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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

Submitted
September 29, 2021

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

Project Title: *Ryan White HIV/AIDS Program Part A, HIV Emergency Relief Grant Program*
Applicant Name: *Harris County, TX* ***Address:*** *HCPH/RWGA, 2223 West Loop S. 601, Houston, TX 77027*
Project Director: *Carin Martin, MPA, Program Manager of RWGA*
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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.

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TEXAS
Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

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

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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**

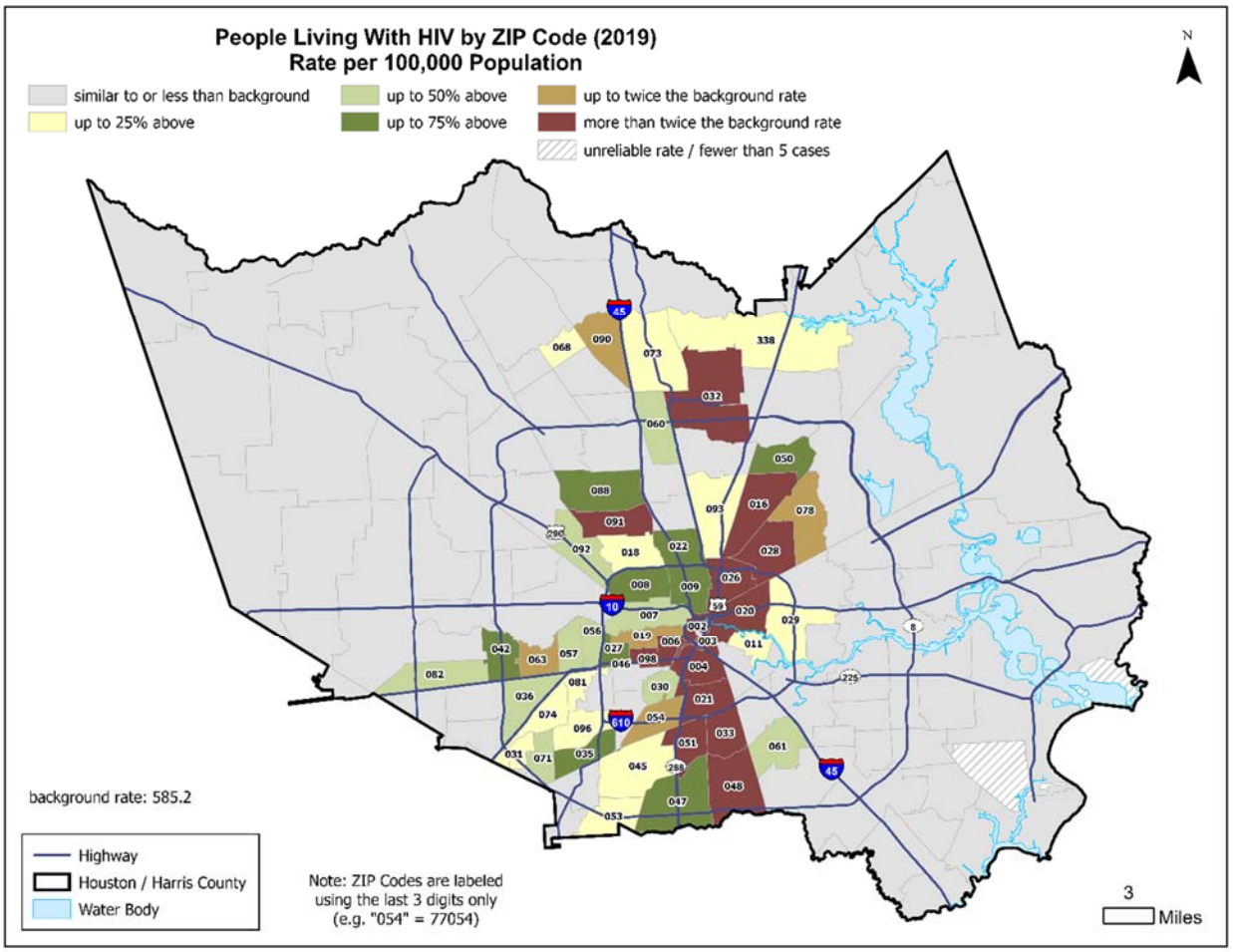
Attachment 3 displays the numbers, percentages, and rates of living HIV/AIDS cases and newly diagnosed HIV cases by demographics in the Houston EMA. Since socioeconomic data is not captured as part of HIV surveillance, this data is not readily available. Instead, socioeconomic indicators collected as 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

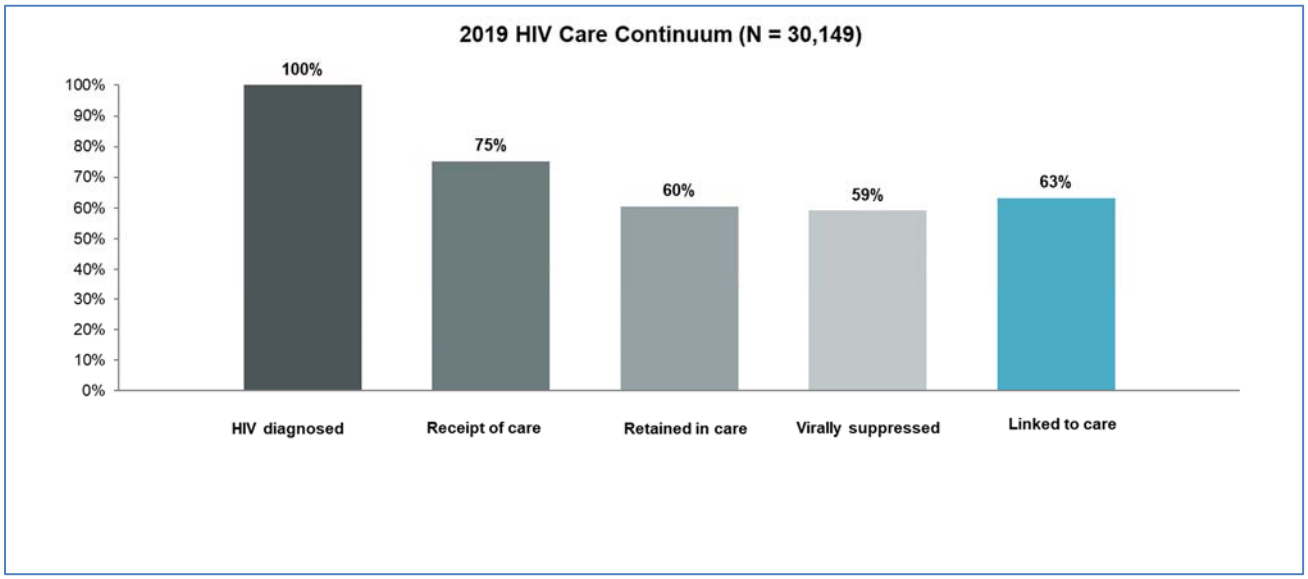
peer directed them to support services. However, these participants reported that both they and their peers used support services as survival resources, rather than with the intent of accessing and staying in care. Participants described this as a survival resource cycle for PLWH who were also experiencing 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* S*tate 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*

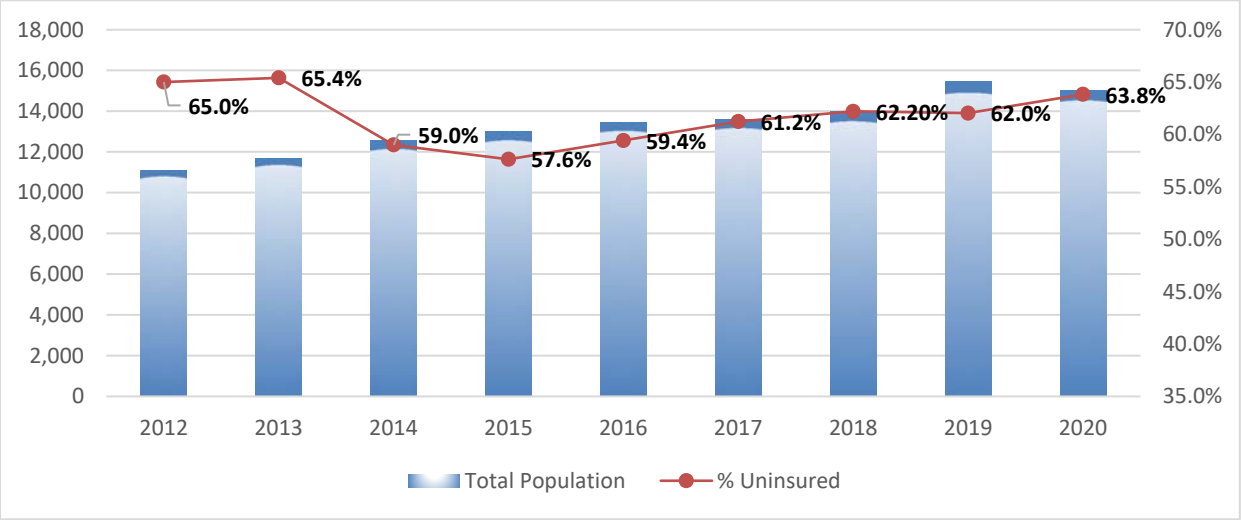
ii) Response – As documented in ***Attachment 9***, the overall response of Houston's Ryan White Planning Council (**RWPC**) over the period of FY21 through FY22 is to continue its focus on ensuring access to Primary Medical Care and other key Core Medical Services including Oral Health Care, Medical 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

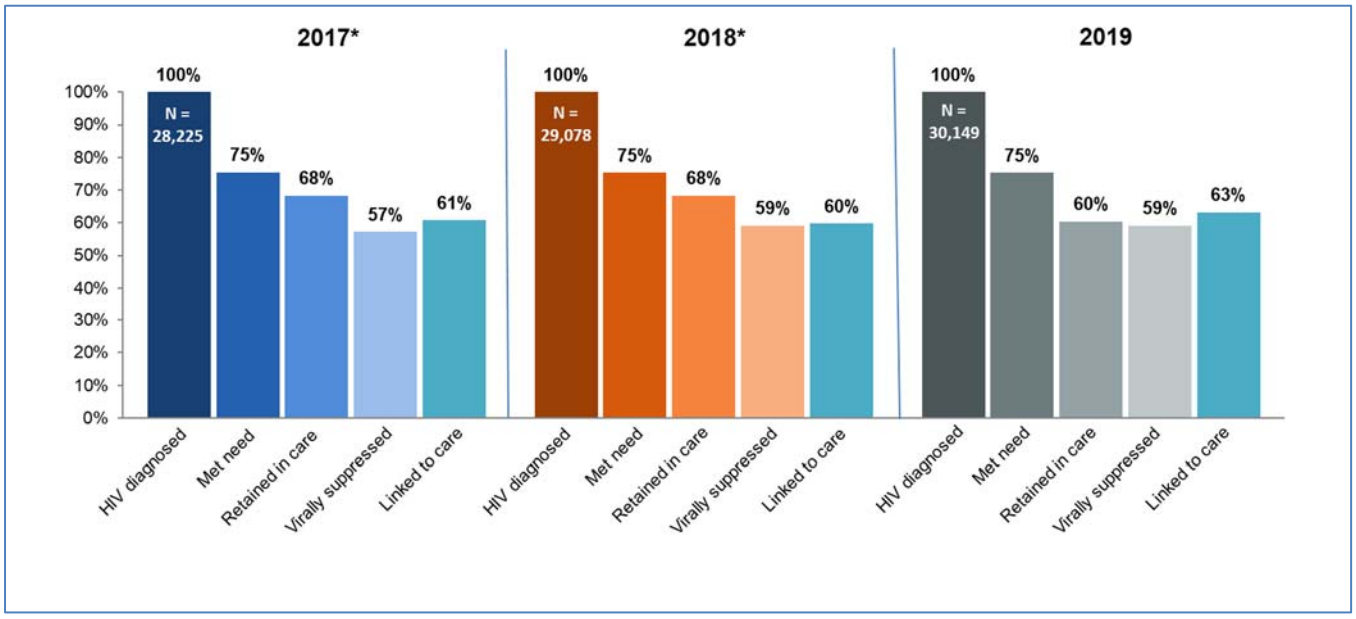
A. HIV CARE CONTINUUM SERVICES TABLE AND NARRATIVE

- **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

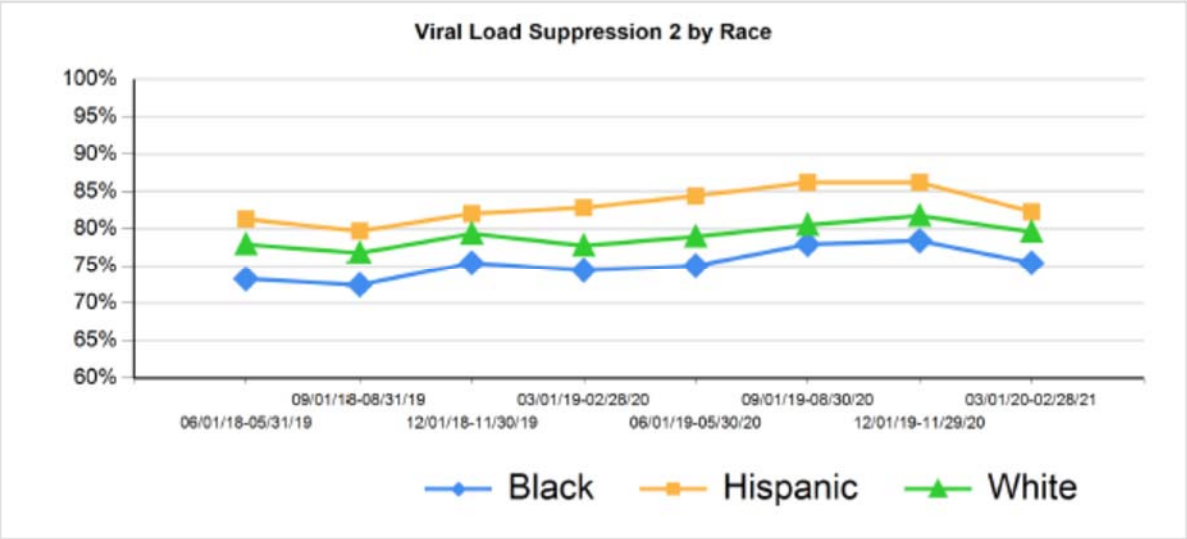
most likely to report not having a case manager and to not seek health care because of inability to pay. However, when reviewing health indicators such as viral suppression rates, HL tend to have better outcomes, as illustrated in the table and chart at the end of this section.

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.

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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												
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								
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%

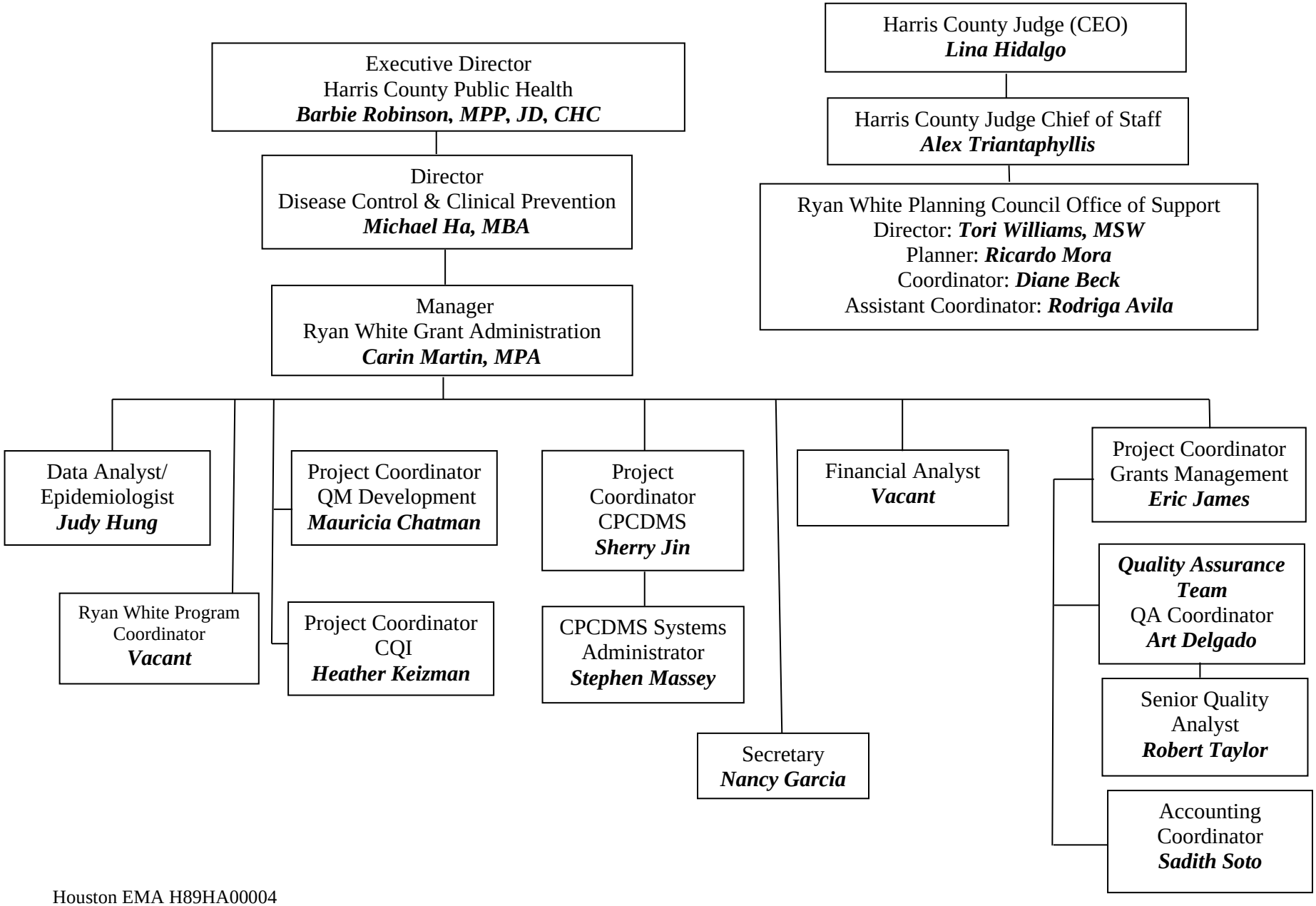
Attachment 9b. MAI Service Category Plan Table

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