials underway include studies of new HIV medicines, studies of vaccines to prevent or treat HIV, and studies of medicines to treat infections related to HIV and AIDS.
- The benefits and possible risks of participating in an HIV and AIDS clinical trial are explained to study volunteers before they decide whether to participate in a study.
- Use the find a study search feature on ClinicalTrials.gov to find HIV and AIDS studies looking for volunteer participants. Some HIV and AIDS clinical trials enroll only people who have HIV. Other studies enroll people who do not have HIV.

What is a clinical trial?

A clinical trial is a research study that evaluates new medical approaches in people. These approaches include:

- new medicines or new combinations of medicines
- new medical devices or surgical procedures
- new ways to use an existing medicine or device
- new ways to change behaviors to improve health

Clinical trials are conducted in several phases to determine whether new medical approaches are safe and effective in people. Results from a Phase 1 Trial, Phase 2 Trial, and Phase 3 Trial are used to determine whether a new drug should be approved for sale in the United States. Once a new drug is approved, researchers continue to track its safety in a Phase 4 Trial.

Interventional trial and observational trial are two main types of clinical trials.

What is an HIV and AIDS clinical trial?

HIV and AIDS clinical trials help researchers find better ways to prevent, detect, or treat HIV and AIDS. Every HIV medicine was first studied through clinical trials.

Examples of HIV and AIDS clinical trials include:

- studies of new medicines to prevent or treat HIV and AIDS
- studies of vaccines to prevent or treat HIV
- studies of medicines to treat infections related to HIV and AIDS

Can anyone participate in an HIV and AIDS clinical trial?

It depends on the study. Some HIV and AIDS clinical trials enroll only people who have HIV. Other studies include people who do not have HIV.

Participation in an HIV and AIDS clinical trial may also depend on other factors, such as age, gender, HIV treatment history, or

other medical conditions.

What are the benefits of participating in an HIV and AIDS clinical trial?

Participating in an HIV and AIDS clinical trial can provide benefits. For example, many people participate in HIV and AIDS clinical trials, because they want to contribute to HIV and AIDS research. They may have HIV or know someone who has HIV.

People with HIV who participate in an HIV and AIDS clinical trial may benefit from new HIV medicines before they are widely available. HIV medicines being studied in clinical trials are called investigational drugs. To learn more, read the HIVinfo What is an Investigational HIV Drug? fact sheet.

Participants in clinical trials can receive regular and careful medical care from a research team that includes doctors and other health professionals. Often the medicines and medical care are free of charge.

Sometimes people get paid for participating in a clinical trial. For example, they may receive money or a gift card. They may be reimbursed for the cost of meals or transportation.

Are HIV and AIDS clinical trials safe?

Researchers try to make HIV and AIDS clinical trials as safe as possible. However, volunteering to participate in a study testing an experimental treatment for HIV can involve risks of varying degrees. Most volunteers do not experience serious side effects; however, potential side effects that may be serious or even life-threatening can occur from the treatment being studied.

Before enrolling in a clinical trial, potential volunteers learn about the study in a process called informed consent. The process includes an explanation of the possible risks and benefits of participating in the study.

Once enrolled in a study, people continue to receive information about the study through the informed consent process.

If a person decides to participate in an HIV and AIDS clinical trial, will their personal information be shared?

The privacy of study volunteers is important to everyone involved in an HIV and AIDS clinical trial. The informed consent process includes an explanation of how a study volunteer's personal information is protected.

How can one find an HIV and AIDS clinical trial looking for volunteer participants?

There are several ways to find an HIV and AIDS clinical trial looking for volunteer participants.

- Use the find a study search feature on ClinicalTrials.gov to find HIV and AIDS studies looking for volunteer participants.
- Call a Clinical Info health information specialist at 1-800-448-0440 or email ContactUs@HIVinfo.NIH.gov.
- Join ResearchMatch, which is a free, secure online tool that makes it easier for the public to become involved in clinical trials.

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

From the National Institutes of Health (NIH):

- NIH Clinical Research Trials and You: The Basics

From the National Library of Medicine:

- Learn About Clinical Studies

Also see the HIV Source collection of HIV links and resources.

RYAN WHITE PROGRAM DEFINITIONS AND ACRONYMS

ACTG	**A**IDS **C**linical **T**rials **G**roup. A network of medical centers around the country in which federally-funded clinical trials are conducted to test the safety and efficiency of experimental treatments for HIV; studies funded by the National Institute of Allergy and Infectious Diseases (NIAID).
Adherence	The word adherence comes from the word "adhere." To adhere to something means to stick to or stay with something. Adherence is very important when taking your HIV medications.
Administrative Agent	Organization, agent or other entity (e.g., public health department, community-based organization) which functions in political jurisdictions within Part A EMAs to assist the grantee in carrying out administrative activities (i.e., disbursing program funds, developing reimbursement and accounting systems, developing Requests for Proposals [RFPs], monitoring contracts, etc.). Not all grantees use a separate administrative agent.
AETC	**A**IDS **E**ducation and **T**raining **C**enter. Regional centers providing education and training for primary care professionals and other HIV-related personnel; authorized under Part F of the CARE Act. https://aidsetc.org/
AIDS	**A**cquired **I**mmune **D**eficiency **S**yndrome. AIDS, currently referred to as Stage 3 HIV, is the most advanced stage of HIV.
ART	**A**nti-**R**etroviral **T**herapy. These are the medications that work to prevent HIV from copying itself in your body. Other names for these medications are ARVs or HAART.
ASO	**A**IDS **S**ervice **O**rganization. An organization that provides medical or support services primarily or exclusively to populations living with and affected by HIV.
Capacity Building	Process to increase the skills, infrastructure, and resources of individuals, organizations, and communities. Capacity building is a key strategy for the promotion, delivery, and sustainability of HIV prevention programs. As a result of capacity building on HIV prevention programs, the programs will (1) operate optimally and (2) increase their capacity to effectively deliver evidence-based interventions and core public health strategies for HIV prevention.
CARE Act	Ryan White **C**omprehensive **A**IDS **R**esources **E**mergency **A**ct. The Federal legislation created to address the health and service needs of people living with HIV and their families in the US; enacted in 1990 and reauthorized in 1996 and 2000. In 2006, Congress passed the Ryan White HIV/AIDS Treatment Modernization Act, extending the CARE Act for an additional three years. In 2009, Congress

	passed the Ryan White HIV/AIDS Treatment Extension Act, extending the CARE Act for four more years.
CBO	**C**ommunity-**B**ased **O**rganization. An organization which provides services to locally defined populations, which may or may not include populations living with or affected by HIV.
CD4	CD4 cells are immune cells that the HIV attacks. Sometimes they are also called T-cells or helper T-cells. The higher your CD4 count, the stronger your immune system is.
CD4 Count	This is a measure of the CD4 cells in your body. Your CD4 count tells your doctor how strong your immune system is. A person with a CD4 count of less than 200 is said to have Stage 3 HIV (previously referred to as AIDS).
CDC	**C**enters for **D**isease **C**ontrol and Prevention. The Federal agency within the U.S. Department of Health and Human Services that administers HIV prevention programs, including the HIV Prevention Community Planning process, among other programs; responsible for monitoring and reporting of all infectious diseases; administers HIV surveillance grants and publishes epidemiological reports such as the HIV Surveillance Report.
CEO	**C**hief **E**xecutive **O**fficial. The official recipient of Part A CARE Act funds within the EMA, usually the mayor or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the CARE Act in the EMA and ensuring that all legal requirements are met. In EMAs with more than one political jurisdiction, the recipient of Part A CARE Act funds is the CEO of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of people with AIDS in the EMA.
Collaboration	Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity—often to achieve a common goal or purpose.
Community Members	1) consumers/members of the priority population that are receiving services, or 2) people who are not affiliated with organizations but are living with or affected by HIV and have a passion to address HIV.
Comprehensive Planning	The process of determining the organization and delivery of HIV services; strategy used by a planning council to improve decision-making about services and maintain a continuum of care for people living with HIV.
Conflict of Interest	Conflict between the private interests and public obligations of a person in an official position.

Continuum of Care	An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of people living with HIV.
Core Services	Ryan White Part A, B, and C grantees must spend at least 75% of funds on "core medical services." These services include outpatient and ambulatory health services; pharmaceutical assistance; substance use outpatient treatment services; oral health; medical nutritional therapy; health insurance premium assistance; home health care; hospice services; mental health services; early intervention services; and medical case management, including treatment adherence services. The remaining funds may be spent on Support Services.
Cost-effectiveness	The relative costs and effectiveness of proposed strategies and interventions, either demonstrated or probable.
CPCDMS	**C**entralized **P**atient **C**are **D**ata **M**anagement **S**ystem. A de-identified computer database that allows Part A-funded providers to share client eligibility information while maintaining client confidentiality. Information collected includes demographics, co-morbidities, biological markers, mortality and service utilization data. Since its inception in June of 2000, over 13,000 clients have been registered in the CPCDMS. In addition, the CPCDMS has been the foundation upon which evaluation and quality management activities in the EMA were built.
Culturally appropriate	Conforming to a culture's acceptable expressions and standards of behavior and thoughts. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.
DSHS	Texas **D**epartment of **S**tate **H**ealth **S**ervices
EIIHA	**E**arly **I**dentification of **I**ndividuals with **H**IV/**A**IDS. Identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to care.
ECHPP	**E**nhanced **C**omprehensive **H**IV **P**revention **P**lanning. A 3-year demonstration project funded by CDC's Division of HIV Prevention (DHP) for the 12 municipalities with the highest number of people living with AIDS in the US. As part of the response to the National HIV/AIDS Strategy (NHAS), the ECHPP project supports the 12 Cities Project which is directed by the U.S. Department of Health and Human Services (HHS).
EMA	**E**ligible **M**etropolitan **A**rea. The geographic area eligible to receive Part A funds. The boundaries of the metropolitan area are defined

	by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Some EMAs include just one city, other EMAs are composed of several cities and/or counties; and some EMAs extend over more than one state. The Houston EMA is a 6- county area comprised of Harris, Fort Bend, Montgomery, Liberty, Chambers and Waller Counties.
Epidemic	The spread of an infectious disease through a population or geographic area.
Formula Grant Application	The application used by EMAs and States each year to request an amount of CARE Act funding which is determined by a formula based on the number of reported AIDS cases in their location and other factors. The application includes guidance from DHS on program requirements and expectations.
FY	**F**iscal **Y**ear. The fiscal year for Ryan White Part A funds is March 1 through February 28. The fiscal year for Part B and State Services funds runs from September 1 through August 31 (subject to change by the State).
Grantee	Another term for the recipient of Part A funds. As the official recipient of those funds in the EMA, the CEO is the grantee. However, the CEO usually delegates his or her authority to administer Part A funds to an organizational unit within the city or county government (e.g., the county health department). Often, this entity is also referred to as the grantee. Use of the terms CEO and grantee helps to distinguish between the person ultimately responsible for the CARE Act grant (the CEO) and the entity which actually carries out the day-to-day operations associated with it (the grantee). In the Houston EMA, the Harris County Judge is the CEO and the grantee is the Harris County Health Department
Harm Reduction	Harm reduction is any behavior or strategy that helps to reduce risk or harm to yourself and others. For example, to reduce your risk of getting HIV you can practice safer sex by using condoms or taking PrEP, and practice safer drug use by using clean needles.
HAART	**H**ighly **A**ctive **A**nti-**R**etroviral **T**herapy. Some people may refer to your ART regimen as HAART.
HHD	**H**ouston **H**ealth **D**epartment
HIV	HIV stands for human immunodeficiency virus. HIV attacks CD4 cells and uses their machinery to make copies of itself.
Homeless	Individuals who lack a fixed, regular and adequate nighttime residence, including those who live in locations not meant for

	human habitation such as public parks and streets, those who live in or are transitioning from temporary housing or shelters, and those who have persistent housing instability.
HOPWA	**H**ousing **O**pportunities for **P**ersons **W**ith **A**IDS. A program administered by the U.S. Department of Housing and Urban Development which provides funding to support housing for people living with and their families. Locally, HOPWA funds are administered by the City of Houston Department of Housing and Community Development.
HRSA	**H**ealth **R**esources and **S**ervices **A**dministration. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Ryan White Program.
HTBMN	**H**ow **t**o **B**est **M**eet the **N**eed. A process of the Planning Council's Quality Improvement Committee where all of the funded service categories are reviewed and/or updated by workgroups comprised of Council and community members.
PWIDU	**P**ersons **w**ith **i**njection **d**rug **u**se as a risk factor for acquiring HIV. Individuals who inject medications or drugs, including illegal drugs, hormones, and cosmetics.
IGA	**I**nter-**G**overnmental **A**greement. A written agreement between a Part A grantee and another governmental agency in the EMA; these agreements usually address the allocation of funds across agencies or jurisdictions.
Immune System	The immune system is the body's infection fighter. It helps the body fight all kinds of illnesses including colds, flu, pneumonia and viruses such as HIV. The immune system is made up of many different types of cells that interact with each other and work together to serve as our defense against bacteria, viruses, fungi and parasites that cause infectious illnesses.
Incidence	The number of new cases of a disease that occur during a specified time period.
Incidence Rate	The number of cases of a disease per population per specified time period often expressed per 100,000 population (HIV rates are often expressed this way).
Intervention	A specific activity, or set of related activities, intended to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals and populations to reduce their health risks. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.

IRR or I/RR	**I**ncarcerated or **R**ecently **R**eleased**.** Individuals who are currently incarcerated in the jail or prison system or have been released from jail or prison within the past 12 months.
Linkage to Care	Post-referral verification that care/services were accessed by an individual diagnosed with HIV being referred into care.
MSA	**M**etropolitan **S**tatistical **A**rea. The geographic area designated to receive CDC prevention funds.
MSM	**M**en who have **s**ex with **m**en, also referred to as same gender loving men.
MSMOC	**M**en of **c**olor who have sex with men.
Needs Assessment	A systematic process to determine the service needs of a defined population; a definition of the extent of need, available services, and service gaps by population and geographic area.
Opportunistic Infection	Opportunistic infections (OIs) are those infections that may harm the body when the immune system is weakened. When the immune system is strong and not weakened by HIV, it fights off OIs. Some examples of OIs include pneumocystitis pneumonia (PCP), thrush, mycobacterium avium complex (MAC), shingles and toxoplasmosis.
Out of Care	HRSA defines an individual as "out-of-care" if they have not had a CD4 count or viral load test, been prescribed antiretroviral therapy (ART) and have not had a primary care visit in the previous 12 months.
Part A	The part of the CARE Act that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV epidemic.
Part B	The part of the CARE Act that enables States and territories to improve the quality, availability, and organization of health care and support services to individuals living with HIV and their families.
Part C	The part of the CARE Act that supports primary medical care and early intervention services to people living with HIV through grants to service organizations.
Part D	The part of the CARE Act that supports research and services for children living with HIV and their families and the HIV Dental Reimbursement Program.
Part F	The part of the CARE Act that funds AETC, SPNS.
Planning Council	A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to establish a plan for the delivery of HIV care services in the EMA and establish priorities for the use of CARE Act funds.
PLWH	**P**erson/People **L**iving **w**ith **H**IV.

Prevalence	The total number of persons living with a specific disease or condition at a given time.
Prevalence Rate	The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).
Prevention Activity	Activity that focuses on behavioral interventions, structural interventions, capacity building, or information gathering.
Prevention Services	Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV or other diseases. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.
Priority Setting	The process used by a planning council or consortium to prioritize service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.
Public Health Surveillance	An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (e.g., the CDC's surveillance system for HIV cases).
QA	**Q**uality **A**ssurance. A broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards.
QI	**Q**uality **I**mprovement. Activities aimed at improving performance.
Qualitative Data	Non-numeric data, including information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of underlying meanings, common themes, and patterns of relationships. Qualitative data often complement and help explain quantitative data.
Quantitative Data	Numeric information—such as such as numbers, rates, and percentages—representing counts or measurements suitable for statistical analysis.
Resource Allocation	The legislatively mandated responsibility of planning councils to assign CARE Act dollars or percentages across specific service categories, using key information such as documented need, defined service priorities and other resources as part of the process.
RFP	**R**equest **F**or **P**roposal. An open and competitive process for selecting providers of services (sometimes called *RFA* or *Request for Application).*
Risk Factor or Risk Behavior	Behavior or other factor that places a person at risk for disease. For example, drug use is a factor that increases risk of acquiring HIV

	infection, and factors such as sharing injection drug use equipment, unprotected anal or vaginal sexual contact, and commercial unprotected sex increase the risk of acquiring HIV.
SAMHSA	**S**ubstance **A**buse and **M**ental **H**ealth **S**ervices **A**dministration. The entity within the U.S. Department of Health and Human Services that administers alcohol, substance abuse and mental health programs.
SCSN	**S**tatewide **C**oordinated **S**tatement of **N**eed. A written statement of HIV-related service needs for the entire State; the SCSN is developed through a process that includes representatives of all CARE Act Parts, providers, people living with HIV, and public health agencies.
Seroconversion	The development of detectable antibodies to HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies to HIV appear in the blood, a person will test positive in the standard ELISA test for HIV.
Seroprevalence	The number of persons in a population who test HIV-positive based on serology (blood serum) specimens; often presented as a percent of the total specimens tested or as a rate per 100,000 persons tested.
Seroprevalence Report	A report that provides information about the percent or rate of people in specific testing groups and populations who have been diagnosed with HIV.
Side Effects	Side effects are the unwanted effects that your medications can cause. Common side effects of ART are nausea, vomiting and fatigue, among many others.
SIRR	**S**erving the **I**ncarcerated and **R**ecently **R**eleased Partnership. SIRR is a project of The Resource Group. It started in 2009, building upon the local discharge planning pilot project between the Harris County Sheriff's Office, Houston Area Community Services, Legacy Community Health Services and the Houston Ryan White Part A Grant Administration. The group meets on the 4th Wednesday of the month.
SPNS	**S**pecial **P**rojects of **N**ational **S**ignificance. A health services demonstration, research and evaluation program funded under Part F of the CARE Act. SPNS projects are awarded competitively.
Socioeconomic Status	A description of a person's societal status using factors or measurements such as income levels, relationship to the national poverty line, educational achievement, neighborhood of residence, or home ownership.

Stakeholder	A person or representative who has personal or professional experience, skills, resources, or expertise in HIV.
STDs	Sexually transmitted diseases (STDs) are also known as venereal diseases (VDs) or sexually transmitted infections (STIs). STDs are diseases or infections that you can transmit between humans by means of sexual contact such as vaginal intercourse, oral sex and anal sex. Practicing safe sex or harm reduction techniques can decrease your chances of getting STDs.
Support Services	Ryan White grantees must spend at least 75% of funds on core medical services. The remaining funds may be spent on support services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person living with HIV. HRSA outlines support services as outreach, medical transportation, language services, respite care for persons caring for individuals living with HIV and referrals for health care and other support services.
Surveillance	The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.
TA	**T**echnical **A**ssistance. The delivery of expert programmatic, scientific, and technical support to organizations and communities in the design, implementation, and evaluation of HIV programs.
Target Population	A population to be reached through some action or intervention; may refer to groups with specific demographic (e.g. Latino, Women, Youth) or geographic characteristics (e.g. rural, specific zip code).
TGA	**T**ransitional **G**rant **A**rea. Geographic areas highly-impacted by HIV that are eligible to receive Ryan White Program Part A funds. To be an eligible TGA, an area must have reported at least 1,000 but fewer than 2,000 new AIDS cases in the most recent 5 years. (See also EMA)
Transgender	Individuals who cross or transcend culturally-defined categories of gender.
Transmission Category	A grouping of disease exposure and infection routes; in relation to HIV, exposure groupings include PWIDU, MSM, heterosexual contact, perinatal (mother to child) transmission, etc.
Unmet Need	Individuals diagnosed with HIV but with no evidence of care for 12 months.
Viral Load	Viral load is a test to measure the amount of HIV in your blood. Your doctor often uses this test to see how well your anti-retroviral medications are working.

GLOSSARY FOR THE ACA

This glossary is intended to serve as a resource for understanding the concepts included in the Affordable Care Act. It provides simple and straightforward definitions of key terms that are part of the health reform law.

A

Affordable Care Act
Also known as the ACA, or Obamacare. A law that creates new options for people to obtain private health insurance coverage or Medicaid.

AIDS Drug Assistance Program (ADAP)
A part of the Ryan White HIV/AIDS Program that provides funding to states to purchase HIV and other medications for people with HIV. ADAP may also help people with HIV pay insurance premiums and co-payments.

Appeal
A challenge of a denial by a health plan to pay for a requested service.

B

Benefits
Services covered by a health plan.

C

Co-payment
A fixed amount of money for each health care service (such as $5 for a doctor's visit or for a prescription). The required fee varies by the service provided and by the health plan.

Cost-sharing
A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

D

Deductible
The amount you must pay for covered services before your health plan begins paying.

Drug class
A category of drugs (such as antiretrovirals).

Drug coverage gap (sometimes called the donut hole)
The gap in coverage in which Medicare Part D enrollees are required to pay the full cost of their drugs until the qualify for catastrophic coverage under Obamacare, the coverage gap is being phased out by 2020. In 2014, people in the coverage gap must bay 50% of the cost of brand name drugs.

E

Essential Health Benefits (EHB)
The core set of benefits that every health plan in the health insurance marketplaces and expanded Medicaid programs must provide.

Exchange
Also called a marketplace. A program in every state where you can compare among multiple health plans and buy coverage for yourself and your family.

Exempt
Individuals who not required to have health insurance, and therefore not subject to a penalty for not purchasing health insurance coverage.

F

Federal Poverty Level
The government's estimate of the amount of income an individual or family needs to meet food, housing, medical care, and other basic living expenses. The poverty level is used to calculate eligibility for financial help under the Affordable Care Act (ACA, also called Obamacare) and other federal programs. It is adjusted for the number of members in a family. There are different levels set for Alaska and Hawaii.

G

Grandfathered plans
Health plans provided by employers, or sold to individuals before the Affordable Care Act (ACA, also called Obamacare) on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the ACA.

Gross (or total) income
The amount of income earned before taxes and other deductions.

H

Health Insurance
Protection for high and sometimes unexpected costs with coverage for medical care and other health-related service needs.

Health Insurance Marketplaces
Also called "exchanges." The marketplace is a program in every state where you can compare among multiple health plans and buy coverage for yourself and your family.

I

Individual mandate
A requirement of Obamacare, officially known as the Affordable Care Act or ACA that requires people to have insurance or pay a penalty. If affordable coverage is not an option, there is an affordability exception.

M

Marketplace
Also called an exchange. A program in every state where you can compare among multiple health plans and buy coverage for yourself and your family.

Marketplace network
The list of hospitals, doctors, and pharmacies where your health plan covers services. Your health plan may decline to cover services or charge you more if you access services from providers who are not in their network.

Medicaid
A federal-state health insurance program for low-income individuals and families. Medicaid is the largest single source of health coverage for people with HIV.

Medicare
A federal health insurance program for people age 65 and older, and for working age people with disabilities. Medicare is a major source of health coverage for people with HIV.

Modified Adjusted Gross Income (MAGI)
A calculation used by the Affordable Care Act (the ACA, also called Obamacare) to determine how much financial assistance you are eligible to receive to help you purchase health insurance and to determine eligibility for Medicaid. To determine your MAGI, start with your adjusted gross income from your tax form and add in any social security benefits you receive that are not subject to federal income tax. Also add in excluded foreign income and tax-exempt interest income.

N

Navigator
A person whose job it is to help people learn about new coverage options under the Affordable Care Act (ACA, also called Obamacare).

O

Out-of-pocket limit
The maximum amount a person has to pay for health care each year when premiums, deductibles, and cost sharing are taken into account.

P

Patient Assistor
A person whose job it is to help people learn about new coverage options under the Affordable Care Act (ACA, also called Obamacare).

Pre-Existing Health Condition
An illness or disability a person has been diagnosed with before enrolling in a health plan.

Premium
The monthly fee for health insurance. The cost of a premium may be shared between employers or government purchasers and individuals.

Preventive services
A set of free services that marketplace health plans and many others are required to cover. These services emphasize the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term.

Q

Qualifying insurance policy
Insurance coverage that meets the minimum requirements to satisfy the requirement to have insurance (individual mandate) under the Affordable Care Act (ACA, also called Obamacare).

R

Ryan White HIV/AIDS Program
A federal program that funds states, cities, and medical clinics across the country to provide various health and supportive services to people with HIV.

S

Spending cap
A maximum amount of money a health plan will pay for covered benefits, sometime set on a yearly basis over a lifetime. Under the Affordable Care Act (ACA, also called Obamacare), spending caps are prohibited.

Subsidies
Under Obamacare tax credits are available for low-income people to help them afford health insurance. The tax credit acts as financial help to lower the premium and deductible paid for health insurance by a person or family. In some cases this also applies to cost sharing and co-payments.

T

Tax credit
Under Obamacare tax credits are available for low-income people to help them afford health insurance. The tax credit acts as financial help to lower the premium and deductible paid for health insurance by a person or family. In some cases this also applies to cost sharing and co-payments.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

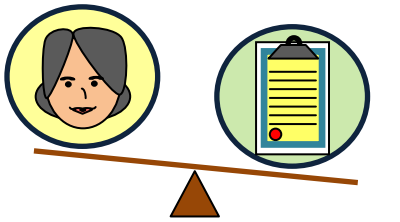
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

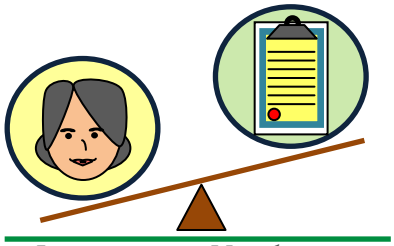
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium.**

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance.**

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments.**

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

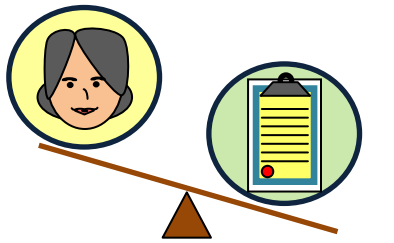
Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments, deductibles, co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

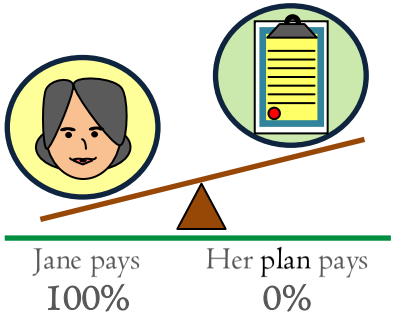
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

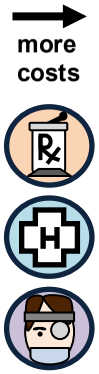
December 31st
End of Coverage Period

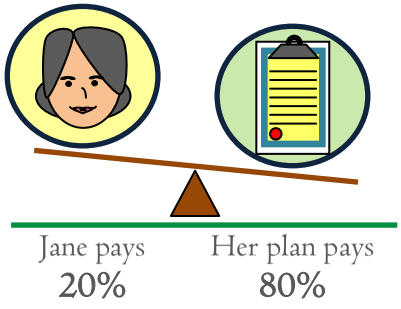


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

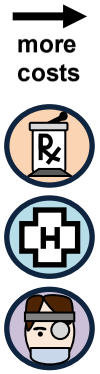


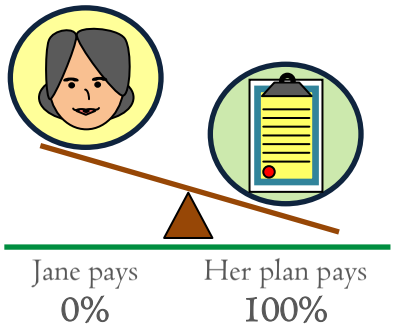


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60





Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

HIV #LanguageMatters:

Using preferred language to address stigma

Created for & by People Living with HIV

Acknowledgements:
thewellproject IrisHouse Rutgers Francois-Xavier Bagnoud Center SERO Francis House hive

Stigmatizing	Preferred
HIV infected person	Person living with HIV, PLHIV. Do not use "infected" when referring to a person. Use *People First Language,* which emphasizes the person, not their diagnosis
HIV or AIDS patient, AIDS or HIV carrier	
Positives or HIVers	
Died of AIDS, to die of AIDS	Died of AIDS-related illness, Died of AIDS-related complications or end stage HIV
AIDS virus	HIV (AIDS is a diagnosis not a virus - it cannot be transmitted)
Full-blown AIDS	There is no medical definition for this phrase - simply use the term AIDS, or Stage 3 HIV.
HIV virus	This is redundant; use HIV.
Zero new infections	Zero new HIV acquisitions/transmissions
HIV infections	HIV transmissions, diagnosed with HIV, PLHIV
HIV infected	living with/diagnosed with HIV, contracted/acquired HIV
Number of infections	Number diagnosed with HIV/number of HIV acquisitions
Became infected	Contracted, acquired, diagnosed with
HIV-exposed infant	Infant exposed to HIV
Serodiscordant couple	Serodifferent, magnetic, or mixed status couple
Mother to child transmission	Vertical transmission/perinatal transmission
Victim, Innocent Victim, Sufferer, contaminated, infected	Person living with HIV, survivor, warrior (Do not use "infected" when referring to a person)
AIDS orphans	Children orphaned by loss of parents/guardians who died of AIDS related complications
AIDS test	HIV test (AIDS is a diagnosis, there is not an AIDS test)
To catch AIDS, To contract AIDS, Transmit AIDS, To catch HIV	An AIDS diagnosis, developed AIDS, to contract HIV (AIDS is a diagnosis, which cannot be passed from one person to the next)
Compliant	Adherent
Prostitute or prostitution	Sex worker, sale of sexual services, transactional sex
Promiscuous	This is a value judgment and should be avoided instead use "having multiple partners"
Unprotected sex	Condomless sex with PrEP, Condomless sex without PrEP, sex not protected by condoms, sex not protected by antiretroviral prevention methods
Death Sentence, Fatal condition or life-threatening condition	A serious health issue, chronic health condition or manageable health for people who have access to care and treatment
"Tainted" blood; "dirty" needles	Blood containing HIV; shared needles, shared shringes
Clean, as in "I am clean are you?"	Referring to yourself or others as being "clean" suggests that those living with HIV are dirty. Avoid!
"a drug that prevents HIV infection"	a drug that prevents the transmission of HIV
End HIV, End AIDS	End HIV transmission, Be specific: are we ending HIV or AIDS?

U=U

HIV Undetectable = Untransmittable

Medicines to treat HIV can eliminate the risk of sexual transmission. In August 2016, the New York City Health Department agreed with other public health and medical organizations that people with HIV who maintain an undetectable viral load for at least six months do not transmit HIV through condomless sex. This is known as: Undetectable = Untransmittable, or U = U.

How does HIV treatment prevent HIV transmission?

Antiretroviral medicines control HIV very effectively. They do not cure HIV or remove the virus from the body, but if taken every day, as prescribed, HIV medicines stop the virus from multiplying. This prevents the virus from damaging the immune system and stops sexual transmission to others.

What does undetectable mean?

Undetectable means that the level of HIV in a person's blood is so low that it doesn't show up on a viral load test. If a person is undetectable, HIV can still be hiding in their body, but the amount is so low that HIV cannot be passed to others through sex.

How do we know that Undetectable = Untransmittable?

Three recent studies — HPTN 052, PARTNER and Opposites Attract — followed male couples and heterosexual couples, in which one partner was HIV positive and the other HIV negative. During these studies, not one HIV-positive person who was taking antiretroviral medicines and was undetectable passed HIV to their negative partner — in over 34,000 instances of condomless anal sex among male couples, and over 36,000 instances of condomless vaginal or anal sex among heterosexual couples.

How do I get my viral load to be undetectable?

If you have HIV, take antiretroviral medicines as prescribed by your health care provider. After you start your medicine, your provider will take blood samples to determine when the level of HIV in your blood has become undetectable. Once you have been undetectable for six months, you will not sexually transmit HIV as long as you take your antiretroviral medicines and keep your viral load undetectable.

If I am HIV negative, should I avoid having sex with people who have HIV?

Having sex with someone who has HIV but is on treatment and is undetectable is much safer than having sex with someone who has HIV but is not on treatment or doesn't know their status. A person who was recently infected with HIV can have a very high viral load and easily pass HIV to their partners through condomless sex. A person with HIV who is undetectable for six months will not pass HIV to their sexual partners, even if they have sex without condoms.

If my partner tells me they have an undetectable viral load, should we still use condoms?

Having an undetectable viral load prevents HIV transmission but does not protect against other sexually transmitted infections (STIs) or unintended pregnancy. Condoms protect against HIV, other STIs and unintended pregnancy. If you are unsure about whether your partner is undetectable, consider using condoms or take daily PrEP (pre-exposure prophylaxis) to protect against HIV. To learn more about PrEP, speak to your doctor or visit **nyc.gov/health** and search **daily PrEP.** You should never feel pressured to have sex without condoms.

If I am on HIV treatment, should my partner be on PrEP?

Couples share the responsibility of preventing HIV. HIV-positive people and their partners should discuss how they can have a healthy, fulfilling and worry-free sex life by using condoms, HIV treatment, PrEP or emergency PEP (post-exposure prophylaxis). HIV-negative partners may choose to take PrEP, especially if they have other sexual partners; are unsure of their partner's HIV status; are unsure of their partner's ability to keep their viral load undetectable; or feel more secure in their sex lives with the added protection of PrEP.

What else can I do to prevent getting or passing HIV and other STIs?

Get an HIV test. A positive test is an opportunity to treat HIV, stay healthy and prevent HIV transmission to others. A negative test gives you the chance to discuss ways to stay negative, like using condoms, taking daily PrEP or taking emergency PEP. Get tested regularly for other STIs. STIs may not cause you to show symptoms, but they can increase an HIV-positive person's viral load or make it easier for the virus to enter an HIV-negative person's body.

For more information on HIV, **visit nyc.gov/health** and search **HIV**.

For assistance with HIV care and treatment, call **311** or text **CARE** to **877877**.

NYC Health

6.18

February 2020

Ending the HIV Epidemic: A Plan for America

The U.S. Department of Health and Human Services (HHS) has launched Ending the HIV Epidemic: A Plan for America. The cross-agency initiative leverages critical scientific advances in HIV prevention, diagnosis, treatment, and outbreak response by coordinating the highly successful programs, resources, and infrastructure of many HHS agencies and offices.

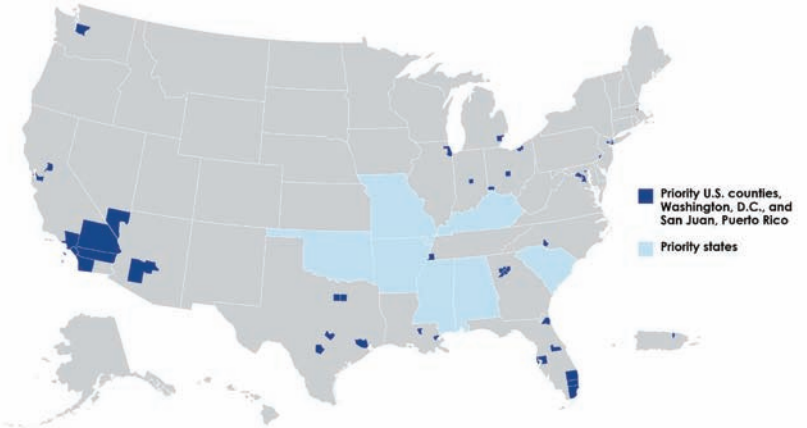
GOAL:

reaching **75%** reduction in new HIV infections by 2025 and at least **90%** reduction by 2030.

HHS will work with each community to establish local teams on the ground to tailor and implement strategies to:

- **Diagnose** all people with HIV as early as possible after infection.
- **Treat** the infection rapidly and effectively to achieve sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

The Initiative is focusing resources on areas where HIV transmission occurs most frequently.



Geographical Selection:
Data on burden of HIV in the US shows areas where HIV transmission occurs more frequently. More than 50% of new HIV diagnoses* occurred in only 48 counties, Washington, D.C., and San Juan, Puerto Rico. In addition, 7 states have a substantial rural burden – with over 75 cases and 10% or more of their diagnoses in rural areas.

*2016-2017 data

Ending the HIV Epidemic

www.HIV.gov

Ending the HIV Epidemic – Key Strategies:

Achieving elimination will require an infusion of resources to employ strategic practices in the right places targeted to the right people to maximize impact and end the HIV epidemic in America. Key strategies of the initiative include:

Leadership Team

Co-Chairs: Ronnie Galley (RWPC), Lesley Williams (RW Pt B) and Shawn Flintroy (CPG)

Status Neutral Systems & Diagnose Committee

Co-Chairs:
Kathryn Fergus
Rodney Mills
S: Chelsea F
M: Ocran H

Treat Committee

Co-Chairs:
Pete Rodriguez
Paul Conley Stone
S: Tori

Prevention & Policy Committee

Co-Chairs
Shawn Flintroy
Beatriz Rivera
S: Ama W
M: Eliot Davis

Respond Committee

Co-Chairs:
Paul Richards
Tana Pradia
S: Sha'Terra

Quality of Life & Social Determinants Committee

Co-Chairs:
Lesley Williams
Tori working on a co-chair
S: Tori

Research, Data, & Implementation Committee

Co-Chairs
Steven Vargas
Gloria Sierra
S: MH & HHD Rep
M: Jeffery Meyer
See CHP Committee

Monitoring, Quality Assurance, & Evaluation Committee

Co-Chairs
Evelio Escamilla
Herman Finley
Mary Guidry
S:Tori & HHD Rep
See CHP Committee

Education & Awareness Committee/Coalition

Co-Chairs: Ashley Barnes, Titan Capri & Rebecca Chapa

Consumer & Community Engagement Workgroup

Co-Chairs:
Adonis May
Ronnie Galley
S: Richon Ohafia & HHD EHE Coor.
M: Josh
Rodney M.
Calvin V.

College Workgroup

Co-Chairs:
Crystal Starr
Dominique G.
S: Sha'Terra
M: Josh
Caleb

Needing In-Person Workgroup

Co-Chairs:
Alexis L.
Shawn F.
S: Tori
M:

Youth Workgroup

Co-Chairs:
Caleb Brown
Ronnie Galley
Johnny Deal
S: Rod
M: Megan
Leslie W.
Crystal
Rodney M.

Professional Healthcare Workgroup

Co-Chairs:
Josh Mica
One more
S: Tori
M: Shital
Kathryn
Ronnie G.

HIV & Aging Workgroup

Co-Chairs:
Denis Kelly
Evelio Escamilla
S: Diane Beck

Housing Workgroup

Co-Chairs:
Megan Rowe
Kenia Gallardo
Johnny D
S: Tori

Racial & Social Justice Workgroup

Co-Chairs:
Cecilia Ligons
Bobby Cruz
Bill Patterson
S: Richon Ohafia

SECTION V: PLAN GOALS AND OBJECTIVES

The following list includes goals, objectives and activities for the Houston EHE and Integrated Plans and is organized by EHE pillar. Clearly, some goals and activities from each plan intersect, hence the goals for both plans have been merged into one list, but goals for the Integrated Plan are in italics to denote service areas. The justification for each goal is identified within the brackets after the goal. This is considered a "living" document, and it is anticipated that more goals, objectives and indicators will be added to each pillar as EHE and Integrated planning and implementation continues.

Pillar 1: Diagnose

Goal 1A: ***Increase individual knowledge of HIV status by diagnosing at least 90% of the estimated individuals who are unaware of their status within five (5) years.*** **[CP-Healthy People 2030, Rdmap, FTC, NEHE, CP]**

Goal 1A.1: **Encourage status awareness through increased screening, diverse non-stigmatizing campaigns, improved hiring practices, and updated accessibility in historically marginalized communities in Houston/Harris County.**
[Rdmap, CM-WD/OCB/EA/RAA/AS/MBH/PA/ CHS/QAE, CP]

Legend for Section V

Regular Text = EHE Planning Goal impacting the Houston/Harris County, Texas service area

Italicized Text = Integrated Planning Goal impacting the EMA/HSDA (10-county), Texas service area

Source of Justification for the following goals:

CP = 2017 Houston Area HIV Comprehensive Plan
CP-____ = HIV & Non-HIV Comprehensive Plans
CM = 2021-2022 Community Meetings
EHEPtA = Ryan White Part A EHE Goal
FTC = International Fast Track Cities
FGPP = 2022 Priority Populations Focus Groups
FGP = 2022 Provider Focus Groups
NEHE = 2019 National EHE Plan
NAC = 2020 HIV Care Needs Assessment
NAP = 2022 HIV Prevention Needs Assessment
NHAS = 2021 National HIV/AIDS Strategy
Rdmap = 2016 Houston Area EHE Plan, commonly referred to as *The Roadmap*
ST = 2022 Stakeholder Interview

Key Activities:

- Extend health center hours and/or partner with healthcare systems to demonstrate consideration for persons seeking services outside traditional hours. **[CM-RAA/MBH/BMP]**
- Explore a collaborative routine opt-out initiative with hospital emergency room providers outside a policy requirement. **[CM-EA/PA/BMP]**
- Add five (5) nurse operated mobile units offering extended hours and bundled services (e.g., STI, Hepatitis C, PrEP, nPEP, BMI assessment, glucose, immunizations, service linkage, partner services, etc.) to dispatch across Houston/Harris County. **[CM-RAA/BMP]**
- Implement at minimum a yearly multilingual health education and promotion campaign empowering ALL sexually active Houstonians/Harris Countians to insist on initial and routine rescreening for HIV. **[Rdmap, CM-EA/RAA/CHS]**
- Prioritize hiring a diverse and representative staff whom people can trust to administer status neutral services. **[Rdmap, CM-WD/OCB/AS]**
- Pilot HIV and STI home testing kits and develop a protocol for timely, status neutral follow-up, and quarterly evaluation to improve the service delivery. **[CM-OCB/EA/RAA/AS/QAE]**

- Reestablish an annual testing for tickets (e.g., "Hip Hop for HIV") event. **[CM-RAA]**
- Conduct outreach efforts in screening locations near identified areas (e.g., college campuses, barber and beauty shops, shopping centers, and recreational) through ongoing partnerships with community leaders and gatekeepers. **[Rdmap, CM-EA/RAA/QAE/MBH/BMP]**

Goal 1A.2: Advance legislative and non-legislative policy changes at the local, state, and federal levels to aid EHE. [Rdmap, CM-EA/RAA/PA/QAE/BMP]

Key Activities:

- Educate policymakers on the need for statewide mandatory offering of routine opt-out testing. **[Rdmap, CM-EA]**
- Revise policies that institute county-wide age-appropriate comprehensive sexual education that empowers youth to make informed decisions about their health. **[Rdmap, CM-PA/QAE]**
- Advance county-wide policy modifications that require HIV testing and access to care for all arriving persons involved with the justice system and retest prior to facility release with enough medication and linkage to care if need determined. **[Rdmap, CM-PA/RAA/BMP]**
- Update local policies and procedures to implement an electronic automated reminder system and/or modify existing options to send annual screening reminders. **[CM-EA/PA]**
- Conduct provider detailing (e.g., Obstetrician/Gynecologist, General Practitioner, Gerontologist) to promote internal policy changes to incorporate universal screening as a standard practice. **[CM-EA/PA/QAE]**

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, community task force, school-based clinics, sexual health clinics, women's health services/prenatal services providers, hospitals, local community members, local correctional institutions, local law enforcement, PWH, shelters, public health professionals, etc.
Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Ryan White HIV/AIDS Program (RWHAP), State and/or Local Funding
Estimated Funding Allocation: $1.8 Million
Outcomes: (reported annually, locally monitored more frequently): Increase number of newly identified persons with HIV and awareness of HIV status; Increase the number of HIV tests conducted in Houston/Harris County; Establish HIV care protocols for persons involved with the justice system.
Monitoring Data Source: EMR data, surveillance data, local protocols and reports

Goal 1B: ***Improve HIV-Related Health Outcomes of All People Being Tested for HIV [QoL]***

Key Activities:

- *Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide whole-person care and treatment for individuals testing for HIV.*
  - *Identify, implement, and evaluate models of care that meet the needs of all people being tested for HIV and ensure quality of care across services.*

  - *Incorporate a status-neutral approach to HIV testing, offering linkage to prevention services for people who test negative and immediate linkage to HIV care and treatment for those who test positive.*
  - *Identify, engage, or reengage people with HIV who are not in care or not virally suppressed.*
  - *Provide low-barrier access to HIV prevention, care and/or treatment.*
  - *Provide same-day or rapid (within 7 days) start of antiretroviral therapy for persons who are able to take it; increase linkage to HIV health care within 30 days for all persons who test positive for HIV.*
- *Identify and address barriers for people who have never engaged in care or who have fallen out of care.*

Key Partners: *Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, sexual health clinics, women's health services/prenatal service providers, hospitals.*
Potential Funding Resources: *CDC HIV Prevention and Surveillance Programs, RWHAP, State and/or Local Funding.*
Estimated Funding Allocation: ***Related to Goal 1A***
Outcomes *(reported annually, locally monitored more frequently) Number of newly identified persons with HIV; Establishment of protocols for HIV/AIDS treatment under incarceration, number of cases linked to care under incarceration.*
Monitoring Data Source: *EMR data, surveillance data, local protocols and reports.*

Goal 1C: ***Increase Knowledge and Understanding of HIV [CM, CP, CP - Viral Hepatitis National Strategic Plan, FGPP, FGP, NAC, NHAS, Rdmap, ST]***

Key Activities:

- *Establish a Houston Area HIV Education Council to provide education for:*
  - *Individuals on prevention, treatment, and care services; and*
  - *Professionals on accurate medical information, training in referring clients to the local HIV prevention and care system, and customer service skills.* ***See Goal 3A*** *for more information. This educational goal will address Diagnose, Treat and Prevent.*
- *Increase knowledge of HIV among individuals and the health workforce in geographic areas disproportionately affected.*

Key Committed Partners: *Southern AIDS Education and Training Center (**AETC**), Texas Southern University (**TSU**), Houston HIV Prevention Community Planning Group (**CPG**) and Ryan White Planning Council (**RWPC**).*
Key Potential Partners: *Representatives from special populations, people with HIV, professional educators, case managers and service linkage workers, large public organizations who work with individuals challenged by substance use disorder and/or mental illness and/or intellectual and developmental disabilities.*
Potential Funding Resources: *CDC, Ryan White, AETC and possibly TSU grant funds already secured to work with community groups such as The Houston Area HIV Education Coalition.*
Estimated Funding Allocations: *$200,000.*
Outcomes: *Increased knowledge among students.*
Monitoring Data Source: *Student pre and post tests.*

Pillar 2: Treat

Goal 2A: Ensure 90% of clients are retained in care and virally suppressed. [CP-Health People 2030, Rdmap, CP, NEHE, FTC]

Goal 2A.1: Ensure rapid linkage to HIV medical care and rapid ART initiation for all persons with newly diagnosed or re-engaging in care. [Rdmap, CM-OCB/RAA/EA/MBH/PA/BMP]

Key Activities:

- Increase retention in medical care through rapid treatment initiation.
  - *In FY 2020, the Ryan White Program, in partnership with South Central AETC, Baylor College of Medicine, and Harris County Public Health, launched Rapid Start Treatment Programs at Ryan White funded primary care sites. The next step is to increase outreach to priority populations and launch Rapid Start Treatment Programs at sites other than RWHAP-funded primary care sites.* ***[EHEPtA, 16Rdmap]***
- Offer a 24-hour emotional support and resources line available with trauma informed staff considerate to the fact individuals are likely still processing a new diagnosis. **[CM-RAA/MBH]**
- Health literacy campaign to educate those diagnosed on benefits of rapid start and TasP. **[CM-RAA/EA]**
- Support rapid antiretroviral therapy by providing ART "starter packs" for newly diagnosed clients and returning patients who have self-identified as being out of care for greater than 12 months. **[CM-EA/PA]**
- Expand community partnerships (e.g., churches and universities) to increase rapid linkage and ART availability at community-preferred gathering venues. **[CM-OCB/PA/BMP]**
- Promote after-hour medical care to increase accessibility by partnering with providers currently offering expanded hours, like urgent care facilities. **[CM-RAA]**
- Develop a provider outreach program focused on best HIV treatment-related practices and emphasizing resources options for clients (Ryan White care system) as well as peer-to-peer support resources for providers (e.g., Project ECHO, AETC, UCSF). **[CM-EA/PA]**

Goal 2A.2: Support re-engagement and retention in HIV medical care, treatment, and viral suppression through improved treatment related practices, increased collaboration, greater service accessibility, and a whole-health emphasis. [CM-OCB/RAA/EA/AS/MBH/CHS/PA/QAE/BMP]

Key Activities:

- Develop informative treatment navigation, viral suppression, and whole-health care support program including regularly held community forums designed to maximize accessibility. **[CM-RAA/EA/PA]**
- Partner with providers to expand hours and service location options based on community preferences (after-hours, mobile units, non-traditional settings). **[Rdmap, CM-RAA/BMP]**

- Assess feasibility of expanded telehealth check-in options to enhance accessibility and promote bundling mobile care services (including ancillary services). **[CM-RAA/BMP]**
- Increase the number of referrals and linkage to RW. **[CM-PA/QAE]**
- Increase integration, promotion, and the number of referrals to ancillary services (e.g., mental health, substance use, RW, and payment assistance) through expanded partnerships during service linkage. **[CM-QAE]**
- Increase case management support capacity. **[CM-OCB]**
- Develop system to monitor referrals to integrated health services. **[CM-QAE]**
- Hire representative navigators, promote job openings in places where community members with relevant lived experience gather, and invest in programs such as the Community Health Worker Certification. **[Rdmap, CM-OCB/QAE]**
- Survey users of services to evaluate additional service-based training needs. **[CM-QAE]**
- Conduct provider outreach (100 initial/100 follow-up visits) to improve multidisciplinary holistic health practices including importance of trauma-informed approach, motivational interview-based techniques, preferred language, culturally sensitive staff/setting, behavior-based risk vs demographic/race, and routine risk assessment screenings (mental health, gender-based or domestic violence, need for other ancillary services related to SDOH). **[Rdmap, CM-EA/AS/MBH/CHS/QAE]**
- Build and implement a mental health model for HIV treatment and care that includes routinizing screenings/opt-out integration into electronic health records. **[CM-MBH/PA]** **[CM-MBH/PA]**
- Source resources for referral/free initial mental health counseling sessions.
- Maintain at least one crisis intervention specialist on service linkage staff. **[CM-MBH]**
- Partner community health workers with local community gathering places (e.g., churches) to recognize and reach individuals who may benefit from support and linkage to resources. **[CM-OCB]**
- Improve value of data to community by promoting inclusive, representative data collection on community selected platforms. **[CM-CHS/PA]**
- Widely share analyses of collected data with emphasis on complete context and value to community, including annual science symposium; Allow opportunities for community to share their stories to illustrate the personal connection. **[CM-BMP]**
- Utilize a reporting system to endorse programs or environments that show training application and effort to end the epidemic. Conduct quarterly quality assurance checks after the secret shopper project established by END. **[CM-QAE]**
- Use the HIV system to fill gaps in healthcare by creating a grassroots initiative focused on social determinants of health. **[CM-AS/PA]**
- Increase access to quality health care through promoting FQHCs to reduce the number of uninsured to under 10% in the next 10 years. **[CM-PA]**
- Revamp data-to-care to achieve full functionality. **[CM-PA]**

Goal 2A.3: Establish organized methods to raise widespread awareness on the importance of treatment. [CM-WD/OCB/CHS/RAA/EA/AS/QAE]

Key Activities:

- Collaborate with CPG to gain real-time public input during meetings on preferred language and promotion of critical messages of Undetectable=Untransmittable (U=U) and Treatment as Prevention (TasP). **[Rdmap, CM-RAA/QAE]**
- Collaborate with CPG to regularly promote diversifying clinical trials. **[Rdmap, CM-CHS/QAE]**
- Increase education and awareness around the concept of U=U and TasP to reduce stigma, fear, and discrimination among PLWH. **[CM-OCB/RAA/EA/AS]**
- Implement community preferred social marketing strategies over multiple platforms to establish messaging on the benefits of rapid and sustained HIV treatment (include basic terminology, updates on treatment/progress advances, and consideration for generational understanding of information). **[Rdmap, CM-RAA/EA/AS]**

Goal 2A.4: Advance internal and external policies related to treatment. [Rdmap, CM-WD/RAA/OCB/EA/MBH/CHS/PA/QAE, CP]

Key Activities:

- Implement and monitor immediate ART with a standard of 72 hours of HIV diagnosis for Test and Treat protocols. **[CP]**
- Revise policies to simplify linkage through use of an encrypted universal technology such as patient portal and/or apps to easily share information across health systems, remove administrative (e.g., paperwork and registration) barriers, incorporate geo-fencing alerts and anonymous partner elicitation. **[CM-RAA]**
- Refresh policies to establish a retention/rewards program that empowers community to optimize health maintenance and encourages collaboration with health department services and resources. **[CM-RAA]**
- Focus on necessary requirements and reduce turnaround time from diagnosis to care (e.g., Change the 90-day window for Linkage Workers). **[CM-OCB]**
- Update prevention standards of care to reflect a person-centered approach. **[CM-WD]**
- Develop standard of treatment and advocate for implementation for those incarcerated upon intake. **[CM-PA]**
- Institute policies that require recurring trainings for staff/providers based on community feedback and focused on current preferred practices (emphasis on status-neutral approach, trauma-informed care, people first-language, cultural sensitivity, privacy/confidentiality, follow-up/follow-through). **[CM-WD/EA/AS/MBH/CHS/QAE]**
- Revise funding processes and incentivize extended hours of operation to improve CBO workflow. **[CM-OCB]**

Key Partners: FQHCs, medical care providers, hospitals, community-based organizations, various professional health care associations, RWGA; TRG; HHD (Potential non-RP partners: RWPC), community task force, urgent care facilities, churches, universities
Potential Funding Resources: RWHAP, CDC HIV Prevention and Surveillance Programs, State Local Funding
Estimated Funding Allocation: $9,081,382

Outcomes: (reported annually, locally monitored more frequently): Increase number of newly identified individuals with HIV linked to care; Increase number of individuals with HIV identified as not in care relinked to care; Increase number of newly identified individuals with HIV linked to care and started on ART within 72 hours of diagnosis; Increase number of individuals with HIV identified as not in care relinked to care and started on ART within 72 hours.
Monitoring Data Source: Surveillance, RWHAP, CPCDMS, CDC testing linkage data

Goal 2B: ***Increase Access to Care and Medication. [CM, NAC, Rdmap, ST]***

Key Activities:

- *Increase access to services that replace or provide identification documents, especially for those who are discharged from jail or prison, people who are experiencing homelessness, and others who lack identification documents. Expand capacity of current providers of identification documents through partnerships with community partners, including Ryan White-funded agencies.*

Key Partners: *Operation I.D., Texas I.D. Connect, The Beacon, Ryan White-funded agencies.*
Potential Funding Resources: *N/A*
Estimated Funding Allocations: *N/A*
Outcomes: *Ten percent more individuals have received identification in a 6-month period.*
Monitoring Data Source: *Agency data on client service utilization.*

Goal 2C: ***Increase access to HIV education, prevention and care services among priority populations. [CM, NHAS, ST]***

Key Activities:

- *Increase individual knowledge of HIV, including HIV prevention and care services information, among individuals with a history of a sexual offense.*
  - *Request the RWPC to create a service definition and allocate funds for one full-time case manager or service linkage worker with lived experience to provide HIV education and case management services to this population. Fund this position from Ryan White Part A, B or State Services funding.*
  - *When releasing the RFP to secure a vendor, give preference to a non-traditional vendor, such as a church, that has a history of working with this population.*
  - *Require the employee to provide quarterly aggregate service utilization and other reports to Serving the Incarcerated and Recently Released Coalition (**SIRR**), CPG and RWPC.*

Key Partners: *SIRR, local churches that work with individuals with a history of a sexual offense, Ryan White-funded HIV discharge planners in the Harris County jail*
***Poten*tial Funding Resources:** *Ryan White Part A or B or State Services funding*
***Estimat*ed Funding Allocations:** *$130,000*
Outcomes: *Case manager/service linkage worker is hired and secures a minimum caseload of 30 individuals within a 12 month period. RWPC incorporates the quarterly reports from the case manager/service linkage worker in its planning process and works to better meet the needs of this priority population.*
Monitoring Data Source: *Quarterly aggregate case management/service linkage reports*

Goal 2D: ***Increase access to care and medication by tying the distribution of prepaid cell phones for clients to pharmacies, making the phone a medical necessity (not an incentive). [CM]***

Key Activities:

- *Meet with representatives of Ryan White-funded agencies to determine if this would resolve the issue of giving consumers prepaid phones, which have been interpreted as an incentive and in opposition to Medicaid contracts that prohibit incentives for consumers.*

Key Partners: *Staff from various Ryan-White funded agencies*
Potential Funding Resources: *N/A*
Estimated Funding Allocations: *N/A*
Outcomes: *More clients receive cell phones in a 6-month period.*
Monitoring Data Source: *Agency phone disbursement records*

Pillar 3: Prevent

Goal 3A: ***Prevent new HIV Infections by increasing knowledge of HIV among people, communities and the health workforce; with particular emphasis on priority populations and non-Ryan White funded agencies with expertise in areas that intersect with HIV. [CM, CP, CP - Viral Hepatitis National Strategic Plan, FGPP, FGP, NAC, NHAS, Rdmap, ST]***

Key Activities:

- *Establish a Houston Area HIV Education Council sponsored by AETC, CPG and RWPC to provide education to the following: individuals who need prevention services and providers.*
- *Develop and implement informational programs that are tailored to priority populations and others, and describe HIV risks, options for prevention, testing, care and treatment, mental health and substance use disorder treatment; and HIV-related stigma reduction.*
- *Increase consumer input into developing educational materials about HIV risks, options for prevention, testing, care and treatment; and HIV-related stigma reduction.*
- *Increase consumer participation in delivering educational information to individuals and service providers about HIV risks, options for prevention, testing, care and treatment; and HIV-related stigma reduction, particularly for priority populations.*
- *Increase education about HIV among people who provide services to those who are at risk or living with HIV.*
- *Include comprehensive sexual health and substance use prevention and treatment information in curricula of medical and other health workforce education and training programs.*
- *Support the transition of health care systems, organizations, and consumers to become more health literate in the provision/receipt of HIV prevention, care, and treatment services.*
- *Provide resources, value-based and other incentives, training, and technical assistance to expand workforce and system capacity to provide or link clients to culturally competent*

and linguistically appropriate care, treatment, and supportive services especially in areas with shortages that are geographic, population, or facility based.

Key Committed Partners: *Southern AETC, TSU, CPG and the RWPC.*
Key Potential Partners: *Representatives from priority and special populations, persons with HIV, professional educators, case managers and service linkage workers, large public organizations who work with individuals challenged by substance use disorder and/or mental illness and/or intellectual and developmental disabilities, for example.*
Potential Funding Resources: *CDC, Ryan White, AETC and possibly TSU grant funds already secured to work with community groups such as The Houston Area HIV Education Coalition.*
Estimated Funding Allocations: *$200,000.*
Outcomes: *Increased knowledge among students.*
Monitoring Data Source: *Student pre and post tests.*

Goal 3B: Achieve 50% reduction in new HIV cases. [CP-Healthy People 2030, Rdmap, NEHE]

Goal 3B.1: Integrate a status neutral approach in HIV prevention services by utilizing proven interventions to reduce new cases. [CM-RAA/MBH/OCB]

Key Activities:

- Develop a continuum of care for those utilizing prevention care services.
- Establish prevention navigators with lived experience of the priority populations to assist engagement and "re"engagement in prevention services. **[CM-OCB]**
- Offer and advocate for ongoing ancillary support options routinely offered during initial engagement. **[CM-RAA/MBH]**
- Tailor proven behavioral, biomedical, and structural interventions, public health strategies, and social marketing campaigns from the Compendium of Evidence-based Interventions and Best Practices for HIV Prevention to the needs of Houston/Harris County.

Goal 3B.2: Improve accessibility, information sharing, and monitoring of PrEP. [Rdmap, CM-EA/RAA/CHS/QAE/OCB]

Key Activities:

- Increase access to PrEP clinical services by integrating PrEP/nPEP into routine services at HHD Health Centers. **[CM-RAA/OCB]**
- Collaborate with medical providers in other specialties to integrate PrEP into routine preventative healthcare. **[Rdmap, CM-EA/RAA/CHS/OCB]**
- Expand PrEP services and hours to increase access including mobile, telehealth (e.g., Mistr, Sistr and Q Care Plus), and non-traditional settings. **[Rdmap, CM-RAA/CHS]**
- Expand access to same-day PrEP for persons HIV negative by providing a 30-day starter pack; utilize non-traditional settings (e.g., faith-based organizations) **[CM-RAA/QAE]**
- Develop purposeful non-stigmatizing awareness messaging that normalizes PrEP and nPEP conversations with care teams. **[CM-EA]**

- Create a PrEP Network information hub to help understand community practices and address challenges. **[CM-EA]**
- Collaborate with local CBOs to develop a 24-hour nPEP hotline and Center of Excellence. **[CM-EA]**
- Develop method of monitoring and reporting PrEP and a Continuum of Care. **[CM-QAE]**

Goal 3B.3: Address social determinants through a multi-level approach that reduces new cases and sustains health equity. [CM-WD/EA/RAA/AS]

Key Activities:

- Increase service provider knowledge and capability to assess those in need of ancillary services. **[CM-RAA/MBH]**
- Provide funded organizations with payment points for linking people to PrEP, keeping appointments, and then linking people on PrEP to housing, transportation, food assistance, and other supportive services. **[CM-RAA]**
- Develop mental health and substance use campaigns to support self-efficacy/resiliency. **[Rdmap, CM-EA/MBH]**
- Health departments partner more with colleges and school districts, Bureau of Adolescent Health to create a tailored strategic plan that better engages adolescent Houstonians/ Harris Countians. **[Rdmap, CM-EA]**
- Revitalize the Youth Task Force and seek funding for adolescent focused initiatives.
- Engage healthcare programs regarding inclusion of all HIV prevention strategies in their curriculums to educate future practitioners (e.g., medical, nurse practitioner, nursing, and other healthcare programs). **[Rdmap, CM-EA/OCB]**
- Reduce stigma and increase knowledge and awareness of PrEP and TasP through a biannual inclusive public health campaign focused on all populations. **[Rdmap, CM-AS]**
- Train the workforce on a patient-centered (i.e., status neutral and trauma informed) prevention approaches to build a quality care system. **[Rdmap, CM-WD/AS/MBH]**

Goal 3B.4: Advance policy gaps through increased education and outreach at all levels. [Rdmap, CM-RAA/AS/PA/QAE, CP]

Key Activities:

- Expand Medicaid in the State of Texas to assist prevention efforts for all Texans, particularly among marginalized communities. **[Rdmap, CM-PA]**
- Update policies to address service gaps by eliminating privacy barriers and expanding prevention clinical services to adolescents under the age of 18. **[CM-PA]**
- Create county-wide policies to implement medically accurate comprehensive sexual education in high schools and colleges/universities that encourages informed decisions. **[Rdmap, CM-PA]**

- Advance policy changes that promote harm reduction strategies for persons who inject drugs (PWID) such as sharps disposal kiosks to address discarded syringes in public locations. **[CM-PA]**
- Advocate for PrEP and nPEP availability over the counter. **[CM-RAA/PA]**
- Overhaul all prevention standards to reflect person-first strategies. **[CM-AS]**
- Reassess policies around the HIV positivity rate. **[CM-QAE]**

Key Partners: Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, community task force, RWPC-OS (*Potential non-RP partners:* TDSHS; AETC; HHS), faith-based organizations
Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care, state and/or local Funding, Minority AIDS Initiative (MAI), SAMHSA, HUD/HOPWA, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, and other public and private funding sources, etc.
Estimated Funding Allocation: $500,000
Outcomes: (reported annually, locally monitored more frequently): Increase number of providers trained; Increase number of prescriptions for PrEP; Increase the percentage of eligible people successfully referred to PrEP provider to 50% in 5 years.
Monitoring Data Source: Local databases, medical records data, pharmacy records

Goal 3C: ***Gather data both for and against policy changes related to the following issues with the goal of making data driven decisions regarding support for: [CM, FG, FTC, Rdmap, ST]***

- ***Condom distribution in jails and prisons***
- ***Texas becoming a Medicaid Expansion state***

Key Activities:

- *After reviewing documentation both for and against condom distribution, consider the establishment of condom distribution in Texas jails and prisons*
    - *Educate public officials in Texas on the benefits of condom distribution and encourage modification of governmental policies that create access barriers to this effective HIV prevention information and tool.*

Key Partners: *Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, community task force, RWPC-OS (Potential non-RP partners: TDSHS; AETC; HHS), St. Luke's Episcopal Foundation .*
Potential Funding Resources: *NA*
Estimated Funding Allocations: *NA*
Outcomes: *State and local policy changes that create barriers to accessing effective HIV prevention information and tools.*
Monitoring Data Source: *State and local policies.*

Pillar 4: Respond

Goal 4A: Increase capacity to identify, investigate active HIV transmission clusters and respond to HIV outbreaks in 1 year. [NEHE]

Goal 4A.1: Actively involve members of local communities in naming, planning, implementation, and evaluation by leveraging social networks, planning bodies, and community stakeholders in developing partnerships, processes, and data systems that facilitate response activities. [Rdmap, ST, CM-EA/RAA/AS/BMP]

- As of October 18, 2022, the Presidential Advisory Council on HIV/AIDS **(PACHA)** has asked the CDC to direct jurisdictions funded for Cluster Detection Response **(CDR)** activities to adapt their implementation of CDR to account for local conditions, including health data privacy protections and laws criminalizing people living with HIV.

Key Activities:

- Invest in technological solutions that further our partnerships, processes, and mass communication dissemination. **[Rdmap, CM-EA/RAA]**
- Host regularly scheduled community forums, presentations, and webinars with a variety of audiences such as residents, business owners, churches, bars, schools, and politicians. Increase transparency and buy-in by providing accurate information on important topics (e.g., privacy, protection, anonymity, gaps, recommended changes, and best practices). **[CM-EA]**
- Expand the response Community Advisory Board **(CAB)** by incorporating interested participants from various taskforces, internal (e.g., Tuberculosis and HCV) and external stakeholders. **[CM-BMP]**
- Conduct a feasibility study on outsourcing response activities to community partners.
- Provide engaging non-stigmatizing safe spaces that promote information sharing on what is going on in neighborhoods and tailor recommendations. Normalize inclusive discussions and team building activities among residents and community leaders by broadly advertising meetings in multiple locations (e.g., Southwest, Montrose, Third Ward, Fifth Ward) to reduce stigma. Utilize these platforms to spotlight the great work communities are accomplishing to constantly reenergize buy-in. **[CM-RAA/AS]**
- Conduct public health detailing to inform and educate providers about required disease reporting and how to effectively inform their patients. **[CM-AS]**

Goal 4B: ***Build a community-tailored program to investigate and intervene in active networks and ensure resources are delivered where need is the greatest. [Rdmap, ST, CM-WD/EA]***

Key Activities:

- Build contingency/surge capacity such as venue-based screenings cluster response efforts with existing contracted CBOs (when needed).

- Utilize case data and case studies to train both community partners and the HHD staff on better approaches to effectively respond to clusters, including the role partner services can play. **[CM-WD/EA]**
- Integrate both CDR and time-space analysis to identify clusters.
- Conduct rapid response, ART linkage, and same-day PrEP in cluster investigations through close collaboration with contractors, care providers and other stakeholders.

Goal 4C: Empower effective advocacy and policy changes at the local, state, and federal levels. [Rdmap, ST, CM-EA/PA/RAA]

Key Activities:

- Reestablish the CPG mandate to ensure community engagement and voice is consistently being heard. **[Rdmap]**
- Explore requirements necessary to change laws in the state by assessing current laws and implement annual assessment. **[CM-PA]**
- Examine the effects of HIV criminalization cases in the state to address policy barriers. **[CM-PA]**
- Reevaluate and revise the partner index requirement within the State of Texas.
- Annually assess and provide report on data protection policies and procedures that ensure safeguards and firewalls protecting public health research and surveillance data from access by law enforcement, immigration, and protective services systems. **[CM-EA/PA]**
- Quarterly update the CDR plan in partnership with the community CAB. **[CM-EA/RAA]**

Key Partners: Local community members, PWH, health departments, public health professionals, politicians, churches, businesses
Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, STD Funding, RWHAP, State and/or Local Funding
Estimated Funding Allocation: $500,000
Outcomes: (reported annually, locally monitored more frequently) Revise CDR protocols for cluster detection and response procedures based on community feedback.
Monitoring Data Source: Local protocols and reports

Pillar 5: Quality of Life

Goal 5A: ***Improve Quality of Life for Persons Living with HIV. [CM, CP – Houston Health Department, CP - Viral Hepatitis National Strategic Plan, FGP,FGPP, FTC, NHAS, Rdmap, ST]***

Key Activities:

- *Develop tools which planning bodies can use to design or strengthen HIV Prevention and Care services that improve the quality of life for people living with HIV.*
  - *Continue to host Quality of Life workgroup meetings that started in Houston on 03/21/22 and were co-hosted by CPG and the RWPC.*
  - Continue to host Racial and Social Justice workgroup meetings that started in Houston on 04/15/21 and were co-hosted by CPG and the RWPC.

- The purpose of both activities is to develop tools that can measure quality of life, integrate these tools into all Houston planning processes and respond appropriately to the results of the data collected through the tools.
- *The long term goal is to share the tools with other communities for comparison and encourage CDC and HRSA to add a fifth pillar that uses a variety of such tools and is dedicated to addressing quality of life concerns.*

Key Partners: *People with HIV, CPG, RWPC, HHD, Houston Area HIV Data Committee (HDC).*
Potential Funding Resources: *HHD.*
Estimated Funding Allocation: *$20,000.*

Goal 5B: ***Increase the proportion of people with diagnosed HIV who report good or better health to 95% from a 2018 baseline of 71.5%. [NHAS]***

Key Activities: *To be determined (TBD) by RWHAP Quality Management staff.*
Key Partners: *Persons with HIV, Ryan White-funded clinics, Ryan White Administrative Agencies, CPG, RWPC, HDC.*
Potential Funding Resources: *N/A.*
Estimated Funding Allocations: *N/A.*
Monitoring Data Source: *Centralized Patient Care Management System (CPCDMS) and Take Charge Texas (TCT) client level data systems.*

Goal 5C: ***Decrease by 50% the proportion of people with diagnosed HIV who report an unmet need for services from a mental health professional from a 2017 baseline of 24.2%. [NHAS]***

Key Activities: *TBD by RW Quality Management staff.*
Key Partners: *People with HIV, Ryan White-funded clinics, Ryan White Administrative Agencies, CPG, RWPC, HDC.*
Potential Funding Resources: *N/A.*
Estimated Funding Allocations: *N/A.*
Monitoring Data Source: *CPCDMS and TCT.*

Goal 5D: ***Decrease by 50% the proportion of people with diagnosed HIV who report ever being hungry and not eating because there wasn't enough money for food from a 2017 baseline of 21.1%. [NHAS]***

Key Activities: *TBD by RW Quality Management staff.*
Key Partners: *People with HIV, Ryan White-funded clinics, Ryan White Administrative Agencies, CPG, RWPC, Houston area food banks, local churches, HDC.*
Potential Funding Resources: *N/A.*
Estimated Funding Allocations: *N/A.*
Monitoring Data Source: *CPCDMS and TCT.*

Goal 5E: ***Decrease by 50% the proportion of people with diagnosed HIV who report being out of work from a 2017 baseline of 14.9%. [NHAS]***

Key Activities: *TBD by RW Quality Management staff.*
Key Partners: *People with HIV, Ryan White Administrative Agencies, CPG, RWPC, HDC.*
Potential Funding Resources: *N/A.*
Estimated Funding Allocations: *N/A.*
Monitoring Data Source: *CPCDMS, TCT, and employment records.*

Goal 5F: ***Decrease by 50% the proportion of people with diagnosed HIV who report being unstably housed or homeless from a 2018 baseline of 21.0%. [NHAS]***

Key Activities: *TBD by RW Quality Management staff.*
Key Partners: *People with HIV, Ryan White Administrative Agencies, CPG, RWPC, Housing Agencies, HOPWA and other housing funders, HDC.*
Potential Funding Resources: *HOPWA.*
Estimated Funding Allocations: *TBD.*
Monitoring Data Source: *CPCDMS and TCT*

Goal 5G: ***Increase coordination and cooperation among Houston area institutions, universities and agencies that collect HIV related data.***

Key Activities:

- *In Spring of 2022, members of the Quality of Life Workgroup met with representatives from Houston area institutions, universities and agencies that collect HIV-related data. The purpose was to assess how much and what kinds of data are being collected, and how it is being used. Workgroup members were especially interested in identifying data that could be used to measure quality of life indicators. Therefore, several additional individuals were invited to participate because of their work in quality of life issues beyond the HIV field. Participants were amazed by the types of data being collected and the fact that very few of the people in the meeting knew each other or were aware of the work that the other was doing.*
    - *Continue to host quarterly meetings of the Houston Area HIV Data Committee in order to: 1.) learn about different data being collected; 2.) create and maintain an inventory of HIV and Quality of Life data being collected; and 3.) distribute the resulting inventory of data to Houston area researchers, students, people living with HIV and others to maximize the use of this data to benefit people living with HIV.*

Key Committed Partners: *HHD/Bureau of HIV, HCPH/RWGA, CPG, RWPC, PACHA, Positive Women's Network – USA and Houston Chapter, Cizik School of Nursing, UTHealth, South Central AETC, Baylor College of Medicine, University of Houston Graduate School of Social Work, Houston Food Bank.*
Potential Funding Resources: *NA*
Estimated Funding Allocations: *NA*
Monitoring Data Source: *CPCDMS, TCT, and other data held by institutions listed above as Key Committed Partners.*

FAST-TRACK CITIES

Frequently Asked Questions: Commitments and Benefits

What do Mayors commit to do by signing the *Paris Declaration on Fast-Track Cities*?
The *Paris Declaration* was first signed by 27 cities from around the world on World AIDS Day 2014 in the city of Paris. As of November 1, 2015, an additional 25 cities have signed the *Paris Declaration*, committing themselves to attaining 90-90-90 (that is 90% of people living with HIV [PLHIV] aware of their status, 90% of diagnosed PLHIV on ART, and 90% of PLHIV on ART with sustained viral suppression) as well as zero discrimination and stigma targets. Moreover, Fast-Track Cities commit to seven objectives:

1. **End AIDS as a public health threat in cities by 2030.** We commit to rapidly reduce new HIV infections and AIDS-related deaths, including from tuberculosis (TB) and comorbid diseases, including viral hepatitis, putting us on the fast-track to ending AIDS as a public health threat by 2030. We commit to provide sustained access to testing, treatment, and prevention services. We will end stigma and discrimination.

2. **Put people at the center of everything we do.** We will focus, especially on people who are vulnerable and marginalized. We will respect human rights and leave no one behind. We will act locally and in partnership with our communities to galvanize global support for healthy and resilient societies and for sustainable development.

3. **Address the causes of risk, vulnerability and transmission. We will use all means including municipal ordinances and other tools to address factors that make people vulnerable to HIV and other diseases.** We will work closely with communities, service providers, law enforcement and other partners, and with marginalized and vulnerable populations including slum dwellers, displaced people, young women, sex workers, people who use drugs, migrants, men who have sex with men, and transgender people to build and foster tolerance.

4. **Use our AIDS response for positive social transformation.** Our leadership will leverage innovative social transformation to build societies that are equitable, inclusive,

responsive, resilient, and sustainable. We will integrate health and social programs to improve the delivery of services including HIV, TB, and other diseases. We will use advances in science, technology, and communication to drive this agenda.

5. **Build and accelerate an appropriate response to local needs.** We will develop and promote services that are innovative, safe, accessible, equitable, and free of stigma and discrimination. We will encourage and foster community leadership and engagement to build demand and to deliver services responsive to local needs.

6. **Mobilize resources for integrated public health and development.** Investing in the local AIDS response, together with a strong commitment to public health, is a sound investment in the future of our cities that fosters productivity, shared prosperity and well-being. We will adapt our city plans and resources for a fast-tracked response. We will develop innovative funding and mobilize additional resources and strategies to end AIDS as a public health threat by 2030.

7. **Unite as leaders.** We commit to develop an implementation plan and join with a network of cities to make the *Paris Declaration* a reality. Working in broad consultation with everyone concerned, we will regularly measure our results and adjust our responses to be faster, smarter, and more effective. We will support other cities and share our experiences, knowledge, and data about what works and what can be improved. We will report annually on our progress.

How are Fast-Track Cities operationalizing their *Paris Declaration* commitments?
In addition to the above higher level commitments, Fast-Track Cities agree to work with IAPAC and other partners to implement the FTCI based on a five-point implementation strategy.

1. **Communications:** Under the auspices of Mayor's offices and local health departments, Fast-Track Cities agree to keep an open line of communication with IAPAC regarding their progress, challenges, and opportunities to further accelerate their urban AIDS responses.

2. **Technical Handshake:** Fast-Track Cities agree to support a "technical handshake" to allow for an exchange of technical information as well as epidemiologic, program, and other relevant data. IAPAC provides a dashboard for each Fast-Track City to map eight simple HIV indicators that will allow cities to report their progress toward attaining the 90-90-90 and zero discrimination and stigma targets, as well as any other HIV- or health-specific targets a city may which to map (e.g., uptake of combination prevention interventions). These city-specific dashboards plug into a Global FTCI Web Portal that includes, among other features, a communications platform facilitating inter-city collaboration and exchanges of information.

3. **Process and Oversight:** As part of their commitment, Fast-Track Cities are expected to convene a task force and/or advisory committee to focus on developing and building

consensus around metrics for success and a city-specific implementation plan to achieve the FTCI's objectives. While many cities already have a leadership group in place, IAPAC is making available a technical package that includes template documents, presentations, and guidelines that can assist with attaining the 90-90-90 and zero discrimination and stigma targets. In select Fast-Track Cities, IAPAC organizes city-specific consultations with local task forces and/or advisory committees in an effort to accelerate the consensus-building and implementation plan development processes.

4. **Report on Progress:** It is expected that Fast-Track Cities will report on their progress at least annually; these reports will be aggregated into an annual Fast-Track Cities report. Cities are encouraged to produce quarterly internal reports and make them available to local stakeholders, particularly affected communities. Guidance templates for these reports are provided in the IAPAC technical package. Additionally, Fast-Track Cities are encouraged to share best practices and case studies with other participating cities.

What are the benefits for cities that elect to join the FTCI?
There are five main benefits that Fast-Track Cities enjoy as members of a global FTCI network:

1. **Join a global network to collectively end AIDS as a public health threat by 2030.** Joining the FTCI network is an opportunity to join the global fight against HIV and to connect with other cities that may be facing similar challenges in accelerating their local AIDS responses, particularly cities of similar jurisdictional structure. The FTCI facilitates formal and informal twinning partnerships and bidirectional technical exchanges between Fast-Track Cities. Additionally, the FTCI assists cities in publicizing their success stories locally, nationally, regionally, and internationally – communicating a sense of momentum.

2. **Use the FTCI as a framework for implementation and metrics of success.** While many Fast-Track Cities already have a local AIDS strategy and/or their own defined metrics for success, many Fast-Track Cities find it helpful to adopt the FTCI's metrics for success as well as augment their strategies with implementation guidance specific to optimizing the HIV care continuum. In some cities, discussions around the added value of the FTCI have served to catalyze collective action among local key stakeholders. Having the FTCI implementation plan helps focus discussions around concrete and measurable steps to accelerate local AIDS responses. In addition, where a Fast-Track City's health department may need assistance with data generation, analysis, and reporting, IAPAC dispatches expert technical assistance teams to support the use of standardized metrics as outlined in the *IAPAC Guidelines for Optimizing the HIV Care Continuum* (2015).

3. **Receive the FTCI technical package.** All Fast-Track Cities receive an IAPAC technical support package which includes an implementation plan template and organizational Gantt chart, meeting agenda templates, invitation letter templates, PowerPoint presentations, communications materials, and other proposal templates. Using the *IAPAC Guidelines for Optimizing the HIV Care Continuum* (2015) as its primary guidance, IAPAC

provides capacity-building support through webinars, teleconferences, and on-site consultations for clinical and service providers, community-based organizations, and affected communities. IAPAC and its partners also facilitate city-to-city technical collaboration on a requested basis through twinning agreements between cities of similar jurisdictional structure, notably Sister Cities. The IAPAC technical package is meant to leverage, augment, and strengthen ongoing local AIDS efforts.

4. **Leverage the Global FTCI Web Portal and city-specific dashboards.** The FTCI includes a Global FTCI Web Portal with city-specific dashboards that support both the overall FTCI and each of the Fast-Track Cities. The web portal maps Fast-Track Cities, present information regarding the FTCI, track overall progress, and provide a platform for people to engage with the FTCI and Fast-Track Cities. Additionally, the web portal features best practice cases and allow for Fast-Track Cities to more easily communicate with other cities to share experiences. Each Fast-Track City is offered a city-specific dashboard which features the city's implementation plan and communicates the city's progress in attaining the 90-90-90, zero discrimination and stigma, and other locally set targets. Depending upon data availability, health facilities, basic epidemiology, and program progress can be mapped, as well as information for the community about how they can support city-wide efforts.

5. **Engage in out-of-the-box financing and resource mobilization.** By focusing on attaining the FTCI's objectives, more efficient use of current local AIDS funding can liberate additional resources to allocate toward HIV care continuum optimization activities. In addition, although joining the FTCI network does not garner direct financial support for Fast-Track Cities, efforts are made to mobilize resources from a variety of sources (e.g., private sector). The FTCI core partners provide participating cities technical support for financing and resource mobilization efforts.