Houston Area HIV Services Ryan White Planning Council
Office of Support
1310 Prairie Street, Suite 800, Houston, Texas 77002
832 927-7926 telephone; http://rwpchouston.org

MEMORANDUM

To: Members, Houston Ryan White Planning Council

Copy: Glenn Urbach, Ryan White Grant Administration
Eric James, Ryan White Grant Administration
Mauricia Chatman, Ryan White Grant Administration
Francisco Ruiz, Ryan White Grant Administration
Tiffany Shepherd, The Resource Group
Sha'Terra Johnson, The Resource Group
Diane Beck, Ryan White Office of Support

Email Copy Only:
Mark Peppler, HRSA
Commander Rodrigo Chavez, PACE
Jason Black, Ryan White Grant Administration
Marlene McNeese, Houston Health Department
Charles Henley, Consultant

From: Tori Williams, Director, Ryan White Office of Support
Date: Tuesday, June 4, 2024
Re: Meeting Announcement

We look forward to seeing everyone at the Council meeting next week. And, since we have now received 100% of our grant award, we will have sandwich trays for those with a medical need. Others are encouraged to bring a brown bag lunch. Thank you for being so patient about this. *Don't forget to come 10 minutes early if you would like to participate in Titan's wonderful exercises to release stress. (Thank you, Titan!)*

To make quorum, **we need 14 people to meet in-person at Bering Church in the Montrose area.** Please contact Rod ASAP to RSVP, even if you cannot attend so we will know if we can make quorum. Rod can be reached at: 832 927-7926 or by responding to her email reminders.

Ryan White Planning Council Meeting

11:50 a.m., Titan's breathing exercises
12 noon, Thursday, June 13, 2024

Meeting Location

Online or via phone: Click on the following link to join the Zoom meeting:
https://us02web.zoom.us/j/995831210?pwd=UnlNdExMVFFqeVgzQ0NJNkpieXlGQT09
Meeting ID: 995 831 210 Passcode: 577264
Or, use the following telephone number: 346 248-7799

In Person: Bering Church, 1440 Harold St, Houston, Texas 77006. Use the parking lot behind the church on Hawthorne Street and **use the code that was given to Council members only to enter the building.**

Thank you!

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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We envision an educated community where the needs of all persons living with and/or affected by HIV are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system.

The community will continue to intervene responsibly until the end of the epidemic.

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

AGENDA

12 noon, June 13, 2024

Meeting Location:

Online or via Telephone:

https://us02web.zoom.us/j/995831210?pwd=UnlNdExMVFFqeVgzQ0NJNkpieXlGQT09

Meeting ID: 995 831 210 Passcode: 577264

Or, use the following telephone number: 346 248-7799

In Person: Bering Church, 1440 Harold St, Houston, Texas 77006.

I. Call to Order — Josh Mica, he/him/él, Chair, Ryan White Planning Council

A. Welcome, Moment of Reflection

B. Adoption of the Agenda

C. Approval of the Minutes

D. Training: HHSC Medicaid Benefits — Roxane May, PC Member & Texas Health & Human Services Commission Community Partner Program

II. Public Comments and Announcements

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

III. Reports from Committees

A. Comprehensive HIV Planning Committee — Kenia Gallardo, she/her/hers & Robert Sliepka, he/him/they,

Item: 2024 Houston HIV Needs Assessment

Recommended Action: FYI: Data collection has ended and the information is being entered into the software so that the Interim Health Planner can analyze and present it to the Priority and Allocations Committee in July.

Item: 2024 Houston Area HIV Epidemiological Profile
Recommended Action: FYI: Beth Allen, the Interim Health Planner is working with City Health Department staff and Nithya Lakshmi Mohem Dass from Ryan White Grant Administration to produce the 2024 Epidemiological Supplement.

Item: EHE/Integrated Planning Body
Recommended Action: FYI: The summary of May Committee and Workgroup activities, as well as the July meeting schedule, will be distributed at the Steering Committee meeting.

Item: EHE/Integrated Planning Body
Recommended Action: FYI: Please be sure to attend the hybrid meeting of the Leadership Team at the end of June. Eliot Davis will be giving an update on all activities in the Houston Ending the HIV Epidemic Plan. The exact date and time will be announced via email.

B. Affected Community Committee — Johnny Deal, he/him/his & Carol Suazo, she/her/ella,

Item: EHE/Integrated Planning Body
Recommended Action: FYI: Members of the Affected Community Committee in conjunction with the Consumer and Community Engagement Workgroup have started to create an inventory of HIV resources on Houston area colleges and universities.

Item: 2024 Project LEAP and Proyecto VIDA
Recommended Action: FYI: Members of the Affected Community Committee have begun to recruit students for the 2024 Project LEAP and Proyecto VIDA classes, which will start at the end of July or early August. Please see Tori if you can help with recruitment.

C. Quality Improvement Committee — Tana Pradia, she/her/hers & Pete Rodriguez, he/him/él, Co-Chairs

Item: Reports from the Administrative Agent - Part A/MAI**
Recommended Action: FYI: See the attached reports from the Part A/Minority AIDS Initiative (MAI) Administrative Agent:

- FY23 Procurement Report – Part A/MAI, dated 04/16/24
- FY23 Service Utilization – Part A/MAI, dated 04/15/24

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

- FY 23/24 Procurement Report – Part B, dated 05/01/24
- FY 23/24 Service Utilization Report – Part B, dated 04/26/24
- FY 23/24 Procurement Report – State Services, dated 05/01/24
- FY 23/24 Health Insurance Assistance Program, dated 04/22/24

(continued)

Item: Public Comment Regarding FY25 Ryan White Service Categories
Recommended Action: FYI: Please see the four attached comments.

Item: FY 2025 Service Definitions and Financial Eligibility
Recommended Action: **Motion:** Approve the attached FY 2025 Service Definitions and Financial Eligibility recommendations for Ryan White Part A/MAI, Part B and State Services funded services. See the attached Summary of How To Best Meet the Need recommendations (neon green paper) and financial eligibility (on the Table of Contents).

Item: Targeting Information for the FY 2025 Service Categories
Recommended Action: **Motion:** Approve the attached Targeting Chart for Ryan White Part A/MAI, Part B and State Services funded service categories (neon pink paper).

D. Priority and Allocations Committee — Peta-gay Ledbetter, she/her/hers and Rodney Mills, he/him/his,
The Committee did not meet since they will be creating the list of FY 2025 service priorities in July instead of May.

E. Operations Committee — Cecilia Ligons, she/her/hers & Crystal R. Starr, she/her/hers,
Item: FY 2025 Council Support Budget
Recommended Action: **Motion:** Approve the attached FY 2025 Council Support Budget.

Item: Read AI Policy
Recommended Action: **Motion:** Artificial Intelligence (AI) will not be allowed at any Ryan White sponsored meetings and a written statement regarding this policy will be included on all meeting agendas, programs and other appropriate materials.

V. Report from the Office of Support — Tori Williams, she/her/hers, Director

VI. Report from Ryan White Grant Administration — Glenn Urbach, he/him/his Manager

VII. Report from The Resource Group — Sha'Terra Johnson, she/her/hers Health Planner

VIII. Medical Updates — Shital Patel, MD, she/her/hers Baylor College of Medicine

IX. New Business (**During Virtual Meetings, Reports Will Be Limited to Written Reports Only**)
A. AIDS Educational Training Centers (AETC) — Shital Patel, she/her/hers
B. Ryan White Part C Urban and Part D
C. HOPWA — Megan Rowe, she/her/hers
D. Community Prevention Group (CPG) — Kathryn Fergus, she/her/hers

E. Update from Task Forces:
   - Sexually Transmitted Infections (STI)
   - African American — Sha'Terra Johnson, she/her/hers
   - Latino
   - Youth
   - MSM
   - Hepatitis C — Steven Vargas, he/him/él
   - Project PATHH (Protecting our Angels Through Healing Hearts) formerly Urban AIDS Ministry

F. HIV and Aging Coalition — Skeet Boyle, he/him/his
G. Texas HIV Medication Advisory Committee
H. Positive Women's Network
I. Texas Black Women's Initiative — Sha'Terra Johnson, she/her/hers
J. Texas HIV Syndicate — Steven Vargas, he/him/él
K. END HIV Houston

IX. Announcements

X. Adjournment

* *RW = Ryan White*
***MAI = Minority AIDS Initiative funding*
*** *SS = State Services funding*

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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

MINUTES

12 noon, Thursday, May 9, 2024

Meeting Location: Bering Church 1440 Harold Street; Houston, TX and Zoom teleconference

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Josh Mica, he/him/él, Chair	Pete Rodriguez	Ronnie Galley, Greeter
Ryan Rose, Secretary	Megan Rowe	Kakeshia Locks, Greeter
Kevin Aloysius	Yolanda Ross	Tyronika Tates, Greeter
Laura Alvarez	Jose Serpa-Alvarez	Paulina Avila-Martinez, SBCHC
Yvonne Arizpe	Robert Sliepka	Josue Rodriguez, Co Judge's Ofc
Jay Bhowmick	Crystal Renee Starr	
Caleb Brown	Steven Vargas	**STAFF PRESENT**
Titan Capri		*Ryan White Grant Administration*
Johanna Castillo		Glenn Urbach
Johnny Deal	**MEMBERS ABSENT**	Jason Black
Michael Elizabeth	Servando Arellano	Mauricia Chatman
Kathryn Fergus	Ardry "Skeet" Boyle	Eric James
Kenia Gallardo	Tony Crawford	
Glen Hollis	Evelio Salinas Escamilla, excused	*The Resource Group*
Kenneth Jones	Rodney Mills	Sha'Terra Johnson
Denis Kelly	Norman Mitchell	
Peta-gay Ledbetter	Diane Morgan	*Office of Support*
Cecilia Ligons	Shital M. Patel, excused	Tori Williams
Roxane May	Oscar Perez	Diane Beck
Bill Patterson	Imran Shaikh, excused	
Tana Pradia	Carol Suazo, excused	
Beatriz Rivera	Priscilla Willridge	

Call to Order: Josh Mica, he/him/él, Chair, called the meeting to order at 12:06 p.m.

During the opening remarks, Mica thanked Titan for his valuable time before each meeting. His 10 minutes of deep breathing exercises have been helpful.

Mica also thanked everyone who is participating on a committee or workgroup for the EHE/Integrated

HIV Prevention and Care Planning body. Please sign up to participate if you haven't already. The groups are generating some very interesting work products. Mica then thanked those who co-chaired and participated in the *How to Best Meet the Need* training and workgroup meetings especially Beatriz, a new Council member who had to chair a workgroup meeting by herself. She did an outstanding job.

On Saturday, June 1st, Mica will be attending the Woodlands Pride Summit along with Dr. Patel and Tori. They invited him and Dr. Patel to be on a panel to address LGBTQ+ healthcare questions. We are looking forward to strengthening our ties with this energetic group of LGBTQ+ organizers outside of Houston.

Mica then called for a Moment of Reflection.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Rivera, Kelly) to approve the May 11, 2024 minutes.* **Motion carried.** Abstentions: Elizabeth, Jones, Rodriguez.

Updates on Ryan White Items of Interest: Eric James, the Assistant Program Manager at Ryan White Grant Administration, gave updates on issues related to the local HIV Care System. See attached PowerPoint slides.

Public Comment and Announcements: Josue Rodriguez, County Judge's Office, said that they really appreciate the work that the Council does and are still trying on finding a date when the County Judge can address the Planning Council. She is currently in Washington DC working to get more FEMA funds to help with the recent flooding in our area.

Gallardo said that there is currently not enough staff that is fluent in Spanish at Ryan White funded agencies. Urbach said they have not received a complaint or comment about this. Vargas said they will make sure they hear about it if three clients have to wait because there is only one Spanish speaking staff person available.

Reports from Committees

Comprehensive HIV Planning Committee: Kenia Gallardo, Co-Chair, reported on the following:
2024 Houston HIV Needs Assessment: Staff continues to collect surveys from people with lived experience and HIV case managers. Data collection will end in late May so that the Interim Health Planner can analyze and present it to the Priority and Allocations Committee in July.

2024 Houston Area HIV Epidemiological Profile: Since the Houston Health Department is only required to submit a complete Epidemiological Profile every 3-5 years, they have determined that they will not be able to dedicate resources to the project until at least January 2025. But, they can work with Office of Support staff on an Epidemiological Supplement. The Director has asked the HRSA Project Officer if this is acceptable to them since the Ryan White Program is required to submit a full Epidemiological Report every three years.

EHE/Integrated Planning Body: The Leadership Team meeting scheduled for Tuesday, April 30th has been postponed until Wednesday May 8th. Committees and workgroups will meet again in May. See the attached meeting schedule and summary of March 2024 activities and look to see if there is something that interests you.

Affected Community Committee: Johnny Deal, Co-Chair, reported on the following: Road 2 Success: Thanks to an invitation from the Resource Group, Committee members provided educational

information to youth who are transitioning to adult care. Many thanks to Skeet and Ronnie for covering this event and providing information on the Blue Book, the Client Complaint process, Project LEAP and Proyecto VIDA.

Quality Improvement Committee: Pete Rodriguez, Co-Chair, reported on the following:
Because of the How to Best Meet the Need Process, most Ryan White committees did not meet in April so that Council and Affiliate members could participate in the workgroups. Many thanks to those who participated and provided input into the FY2025 Ryan White service categories. The recommendations made by consumers, providers and others will be presented to the Council next month.

Priority and Allocations Committee: Peta-gay Ledbetter, Co-Chair, reported on the following:
Reports from the Administrative Agents
See the attached reports from the Part A/Minority AIDS Initiative (MAI) Administrative Agent:

- FY23 Procurement Part A & MAI, dated 04/16/24
- FY23 Service Utilization Part A & MAI, dated 04/15/24

See the attached reports from the Part B/State Services (SS) Administrative Agent:

- FY23-24 Procurement Part B, dated 04/04/24
- FY23-24 Procurement State Services, dated 04/04/24

FY 2025 Priority Setting Process: ***Motion #3:*** *Approve the attached FY 2025 Priority Setting Process which assures that the Council will set priorities for all HRSA allowable services.* **Motion Carried.**

Reallocation of FY 23-24 State Services Funding: ***Motion #4:*** *Recommend the reallocate of $175,000 in FY 23-24 State Services funding from Referral for Healthcare – Incarcerated to Health Insurance Assistance (HIA) to avoid duplication of services and because of an increased need for the HIA service category. See attached memo from The Resource Group dated 04/15/24.* **Motion Carried.** Abstentions: Aloysius, Arizpe, Rivera.

Request for Service Category Increase Form: ***Motion #5:*** *Approve the form entitled Request for Service Category Increase which includes a definition for "Disbursements". The definition is: reimbursement for actual costs (vs. unit costs). Examples are: medication, diagnostic procedures, food and utilities. The Ryan White Part A/Minority AIDS Initiative and Ryan White Part B/State Services (SS) administrative agencies are asked to use this form to notify agencies when unobligated or unspent funds are available. The Ryan White Part B/SS administrative agency is asked to adjust the form to identify their organization and to start using it in the next funding cycle.* **Motion Carried.** Abstentions: Arizpe, Kelly, Rivera.

Operations Committee: Cecilia Ligons, Co-Chair, reported on the following:
Personnel Subcommittee of the Operations Committee: Many thanks to all who submitted surveys regarding their managerial skills. The Council will be notified as soon as the Judge's Office releases the Manager of the Office of Support job opening. Hopefully, it will be soon.

Read AI Information: In view of some of the newer forms of technology, Council member Glen Hollis will be providing the Operations Committee with information about Read AI at 11:00 am on May 13, 2024. All are welcome to sit in on the session. The Committee will also be reviewing the DSHS' policy regarding the use of this type of technology and the possible need for the Council to develop a policy.

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

Report from Ryan White Grant Administration: Glenn Urbach, Manager, summarized the attached report.

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

Task Force Reports: The Council agreed several years ago that they preferred not to have verbal Task Force Reports while meeting on Zoom. The Office of Support is happy to receive and distribute written reports in advance of all Council meetings.

Announcements: Today is Mica's birthday, everyone wished him a very Happy Birthday.

Rowe said that HOPWA will be procuring a contractor for a Needs Assessment to be done for the first time in about 18 years. It is a very large project and they will contact everyone for input.

Adjournment: ***Motion:*** *it was moved and seconded (Deal, Rose) to adjourn the meeting at 1:21 p.m.* **Motion Carried.**

Respectfully submitted,

_____ Date _____
Victoria Williams, Director

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for May 9, 2024

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** 2025 Priority Setting Process **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** 2025 Priority Setting Process **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Josh Mica, he/him/él, Chair				C				C				C	Pete Rodriguez		X				X				X		
Ryan Rose, Secretary		X				X				X			Megan Rowe		X				X				X		
Kevin Aloysius		X				X				X			Yolanda Ross		X				X				X		
Laura Alvarez		X				X				X			Jose Serpa-Alvarez		X				X				X		
Yvonne Arizpe		X				X				X			Robert Sliepka		X				X				X		
Jay Bhowmick		X				X				X			Crystal Renee Starr		X				X				X		
Caleb Brown ja 12:14 pm	X				X					X			Steven Vargas		X				X				X		
Titan Capri		X				X				X															
Johanna Castillo ja 1:04 pm	X				X				X																
Johnny Deal		X				X				X			**MEMBERS ABSENT**												
Michael Elizabeth		X				X				X			Servando Arellano												
Kathryn Fergus ja 12:15 pm	X				X					X			Ardry “Skeet” Boyle												
Kenia Gallardo		X				X				X			Tony Crawford												
Glen Hollis		X				X				X			Evelio Salinas Escamilla												
Kenneth Jones		X				X				X			Rodney Mills												
Denis Kelly		X				X				X			Norman Mitchell												
Peta-gay Ledbetter		X				X				X			Diane Morgan												
Cecilia Ligons		X				X				X			Shital M. Patel												
Roxane May		X				X				X			Oscar Perez												
Bill Patterson		X				X				X			Imran Shaikh												
Tana Pradia		X				X				X			Carol Suazo												
Beatriz Rivera		X				X				X			Priscilla Willridge												

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room	**Motion #4** Reallocate State Services funds **Carried**				**Motion #5** Request for Service Category Increase form **Carried**					**Motion #4** Reallocate State Services funds **Carried**				**Motion #5** Request for Service Category Increase form **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Josh Mica, he/him/él, Chair				C				C	Pete Rodriguez		X				X		
Ryan Rose, Secretary		X				X			Megan Rowe		X				X		
Kevin Aloysius		X				X			Yolanda Ross		X				X		
Laura Alvarez		X				X			Jose Serpa-Alvarez		X				X		
Yvonne Arizpe		X				X			Robert Sliepka		X				X		
Jay Bhowmick		X				X			Crystal Renee Starr		X				X		
Caleb Brown ja 12:14 pm	X				X				Steven Vargas		X				X		
Titan Capri		X				X											
Johanna Castillo ja 1:04 pm	X				X												
Johnny Deal		X				X			**MEMBERS ABSENT**								
Michael Elizabeth		X				X			Servando Arellano								
Kathryn Fergus ja 12:15 pm	X				X				Ardry “Skeet” Boyle								
Kenia Gallardo		X				X			Tony Crawford								
Glen Hollis		X				X			Evelio Salinas Escamilla								
Kenneth Jones		X				X			Rodney Mills								
Denis Kelly		X				X			Norman Mitchell								
Peta-gay Ledbetter		X				X			Diane Morgan								
Cecilia Ligons		X				X			Shital M. Patel								
Roxane May		X				X			Oscar Perez								
Bill Patterson		X				X			Imran Shaikh								
Tana Pradia		X				X			Carol Suazo								
Beatriz Rivera		X				X			Priscilla Willridge								

Public Comments

FOLLOW UP INFORMATION AFTER A PRESENTATION AT THE MAY 2024 HOUSOTN RYAN WHITE PLANNING COUNCIL MEETING

At the May 2024 Houston Ryan White Planning Council meeting, Eric James, Assistant Program Manager, Ryan White Grant Administration, presented important information that was discussed during the April 2024 How To Best Meet the Need process. After the Council meeting adjourned, Steven Vargas reached out to Eric with additional questions. Below, you will find an email between Steven and Eric where Steven's additional questions start with a bullet point and are in plain type and Eric's responses are indented and in italics.

May 15, 2024

Good morning, Steven –

I wanted to follow up on your questions/recommendations.

Slide 1, pg. 1:

- Are there concerns over sustainability, either current or anticipated?
- I heard a discrepancy between people actually having a choice and not when it came to the solution. Were there other options or only one?

> *If subrecipients or clients notify us of other insurance providers dropping single pill regimens, we would work with the subrecipients to provide additional coverage for a single pill while a plan is developed with the client. If the provider of the health insurance premium and cost sharing assistance program struggles to keep up with demand, we would work with the council to request additional funds find their way to that service category.*
>
> *One of the council members who is a pharmacist did mention that several clients decided to stay on Community Health Choice which would require a multi-pill regimen. It did not sound like the ideal choice but the benefit of the insurance was deemed more important. I would need to dig a bit more into this to gather more information.*

Slide 8, pg.4:

- and they were provided MH services in their language?
- What other languages besides Spanish surfaced?

> *Spanish-speaking clients should be provided mental health services in Spanish. The Resource Group funds this service category – as well as interpreter services – and might be better able to answer this question as well as provide a list of other requested languages. From my 18 years of experience on the subrecipient side, French and Swahili were the two most requested languages. I'm happy to follow up with The Resource Group and provide additional information.*

Slide 9, pg.4:

- Do agencies have enough employees fluent in Spanish to alleviate the longer waits reported?

> *We have not received reports or complaints of longer wait times for services provided in Spanish. If this is an issue specific to mental health, we would need to follow up with The Resource Group. Once again, I'm happy to reach out.*

- My question was not clear, but was not limited to MH services, but overall. I spoke with a group of HHD staff who mentioned longer wait times when accompanying PWH who are monolingual Spanish-speaking. They shared experiencing improvement but do experience longer waits. I will pose this question to the members of the Latino HIV Task Force for their input and direct experience and relay what I secure. I know we have a shortage of Spanish-speaking HIV specialists, according to a couple of coordinators at 2 separate agencies. I wonder though if this perception is from the staff perspective and not the patient's. When I accompanied PWH as a Case Manager to their appointments what I experienced as a soul-draining, interminable wait was seen as routine by my Clients. When I asked if they wanted to say anything about it, they generally said no. They planned their entire or half their day around clinic appointments. But Service Linkage Workers, or really good and true Case Managers, had other Clients waiting, documentation of the encounter (which kills the spirit of helping) left to do. Hence, the workforce may feel the wait times more keenly than PWH.

Slide 12, pg.8:

- **recommendation:** We need to **include in the bullet points a measure for ensuring the outcomes are relayed to the client.** As my note states, it sounds like the process may help agencies, but still leaves people feeling unheard and not valued. That's not a characteristic of a satisfying complaint process.

  I should have made it more clear that no complaint is considered "closed" without relaying the final outcome to the client. This does not always end with the client getting exactly what they want, but the final resolution and close of the complaint is agreed upon by all parties. The resolution is tracked in the complaint log kept by the Quality Assurance team.

Last:

- **Do I have this right?** Whether through Rapid Start or enrollment into CPCDMS & RW-funded services, not having a picture identification should not be a barrier to care for unhoused or undocumented people with HIV. All they have to do is listed on page 8 of the Blue Book, 3rd bullet from the bottom. I have had to share this so many times with Case Managers trying to advocate for their Client's to their supervisors. I had to do it back in the day myself. It's terrible we are still having to remind people not to perpetuate this barrier. **If so, please stress this at every training.**

  You are correct that a picture ID is not the only form of acceptable identification. The list you pointed to on page 8 of the Blue Book should be shared with all front line staff who handle intake/eligibility. I know I always had the list posted at the front desk when I managed a RW-funded program. I will ask our Quality Management team to share this information in future meetings with case management staff. We can emphasize that it should be part of training for all intake/eligibility staff.

- This needs to be shared with their Supervisors, Coordinators and Managers, even Directors. These are the people stopping the CM staff from doing what they know they can. We need to find where the weak link is in agency communications preventing our changes to the system from taking full effect.

Quality Improvement Committee

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2023 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**10,965,788**	**460,625**	**535,679**	**0**	**-283,680**	**0**	**11,678,412**	**45.56%**	**11,678,412**	**0**		**10,349,078**	**89%**	**100%**
1.a	Primary Care - Public Clinic (a)	3,927,300	182,397					4,109,697	16.03%	4,109,697	0	3/1/2023	$3,995,687	97%	100%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576	49,443	182,131				1,296,150	5.06%	1,296,150	0	3/1/2023	$1,303,807	101%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551	42,289	155,347				1,108,187	4.32%	1,108,187	0	3/1/2023	$1,716,309	155%	100%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924	53,314	198,201				1,399,439	5.46%	1,399,439	0	3/1/2023	$557,823	40%	100%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000	51,088			-228,730		922,358	3.60%	922,358	0	3/1/2023	$1,041,519	113%	100%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000	97,531					2,197,531	8.57%	2,197,531	0	3/1/2023	$1,336,092	61%	100%
1.g	Primary Care - Pediatric (a.1)	15,437	-15,437					0	0.00%	0	0	3/1/2023	$0	0%	0%
1.h	Vision	500,000	0			-54,950		445,050	1.74%	445,050	0	3/1/2023	$397,840	89%	100%
1.x	Primary Care Health Outcome Pilot	200,000	0			0		200,000	0.78%	200,000	0	3/1/2023	$0	0%	100%
2	**Medical Case Management**	**1,880,000**	**-97,859**	**63,063**	**0**	**-96,974**	**0**	**1,748,230**	**6.82%**	**1,748,230**	**0**		**1,470,657**	**84%**	**100%**
2.a	Clinical Case Management	531,025	0	63,063		35,176		629,264	2.46%	629,264	0	3/1/2023	$568,458	90%	100%
2.b	Med CM - Public Clinic (a)	301,129	0					301,129	1.17%	301,129	0	3/1/2023	$ 305,477	101%	100%
2.c	Med CM - Targeted to AA (a) (e)	183,663	0					183,663	0.72%	183,663	0	3/1/2023	$133,506	73%	100%
2.d	Med CM - Targeted to H/L (a) (e)	183,665	0					183,665	0.72%	183,665	0	3/1/2023	$56,208	31%	100%
2.e	Med CM - Targeted to W/MSM (a) (e)	66,491	0					66,491	0.26%	66,491	0	3/1/2023	$53,283	80%	100%
2.f	Med CM - Targeted to Rural (a)	297,496	0			-62,150		235,346	0.92%	235,346	0	3/1/2023	$131,538	56%	100%
2.g	Med CM - Women at Public Clinic (a)	81,841	0					81,841	0.32%	81,841	0	3/1/2023	$159,798	195%	100%
2.h	Med CM - Targeted to Pedi (a.1)	97,859	-97,859					0	0.00%	0	0	3/1/2023	$0	0%	0%
2.i	Med CM - Targeted to Veterans	86,964	0			-70,000		16,964	0.07%	16,964	0	3/1/2023	$4,204	25%	100%
2.j	Med CM - Targeted to Youth	49,867	0					49,867	0.19%	49,867	0	3/1/2023	$58,186	117%	100%
3	**Local Pharmacy Assistance Program**	**2,067,104**	**0**	**0**	**-37,920**	**12,178**	**0**	**2,041,362**	**7.96%**	**2,041,362**	**0**	3/1/2023	**$2,326,099**	**114%**	**100%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	367,104	0					367,104	1.43%	367,104	0	3/1/2023	$247,873	68%	100%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,700,000	0		-37,920	12,178		1,674,258	6.53%	1,674,258	0	3/1/2023	$2,078,226	124%	100%
4	**Oral Health**	**166,404**	**0**	**30,429**	**0**	**0**	**0**	**196,833**	**0.77%**	**196,833**	**0**	3/1/2023	**196,800**	**100%**	**100%**
4.b	Oral Health - Targeted to Rural	166,404	0	30,429				196,833	0.77%	196,833	0	3/1/2023	$196,800	100%	100%
5	**Health Insurance (c)**	**1,383,137**	**223,222**	**479,154**	**0**	**94,004**	**0**	**2,179,517**	**8.50%**	**2,179,517**	**0**	3/1/2023	**$2,179,486**	**100%**	**100%**
7	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**					**341,395**	**1.33%**	**341,395**	**0**	**3/1/2023**	**$338,531**	**99%**	**100%**
10	**Substance Abuse Services - Outpatient (c)**	**45,677**	**0**	**0**	**0**	**-20,677**	**0**	**25,000**	**0.10%**	**25,000**	**0**	3/1/2023	**$25,000**	**100%**	**100%**
13	**Non-Medical Case Management**	**1,267,002**	**0**	**0**	**0**	**-72,790**	**0**	**1,194,212**	**4.66%**	**1,194,212**	**0**	**3/1/2023**	**$1,524,712**	**128%**	**100%**
13.a	Service Linkage targeted to Youth	110,793	0			-15,500		95,293	**0.37%**	95,293	0	3/1/2023	$93,766	98%	100%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0			-46,500		53,500	**0.21%**	53,500	0	3/1/2023	$46,838	88%	100%
13.c	Service Linkage at Public Clinic (a)	370,000	0					370,000	**1.44%**	370,000	0	3/1/2023	$480,088	130%	100%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	0			-10,790		675,419	**2.64%**	675,419	0	3/1/2023	$904,019	134%	100%
14	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**-70,024**	**0**	**354,887**	**1.38%**	**354,887**	**0**		**349,864**	**99%**	**100%**
14.a	Medical Transportation services targeted to Urban	252,680	0					252,680	0.99%	252,680	0	3/1/2023	$247,270	98%	100%
14.b	Medical Transportation services targeted to Rural	97,185	0					97,185	0.38%	97,185	0	3/1/2023	$102,594	106%	100%
14.c	Transportation vouchering (bus passes & gas cards)	75,046	0			-70,024		5,022	0.02%	5,022	0	3/1/2023	$0	0%	100%
15	**Emergency Financial Assistance**	**1,653,247**	**485,889**	**180,337**	**37,920**	**665,735**	**0**	**3,023,128**	**11.79%**	**3,023,128**	**0**		**3,869,032**	**128%**	**100%**
15.a	EFA - Pharmacy Assistance	1,553,247	485,889	180,337	37,920	690,735		2,948,128	11.50%	2,948,128	0	3/1/2023	$3,804,050	129%	100%
15.b	EFA - Other	100,000	0			-25,000		75,000	0.29%	75,000	0	3/1/2023	$64,982	87%	100%
17	**Outreach**	**420,000**	0					**420,000**	**1.64%**	**420,000**	**0**	**3/1/2023**	**$223,631**	**53%**	**100%**
FY23_RW_DIR	**Total Service Dollars**	**20,614,665**	**1,071,877**	**1,288,662**	**0**	**227,772**	**0**	**23,202,976**	**90.53%**	**23,202,976**	**0**		**22,852,889**	**98%**	**100%**
									Unallocated	Unobligated					100%
	Part A Grant Award (without Carryover):	**24,342,151**	***Carryover:***	**1,288,662**	**0**	**0**	***Total Part A:***	**25,630,813**	**0**	**0**					

		Original Allocation	Award Reconcilation	July Adjusments (carryover)	August 10% Rule Adjustments	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	Award Category	Award Amount	Amount Spent	Balance
	Core (must not be less than 75% of total service dollars)	**16,849,505**	**585,988**	**1,108,325**	**-37,920**	**-295,149**	**0**	**18,210,749**	**78.48%**	**16,885,650**	**73.89%**	Formula			0
	Non-Core (may not exceed 25% of total service dollars)	**3,765,160**	**485,889**	**180,337**	**37,920**	**522,921**	**0**	**4,992,227**	**21.52%**	**5,967,239**	**26.11%**	Supplemen			0
	Total Service Dollars (does not include Admin and QM)	**20,614,665**	**1,071,877**	**1,288,662**	**0**	**227,772**	**0**	**23,202,976**		**22,852,889**		Carry Over	0		0

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2023 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
												Totals	0	0	0
	Total Admin (must be ≤ 10% of total Part A + MAI)	**2,208,914**	**18,000**	**0**	**0**	**-171,947**	**0**	**2,054,967**	**7.33%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**428,695**	**0**	**0**	**0**	**-55,825**	**0**	**372,870**	**1.33%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**2,107,819**	**-39,764**	**17,664**	**0**	**0**	**0**	**2,085,719**	**86.91%**	**2,085,719**	**0**		**2,170,575**	**104%**	**100%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,065,775	-20,106	8,832	0			1,054,501	43.94%	1,054,501	0	3/1/2023	$1,193,260	113%	100%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	1,042,044	-19,658	8,832	0			1,031,218	42.97%	1,031,218	0	3/1/2023	$977,315	95%	100%
2	**Medical Case Management**	**320,099**	**-6,038**	**116**	**0**	**0**	**0**	**314,177**	**13.09%**	**314,177**	**0**		**$181,861**	**58%**	100%
2.c (MAI)	MCM - Targeted to African American	160,050	-3,019	58				157,089	6.55%	157,089	0	3/1/2023	$126,576	81%	100%
2.d (MAI)	MCM - Targeted to Hispanic	160,049	-3,019	58				157,088	6.55%	157,088	0	3/1/2023	$55,285	35%	100%
	Total MAI Service Funds	**2,427,918**	**-45,802**	**17,780**	**0**	**0**	**0**	**2,399,896**	**100.00%**	**2,399,896**	**0**		**2,352,436**	**98%**	**100%**
	Grant Administration	0	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
	Total MAI Funds	**2,427,918**	**-45,802**	**17,780**	**0**	**0**	**0**	**2,399,896**	**100.00%**	**2,399,896**	**0**		**2,352,436**	**98%**	**100%**
	MAI Grant Award	**2,382,116**	***Carry Over:***	**17,780**			***Total MAI:***	**2,399,896**							
	Combined Part A and MAI Orginial Allocation Total	**25,680,192**							Unallocated	Unobligated					100%
									0	**0**		***MAI Award***	**2,399,896**		
Footnotes:							**Total Part A & MAI**	**28,030,709**							
All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.														
(a)	Single local service definition is multiple HRSA service categories. (1) does not include LPAP. Expenditures must be evaluated both by individual service category and by combined service categories.														
(c)	Funded under Part B and/or SS														
(e)	10% rule reallocations														

Prepared by: Ryan White Grant Administration

FY 2023 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR (3/1/2023-2/29/2024)																		
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-54	55-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**8,643**	**8,916**	**75%**	**22%**	**2%**	**42%**	**11%**	**2%**	**45%**	**0%**	**0%**	**4%**	**28%**	**27%**	**22%**	**15%**	**3%**
1.a	Primary Care - Public Clinic (a)	2,959	3,055	70%	28%	1%	43%	9%	2%	47%	0%	1%	3%	18%	26%	26%	22%	5%
1.b	Primary Care - CBO Targeted to AA (a)	2,417	2,311	70%	26%	4%	99%	0%	1%	0%	0%	0%	6%	37%	28%	18%	9%	2%
1.c	Primary Care - CBO Targeted to Hispanic (a)	1,916	2,397	83%	14%	3%	0%	0%	0%	100%	0%	1%	6%	33%	28%	21%	10%	2%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	774	732	86%	12%	1%	0%	84%	15%	0%	0%	0%	3%	27%	26%	23%	18%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	683	1,030	70%	29%	1%	44%	15%	2%	40%	0%	0%	4%	27%	28%	24%	13%	3%
1.f	Primary Care - Women at Public Clinic (a)	793	870	0%	99%	1%	53%	6%	1%	40%	0%	1%	2%	14%	26%	31%	21%	6%
1.g	Primary Care - Pediatric (a)	5	0															
1.h	Vision	2,815	2,186	74%	25%	2%	44%	12%	3%	41%	0%	0%	3%	20%	25%	26%	21%	6%
2	**Medical Case Management (f)**	**5,429**	**3,722**															
2.a	Clinical Case Management	936	728	71%	27%	2%	56%	15%	2%	27%	0%	0%	3%	22%	27%	22%	18%	7%
2.b	Med CM - Targeted to Public Clinic (a)	569	558	92%	6%	2%	50%	12%	1%	37%	0%	1%	2%	26%	22%	22%	23%	4%
2.c	Med CM - Targeted to AA (a)	1,625	885	70%	26%	4%	99%	0%	1%	0%	0%	0%	6%	28%	28%	18%	15%	6%
2.d	Med CM - Targeted to H/L(a)	813	558	83%	13%	4%	0%	0%	0%	100%	0%	1%	5%	31%	27%	21%	13%	3%
2.e	Med CM - Targeted to White and/or MSM (a)	504	267	87%	12%	1%	0%	91%	9%	0%	0%	0%	2%	23%	20%	23%	23%	9%
2.f	Med CM - Targeted to Rural (a)	548	409	64%	35%	1%	51%	26%	2%	21%	0%	0%	4%	19%	22%	25%	22%	9%
2.g	Med CM - Targeted to Women at Public Clinic (a)	246	273	0%	100%	0%	68%	6%	1%	25%	0%	0%	2%	26%	30%	23%	15%	4%
2.h	Med CM - Targeted to Pedi (a)	0	0															
2.i	Med CM - Targeted to Veterans	172	31	94%	6%	0%	74%	19%	0%	6%	0%	0%	0%	0%	0%	26%	23%	52%
2.j	Med CM - Targeted to Youth	15	13	77%	23%	0%	46%	15%	0%	38%	0%	31%	69%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**5,775**	**6,512**	**76%**	**21%**	**3%**	**43%**	**11%**	**2%**	**43%**	**0%**	**0%**	**4%**	**28%**	**28%**	**23%**	**14%**	**3%**
4	**Oral Health**	**356**	**349**	**70%**	**30%**	**1%**	**40%**	**25%**	**1%**	**34%**	**0%**	**0%**	**2%**	**20%**	**24%**	**27%**	**17%**	**9%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	356	349	70%	30%	**1%**	40%	25%	1%	34%	0%	0%	2%	20%	24%	27%	17%	9%
5	**Mental Health Services (d)**	0	**NA**															
6	**Health Insurance**	**1,918**	**2,268**	**79%**	**19%**	**2%**	**44%**	**23%**	**3%**	**30%**	**0%**	**0%**	**2%**	**14%**	**19%**	**22%**	**27%**	**15%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**17**	**22**	**91%**	**5%**	**5%**	**27%**	**41%**	**5%**	**27%**	**0%**	**0%**	**0%**	**36%**	**36%**	**23%**	**5%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**546**	**461**	**77%**	**22%**	**2%**	**45%**	**18%**	**3%**	**33%**	**0%**	**0%**	**1%**	**8%**	**14%**	**25%**	**34%**	**19%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**1,042**	**827**	**72%**	**25%**	**3%**	**60%**	**9%**	**3%**	**27%**	**0%**	**0%**	**5%**	**31%**	**27%**	**18%**	**14%**	**4%**
13	**Non-Medical Case Management**	**8,657**	**8,727**															
13.a	Service Linkage Targeted to Youth	175	170	73%	25%	2%	51%	7%	2%	41%	0%	16%	84%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	100	80	79%	20%	1%	51%	4%	4%	41%	0%	0%	0%	48%	30%	15%	3%	5%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,546	3,495	67%	31%	1%	51%	9%	2%	39%	0%	0%	0%	18%	25%	25%	23%	8%
13.d	Service Linkage at CBO Primary Care Programs (a)	4,537	4,982	75%	23%	2%	50%	11%	2%	37%	0%	0%	4%	28%	27%	21%	15%	4%
14	**Transportation**	**2,366**	**1,773**															
14.a	Transportation Services - Urban	796	430	65%	33%	2%	57%	7%	3%	33%	0%	0%	3%	23%	24%	25%	16%	9%
14.b	Transportation Services - Rural	237	134	66%	33%	1%	31%	31%	1%	38%	0%	0%	3%	17%	19%	31%	21%	8%
14.c	Transportation vouchering	1,333	1,209	72%	25%	2%	67%	9%	2%	22%	0%	0%	2%	13%	19%	25%	33%	8%
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**1,830**	**2,125**	**76%**	**22%**	**2%**	**45%**	**8%**	**2%**	**45%**	**0%**	**0%**	**4%**	**27%**	**27%**	**23%**	**16%**	**2%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**14,991**	**74%**	**23%**	**2%**	**48%**	**13%**	**2%**	**37%**	**0%**	**0%**	**4%**	**25%**	**25%**	**21%**	**18%**	**7%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		**NA**	**30,198**	**75%**	**25%**		**48%**	**17%**	**5%**	**30%**	**0%**	**4%**		**21%**	**23%**	**25%**	**20%**	**7%**

Available Data As Of: 4/15/2024

FY 2023 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report (03/01/2023-02/29/2024)

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,664	2,201	**72%**	**25%**	**3%**	**99%**	**0%**	**1%**	**0%**	**0%**	**0%**	**6%**	**36%**	**27%**	**18%**	**10%**	**2%**
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	1,380	1,770	**83%**	**14%**	**3%**	**0%**	**0%**	**0%**	**100%**	**0%**	**1%**	**6%**	**34%**	**27%**	**21%**	**10%**	**2%**
2	**Medical Case Management (f)**	0																
2.c	Med CM - Targeted to AA (a)	967	575	**78%**	**18%**	**3%**	**46%**	**10%**	**2%**	**42%**	**0%**	**1%**	**8%**	**37%**	**25%**	**17%**	**9%**	**2%**
2.d	Med CM - Targeted to H/L(a)	735	370	**80%**	**20%**	**0%**	**60%**	**16%**	**2%**	**22%**	**0%**	**0%**	**11%**	**22%**	**25%**	**18%**	**18%**	**6%**

RW Part A New Client Service Utilization Report (03/01/2023-02/29/2024)

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/22- 2/28/23)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**1,871**	**2,101**	**77%**	**21%**	**2%**	**48%**	**10%**	**2%**	**40%**	**0%**	**1%**	**9%**	**37%**	**25%**	**16%**	**2%**	**10%**
2	**LPAP**	**954**	**1048**	**78%**	**18%**	**3%**	**46%**	**10%**	**2%**	**42%**	**0%**	**1%**	**8%**	**37%**	**25%**	**17%**	**2%**	**9%**
3.a	Clinical Case Management	95	95	80%	20%	0%	60%	16%	2%	22%	0%	0%	11%	22%	**25%**	**18%**	6%	**18%**
3.b-3.h	Medical Case Management	1,097	854	73%	25%	2%	50%	12%	1%	37%	0%	2%	7%	34%	**24%**	**18%**	4%	**11%**
3.i	Medical Case Manangement - Targeted to Veterans	33	3	67%	33%	0%	100%	0%	0%	0%	0%	0%	0%	0%	**0%**	**33%**	67%	**0%**
4	**Oral Health**	**50**	**46**	**80%**	**20%**	0%	**43%**	**26%**	**2%**	**28%**	**0%**	**0%**	**7%**	**24%**	**26%**	**17%**	**4%**	**22%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**1,870**	**1,989**	**70%**	**28%**	**2%**	**54%**	**11%**	**1%**	**33%**	**0%**	**1%**	**7%**	**29%**	**25%**	**18%**	**14%**	**6%**
12.b	**Service Linkage at Testing Sites**	**92**	**83**	**72%**	**23%**	**5%**	**49%**	**4%**	**5%**	**42%**	**0%**	**7%**	**11%**	**35%**	**27%**	**13%**	**2%**	**5%**

Footnotes:

(a)	Bundled Category
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(d)	Funded by Part B and/or State Services
(e)	Total MCM served does not include Clinical Case Management
(f)	CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2324 Ryan White Part B

Procurement Report

April 1, 2023 - March 31, 2024

Reflects spending through March 2024

Spending Target: 100%

Revised 5/1/24

Priority	Service Category	Original Allocation per	% of Grant	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
4	Oral Health Service	$1,833,318	53%	$0	$1,833,318		$1,833,318	4/1/2023	$1,664,725	91%
4	Oral Health Service -Prosthodontics (1)	$576,750	17%	$0	$576,750		$576,750	4/1/2023	$692,336	120%
5	Health Insurance Premiums and Cost Sharing	$1,028,433	30%	$0	$1,028,433		$1,028,433	4/1/2023	$1,002,377	97%
			3%	$0	$0		$0			
		$0	0%	$0	$0					
	Total Houston HSDA	3,438,501	103%	0	3,438,501	$0	$3,438,501		3,359,438	98%

Note: Spending variances of 10% of target will be addressed:

(1) TRG is in the process of reallocations.

2023-2024 Ryan White Part B Service Utilization Report
04/01/2023 thru 03/31/2024 Houston HSDA (4816)
4th Quarter (04/01/23 - 03/31/2024)

Revised 4/26/2024

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums	***1,150***	759	83.73%	16.20%	2.00%	5.00%	37.94%	25.82%	33.08%	3.16%	0.00%	0.00%	0.65%	16.60%	20.68%	24.76%	29.94%	7.37%
Home and Communiy Based Health Services	***0***	0	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Oral Health Care	***4,224***	2,792	72.71%	25.22%	0.00%	2.07%	51.21%	11.21%	35.13%	2.45%	0.00%	0.25%	1.67%	18.12%	22.85%	23.31%	23.53%	10.27%
Unduplicated Clients Served By State Services Funds:	*NA*	3,551	76.49%	18.97%	1.00%	3.54%	44.58%	18.50%	34.11%	2.81%	0.00%	0.13%	1.16%	17.36%	21.77%	24.04%	26.72%	8.82%

Completed By: L.Ledezma

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2324 DSHS State Services

Procurement Report

September 1, 2023 - August 31, 2024

Chart reflects spending through March 2024

Spending Target: 58.33%

Revised 5/1/2024

Priority	Service Category	Original Allocation per	% of Grant	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$892,101	31%	**$0**	$892,101	$0	$892,101	9/1/2023	$891,011	100%
6	**Mental Health Services**	$300,000	10%	**$0**	$300,000	$0	$300,000	9/1/2023	$89,670	30%
11	**Hospice**	$293,832	10%	**$0**	$293,832	$0	$293,832	9/1/2023	$133,100	45%
13	**Non Medical Case Management (2)**	$350,000	12%	**$0**	$350,000	$0	$350,000	9/1/2023	$84,679	24%
16	**Linguistic Services (3)**	$68,000	2%	**$0**	$68,000	$0	$68,000	9/1/2023	$6,300	9%
	ADAP/Referral for Healthcare (4)	$525,000	18%	**$0**	$525,000	$0	$525,000	9/1/2023	$311,142	59%
	Food Bank	$5,400		**$0**	$5,400	$0	$5,400	9/1/2023	$2,378	44%
	Medical Transportation	$84,600		**$0**	$84,600	$0	$84,600	9/1/2023	$33,326	39%
	Emergency Financial Assistance (Compassionate Care)	$368,123		**$0**	$368,123	$0	$368,123	9/1/2023	$134,282	36%
		2,887,056	**84%**	**$0**	$1,903,933	$0	$1,903,933		1,685,886	89%

Note

(1) HIP- Funded by Part A, B and State Services/. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31.

(2) Reallocation will occur due to a change in provider.

(3) Delayed billing

(4) Staff turnover

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2023-3/31/2024

Revised: 4/22/2024

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	940	$144,581.25	413	*0*	*$0.00*	*0*
Medical Deductible	6	$8,326.12	6	*0*	*$0.00*	*0*
Medical Premium	4267	$1,541,973.12	801	*0*	*$0.00*	*0*
Pharmacy Co-Payment	18779	$823,346.04	1850	*0*	*$0.00*	*0*
APTC Tax Liability	0	$0.00	0	*0*	*$0.00*	*0*
Out of Network Out of Pocket	0	$0.00	0	*0*	*$0.00*	*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	23992	$2,518,226.53	3070	0	$0.00	

Comments: This report represents services provided under all grants.

Public Comments

Public Comment

Re: Medical Equipment
April 3, 2024

Kevin Aloysius, Director- Pharmacy Operations at Legacy Community Health submitted the following comment to the Office of Support via email:

> "Currently our clients without insurance and on Ryan White have no access to blood pressure monitors. When I asked around, I was told that Blood Pressure monitors are considered Durable Medical Equipment (DME) only reimbursed under "Home and Community-Based Health Services". This category is no longer funded. I was also told that we could obtain them Part A funds but not really sure if this is true. This causes concern about other DME such Freestyle Continuous Glucose Monitor which would be considered a DME. Can the workgroup look into ensuring agencies know how to provide BP monitors for their uninsured RW clients and what is the funding mechanism."

Public Comment

Re: Transportation FPL
April 4, 2024

Kevin Aloysius, Director- Pharmacy Operations at Legacy Community Health submitted the following comment to the Office of Support via email:

> "Currently for Local Pharmaceutical Assistance Program, the federal poverty level is 500%. I am asking that the workgroup consider increasing the financial eligibility for transportation to 500% as well. This would ensure that clients that are getting their medications on LPAP also have access to transportation. Not all clients that have transportation barriers prefer to get their medications mailed or do virtual provider appointments. This would ensure they have more than one option to receive care they choose."

Public Comment

Re: Medically Tailored Meals
May 14, 2024

Jasmynn Lahner, Nutrition and Partnerships Senior Manager at the Houston Food Bank submitted the following comment to the Office of Support via email:

Thank you so much for allowing me to submit my public comment for the upcoming Quality Improvement Committee meeting, 5/14 as I'm unable to attend.

> Medically Tailored Meals (MTMs) positively impact the health of individuals living with complex severe and chronic illness, prevent unnecessary emergency department visits and hospitalization, and ensure essential nutrition access for individuals with complex illnesses across the country. Specifically, PLWH - research has shown reductions in hospitalizations, and improvements in food security, depressive symptoms, and antiretroviral therapy adherence. Offering this services through an established referral infrastructure that's already serving PLWH can make an impact on overall quality of life and cost-effective in other funded areas of Ryan White. Lastly, I've attached a recent study that was released on "The Benefits of Medically Tailored Meals for People Living with HIV" to share with the QI committee.

~Jasmynn Lahner, Registered Dietitian-Nutritionist

The Journal of Infectious Diseases

EDITORIAL

The Benefits of Medically Tailored Meals for People Living with HIV

Seth A. Berkowitz MD MPH[1*]

[1]Division of General Medicine and Clinical Epidemiology, Department of Medicine, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC

Key Words: Human Immunodeficiency Virus; Socioeconomic Factors; Population Health; Health Equity; Social Determinants of Health; Food is Medicine

In this issue of the Journal of Infectious Diseases, Palar et al. present the results of the Changing Health through Food Support for HIV (CHEFS-HIV) pragmatic randomized comparative effectiveness trial.[1] This study compares, among adults living with HIV, an intensive package of medically tailored meals, groceries, and nutritional education with a less intensive medically tailored meal intervention. The study was done in partnership with Project Open Hand, a community-based organization that specializes in providing medically tailored meals, particularly for people living with HIV.

In its design, the CHEFS-HIV approach is an example of a 'food is medicine' intervention, which can be thought of as food and nutrition interventions that involve some level of healthcare integration with the specific goal of improving clinical outcomes.[2] In this study, the primary outcomes were viral load (and in particular whether the viral load was suppressed) and health-related quality of life, as measured by the Short Form 36 (SF-36). Additional outcomes included

Address for correspondence: Seth A. Berkowitz, MD MPH, 5034 Old Clinic Bldg, CB 7110, Chapel Hill, NC 27599, seth_berkowitz@med.unc.edu, Tel: 919-966-2276

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inpatient hospitalizations, depressive symptoms, food security, and anti-retroviral therapy adherence, among others.

After enrolling 191 participants and following them for 6 months, 168 (88%) remained in the study, which is excellent study retention in this setting and minimizes concern about differential loss to follow-up as a potential source of bias. The study did not observe a difference between groups for the outcomes of viral load suppression or health-related quality of life, but did find substantial reductions in hospitalizations, and improvements in food security, depressive symptoms, and anti-retroviral therapy adherence. Overall, the results of the study are consistent with important benefits for the intervention.

The study findings are all the more impressive as the comparison group received an active treatment—namely, a less intensive version of a medically tailored meals program, also provided by Project Open Hand. This represents substantially greater support than many people living with HIV receive in other parts of the U.S. Further, as described in the paper, the trial was conducted during a time in California when there was substantial expansion of supportive interventions for people living with HIV through public health initiatives. With a less substantial comparison intervention, and/or in a state which made less effort to support people living with HIV, it is possible the results of the study would have favored the intervention group even more strongly.

In reflecting on the important findings of this well-conducted study, a few considerations come to mind. First, the reduction in inpatient admissions is very important. Though changes in healthcare utilization are often viewed through the lens of healthcare cost, they are also an important window into individuals' health.[3] Health is a multi-dimensional construct, for which it is important to use multiple indicators.[2,4] In the absence of any changes that would prevent people from being able to receive inpatient care, a reduction in hospitalizations can be seen as an indicator of improved health.

Second, the results of this study make clear the importance of examining multiple outcomes in food is medicine studies.[2,5] Unlike with pharmaceutical interventions where any change in outcomes would be expected to track closely with a particular mechanism of action and related physiological pathway, food is medicine interventions have the potential to affect health in many ways through many different pathways. Though this comparative effectiveness study did not see differential improvement in two indicators of better health (viral suppression and health-related quality of life), it did show improvement in several other indicators. Had the investigators focused their outcome assessment too narrowly, changes in other outcomes could have been missed, which would have undercounted the benefits of the intervention. The investigators deserve credit for thinking through the many ways the CHEFS-HIV intervention could have improved health, and collecting data to examine those possibilities.

Third, the results of this study should be considered in the context of other food is medicine randomized trials in this burgeoning field.[6] While the results of this study were largely, though not

entirely, positive, some food is medicine trials, particularly for the purpose of glycemic lowering for people with diabetes, have not demonstrated clear benefits.[7,8] One explanation for this difference may be the high engagement with the intervention in the CHEFS-HIV trial[9]—intervention arm participants actually received over 75% of the food offered, which is notably higher than studies in which food was picked up by participants rather than delivered.[7,8] Even aside from differences in engagement, however, a mixture of results is to be expected in a developing field, as investigators learn what works better and what does not work in particular situations.

Fourth, the lack of differential improvement in health-related quality of life, even as other factors like food security improved, may speak to the limitations of current health-related quality of life tools in capturing benefits of food is medicine interventions. It may be that the aspects of health-related quality of life that commonly used tools emphasize, such as pain or sleep, are not the ones most affected by food is medicine interventions.[10] This would support development of tools that can capture changes in health-related quality of life such interventions may produce.

Fifth, it is important to put the results of this study in a broader social context. Interventions like medically tailored meals often can be offered to people living with HIV because of funding made available through the Ryan White act.[11] This legislation appropriately recognizes the adverse social circumstances many people living with HIV face, and so makes possible interventions to address those social circumstances alongside standard biomedical interventions covered by health insurance, such as medications and laboratory testing. As such, this is a model that certainly could be useful for other clinical conditions, such as type 2 diabetes mellitus, that are also frequently bound up in adverse social circumstances. At the same time however, we should not lose sight of the fact that efforts to address issues like food insecurity to improve clinical outcomes are attempts to mitigate the consequences of adverse social circumstances, not efforts to fundamentally change the system of social relations that creates these circumstances in the first place.[12] As such, they should be understood as useful complements to biomedically-based clinical management, rather than efforts towards meaningfully altering the social determinants of health. To do the latter, we need to think much more seriously about the social institutions that distribute power and resources in the U.S. For example, efforts to reform our systems of child allowances, unemployment insurance, or disability benefits so that food insecurity does not occur in the first place should be pursued in parallel with any growth in food is medicine offerings.[13]

Ultimately, the investigators[1] should be congratulated for their important study demonstrating the benefit of the CHEFS-HIV food is medicine intervention. In considering the results of this study along with those of other recent food is medicine interventions across clinical contexts, the right question for investigators and policy makers alike is not whether food is medicine interventions work in a general sense, but instead, which food is medicine intervention work, in what context, and for whom?

Funding: None

Conflicts of interest: None

References

1. Palar K. Food is Medicine for HIV: Improved health and hospitalizations in the Changing Health through Food Support (CHEFS-HIV) pragmatic randomized trial. *PLACEHOLDER*.
2. Volpp KG, Berkowitz SA, Sharma SV, et al. Food Is Medicine: A Presidential Advisory From the American Heart Association. *Circulation*. Published online September 28, 2023. doi:10.1161/CIR.0000000000001182
3. Johnson KT, Palakshappa D, Basu S, Seligman H, Berkowitz SA. Examining the bidirectional relationship between food insecurity and healthcare spending. *Health Serv Res*. Published online February 17, 2021. doi:10.1111/1475-6773.13641
4. Berkowitz SA, Shahid NN, Terranova J, et al. "I was able to eat what I am supposed to eat"--patient reflections on a medically-tailored meal intervention: a qualitative analysis. *BMC Endocr Disord*. 2020;20(1):10. doi:10.1186/s12902-020-0491-z
5. Brandt EJ, Mozaffarian D, Leung CW, Berkowitz SA, Murthy VL. Diet and Food and Nutrition Insecurity and Cardiometabolic Disease. *Circ Res*. 2023;132(12):1692-1706. doi:10.1161/CIRCRESAHA.123.322065
6. Mozaffarian D, Aspry KE, Garfield K, et al. "Food Is Medicine" Strategies for Nutrition Security and Cardiometabolic Health Equity: JACC State-of-the-Art Review. *J Am Coll Cardiol*. 2024;83(8):843-864. doi:10.1016/j.jacc.2023.12.023
7. Seligman HK, Smith M, Rosenmoss S, Marshall MB, Waxman E. Comprehensive Diabetes Self-Management Support From Food Banks: A Randomized Controlled Trial. *Am J Public Health*. Published online July 19, 2018:e1-e8. doi:10.2105/AJPH.2018.304528
8. Doyle J, Alsan M, Skelley N, Lu Y, Cawley J. Effect of an Intensive Food-as-Medicine Program on Health and Health Care Use: A Randomized Clinical Trial. *JAMA Intern Med*. Published online December 26, 2023:e236670. doi:10.1001/jamainternmed.2023.6670
9. Li CX, Cole SR, Seligman HK, Berkowitz SA. Comparing Per-Protocol Effect Estimates for Randomized Clinical Trials in Population Health: A Reanalysis of the Feeding America Intervention Trial for Health For Diabetes Mellitus. *Am J Epidemiol*. 2023;192(12):2094-2098. doi:10.1093/aje/kwad156
10. Hanmer J, DeWalt DA, Berkowitz SA. Association between Food Insecurity and Health-Related Quality of Life: a Nationally Representative Survey. *J Gen Intern Med*. Published online January 6, 2021. doi:10.1007/s11606-020-06492-9
11. Weiser J, Dempsey A, Mandsager P, Shouse RL. Documenting Successes 30 Years After Passage of the Ryan White CARE Act. *J Assoc Nurses AIDS Care JANAC*. 2021;32(2):138-139. doi:10.1097/JNC.0000000000000224
12. Berkowitz SA. *Equal Care: Health Equity, Social Democracy, and the Egalitarian State*. Johns Hopkins University Press; 2024.
13. Berkowitz SA, Seligman HK, Palakshappa D. Understanding food insecurity risk in the United States: A longitudinal analysis. *SSM - Popul Health*. 2024;25:101569. doi:10.1016/j.ssmph.2023.101569

Houston Area HIV Services Ryan White Planning Council

FY 2025 How to Best Meet the Need Quality Improvement Committee Service Category Recommendation Summary (as of 05/15/24)

Those services for which no change is recommended include:

Ambulatory Outpatient Medical Care - CBO and Public Clinic (which includes Emergency Financial Assistance - Pharmacy Assistance, Local Pharmacy Assistance Program, and Outreach)

Case Management (Non-Medical Targeting Substance Use Disorders)

Health Insurance Premium and Cost Sharing Assistance

Hospice Services

Linguistic Services

Mental Health Services (Untargeted and Targeting Special Populations)

Oral Health (Untargeted and Targeting the Northern Rural Area)

Referral for Health Care - ADAP Enrollment Workers

Substance Use Disorder Treatment

Vision Care

Services <u>with</u> recommended changes include the following:

***New ideas recommended for services currently not funded** **(see page 2)**

Ambulatory Outpatient Medical Care - *<u>Rural</u>* (which includes Emergency Financial Assistance - Pharmacy Assistance, and Local Pharmacy Assistance Program)

- Keep the service definition as is. Increase the financial eligibility for PriCare to 400% and keep the financial eligibility the same for EFA=500%, Outreach=none, LPAP= 500%.

Case Management (Medical and Clinical)

- Keep the service definition as is and the financial eligibility the same: none. Recommend that the Priority and Allocations Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.

Case Management (Non-Medical Service Linkage)

- In the service definition under Staff Requirements, remove the bachelor's degree requirement, change paid working experience to one-year experience working with people living with HIV (PLWH) or a community health worker. Keep the financial eligibility the same: none.

Emergency Financial Assistance – Other

- Keep the service definition and financial eligibility the same: 400%.
- Add durable medical equipment to the service definition, ask the Priority and Allocations Committee to assign it to Part B or State Services and ask the Houston area Part B Recipient to bring information to the Quality Improvement Committee on how the mechanics of delivering the service will work.

Food Bank/Home Delivered Meals

- Revive the Food Bank/Home Delivered Meals service definition for the purpose of possibly providing Medically Tailored Meals.

Housing

- Revive the Housing service definition for the purpose of providing temporary assisted living, and ask staff to conduct a resource inventory of facility based medical respite programs and underutilized hospice services.

Medical Nutritional Therapy/Supplements

- Keep the service definition and financial eligibility the same: 400%. Request that the provider increase awareness about the availability of supplemental nutrition drinks.

Referral for Health Care – Incarcerated

- Eliminate the portion of the service category that addresses the needs of incarcerated individuals due to the availability of alternative resources and to avoid a duplication of services.

Transportation

- Add text to the service definition to ensure all clients with mobility issues have access to appropriate transportation and increase the financial eligibility for all transportation services to 500%. Ask the Recipient to make it possible for clients to receive a bus pass from any Ryan White funded agency where they are a client, not just their CPCDMS record holder.

Table of Contents

FY 2025 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2024 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 05/10/2023)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 5. Emergency Financial Assistance/Pharmacy: $0.00 6. Outreach: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWH residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See current fiscal year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** • No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the

	following exceptions: • 100% of clients served with MAI funds must be members of the targeted population. • 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. • Subrecipients may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** • Houston Ryan White Planning Council (RWPC) guidelines for Local Pharmacy Assistance Program (LPAP) services: Subrecipient shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Subrecipient shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. • Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. • At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **EFA-Pharmacy Assistance:** • Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s: **RWGA Only**	**Outpatient/Ambulatory Medical Care:** One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests)

	• Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. **Outpatient Psychiatric Services:** 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. **Nutritional Assessment and Plan:** 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. **AIDS Pharmaceutical Assistance (local):** A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. **Medical Case Management:** 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. **Service Linkage (non-Medical Case Management):** 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. **Outreach:** 1 unit of service = 15 minutes of direct client service providing outreach services by an Outreach Worker for eligible clients living with HIV, including other allowable activities (includes staff trainings, meetings, and assessments at determined by Ryan White Grant Administration).
HRSA Service Category Definition: **RWGA Only**	**Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral

	to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, **and medication**. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. **Outreach Services** include the provision of the following three

	activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Subrecipients must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Subrecipient must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Subrecipient must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV disease; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Subrecipient must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine

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

ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:

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

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

Local Pharmaceutical Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as

	birth control and TB medications) or medications available over the counter (OTC) without prescription. Subrecipient must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Subrecipient must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. **Emergency Financial Assistance – Pharmacy Assistance:** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30-day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Allowable medications are only those HIV medications on the Houston EMA Ryan White Part A Formulary. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate

	activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Subrecipient must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWH who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Subrecipient must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and

	benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA Services:** Subrecipient must: • Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. • Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: • Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. • Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. • Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. • Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. • Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Subrecipient must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. • Ensure Houston area HIV service providers are informed of this program and how the client referral and enrollment processes functions and must maintain documentation of such marketing efforts. • Implement a consistent process to enroll eligible patients in

	available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. • Ensure information regarding the program is provided to PLWH, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. • Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. • **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Subrecipient and receive ongoing supervision that meets or exceeds published Standards of Care. A MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided

	by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWH. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWH. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Subrecipient must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HIA) program

	guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HIA provider for assistance. Under no circumstances may the Subrecipient bill the County for the difference between the reimbursement from Medicaid, Medicare or Third-Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Subrecipient based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphtx.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Subrecipient must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:__X__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2. Recommend that the Priority and Allocations Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.	
3.	

FY 2024 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 5/10/2023)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWH residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See current fiscal year (FY) Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** • 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female • 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. • Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case

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

	exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. **Nutritional Assessment and Plan:** 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. **AIDS Pharmaceutical Assistance (local):** A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. **Medical Case Management:** 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWH performed by a qualified medical case manager. **Service Linkage (non-Medical Case Management):** 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWH performed by a qualified service linkage worker. **Outreach:** 1 unit of service = 15 minutes of direct client service providing outreach services by an Outreach Worker for eligible clients, including other allowable activities (includes staff trainings, meetings, and assessments at determined by Ryan White Grant Administration).
HRSA Service Category Definition: **RWGA Only**	**Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV

	includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into

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

term survival and maintenance of the highest quality of life possible.
- On-site Outpatient Psychiatry services.
- On-site Medical Case Management services.
- On-site Medication Education.
- Physical therapy services (either on-site or via referral).
- Specialty Clinic Referrals (either on-site or via referral).
- On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral.
- On site Nutritional Counseling by a Licensed Dietitian.

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

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

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

	medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary,

	for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by

	providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Emergency Financial Assistance – Pharmacy Assistance:** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30-day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Allowable medications are only those HIV medications on the Houston EMA Ryan White Part A Formulary. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWH who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible

	benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: • Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. • Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: • Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. • Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. • Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. • Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. • Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. • Ensure Houston area HIV service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. • Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP

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

	counseling to PLWH. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWH. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the

	local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.HCPH.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2. Recommend that the Priority and Allocations Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.	
3.	

FY 2024 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural** (Revision Date: 5/10/2023)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** • No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: • 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. • Subrecipients may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** • Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Subrecipient shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Subrecipient shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined

	by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. • Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. • At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **EFA-Pharmacy Assistance:** • Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s:	**Outpatient/Ambulatory Medical Care:** One (1) unit of service = One (1) primary care office/clinic visit or telehealth which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. **Outpatient Psychiatric Services:** 1 unit of service = A single (1) office/clinic visit or telehealth wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. **Nutritional Assessment and Plan:** 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other

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

	funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Subrecipients must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**

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

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

Services for women must also provide:

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

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

Patient Medication Education Services must adhere to the following requirements:

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

and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

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

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

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

Subrecipient must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Subrecipient must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client.

	Emergency Financial Assistance – Pharmacy Assistance: provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30-day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Allowable medications are only those HIV medications on the Houston EMA Ryan White Part A Formulary. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the

	often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Subrecipient must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals living with HIV and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for acquiring HIV.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Subrecipient must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.

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

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

	Services. The Subrecipient must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Subrecipient must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/31/22, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Subrecipient must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Subrecipient must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/31/22, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Subrecipient and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. A MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Subrecipient must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Subrecipient bill the County for the difference between the reimbursement from Medicaid, Medicare or Third-Party insurance and the fee schedule under the contract.

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

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:__X__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: PriCare=400%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%
1. Update the justification chart, keep the service definition as is. Increase the financial eligibility for PriCare to 400% and keep the financial eligibility the same for EFA, MCM, SLW, and LPAP.	
2. Recommend that the Priority and Allocations Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.	
3.	

FY 2024 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Clinical Case Management**	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition **(do <u>not</u> change or alter):** **RWGA Only**	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies.
Target Population (age,	Services will be available to eligible clients with HIV residing in the

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

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

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

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: None
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2. Recommend that the Priority and Allocations Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.	
3.	

FY 2024 Houston EMA/HSDA Ryan White Part A Service Definition **Service Linkage at Testing Sites** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWH in the Houston EMA/HDSA** **Not-In-Care PLWH** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWH are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B. *Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWH are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Local Service Category Definition:	**A. *Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWH who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills

	and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. **B. *Youth targeted Service Linkage, Care and Prevention:*** Providing Ryan White Program appropriate outreach and service linkage activities to newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**A. Service Linkage:** Services will be available to eligible persons with HV residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual. **B. *Youth targeted Service Linkage, Care and Prevention:*** Services will be available to eligible Youth (ages 13 – 24) living with HIV residing in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served

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

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

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: None
1. In the service definition under Staff Requirements, remove the bachelor's degree requirement, change paid working experience to one year experience working with people living with HIV (PLWH) or a community health worker. Update the justification chart and keep the financial eligibility the same.	
2.	
3.	

Local Service Category:	**Care Coordination (Non-Medical Case Management) Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Care Coordination** is a continuum of services that allow people living with HIV to be served in a holistic method. Services that are a part of the Care Coordination Continuum include case management, (both medical and non-medical, outreach services, referral for health care, and health education/risk reduction. **Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned

	for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: – Transgender, – Men who have sex with men (MSM), – Women or – Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a

	duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals. N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider**.**
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Eligibility for Services:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements **(TRG Only)**:	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

	Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling. Non-medical Case Management services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:__X__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: None
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2.	
3.	

FY 2024 Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Other** (Revised April 2020)	
HRSA Service Category Title:	**Emergency Financial Assistance**
Local Service Category Title:	**Emergency Financial Assistance - Other**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $30.00/unit
HRSA Service Category Definition **(do <u>not</u> change or alter):** **RWGA Only**	**Emergency Financial Assistance -** Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	**Emergency Financial Assistance** is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used. Emergency essential living needs include food, telephone, utilities (i.e. electricity, water, gas and all required fees) and housing, limited to people who are displaced from their home due to acute housing need, for eligible PLWH.
Target Population (age, gender, geographic, race, ethnicity, etc.):	PLWH living within the Houston Eligible Metropolitan Area (EMA).

Services to be Provided:	**Emergency Financial Assistance** provides funding through: • Short-term payments to agencies • Establishment of voucher programs Service to be provided include: • Food Vouchers • Utilities (gas, water, basic telephone service and electricity) • Short term housing for up to 14 days The agency must adhere to the following guidelines in providing these services: • Assistance must be in the form of vouchers made payable to vendors, merchants, etc. No payments may be made directly to individual clients or family members. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. • Allowable support services with an $800/year/client cap.
Service Unit Definition(s): **(HIV Services use only)**	A unit of service is defined as provision of food vouchers or and/or utility assistance to an eligible client.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Agency must be dually awarded as HOWPA sub-recipient work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Additionally, agency must document ability to refer clients for food, transportation, and other needs from other service providers when client need is justified.
Staff Requirements:	None.
Special Requirements:	Agency must: Comply with the Houston EMA/HSDA Standards of Care and Emergency Financial Assistance service category program policies.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:__X__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/17/2024**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition and financial eligibility the same.	

Step in Process: **HTBMTN Special Workgroup**	Date: **04/29/2024**
1. Add durable medical equipment to the service definition, ask the Priority and Allocations Committee to assign it to Part B or State Services and ask Houston area Part B Recipient to bring information to the Quality Improvement Committee on how the mechanics of delivering the service will work	

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

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 0 - 400%, ACA plans must have a subsidy
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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FY 2024 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Health Insurance Co-Payments and Co-Insurance Assistance** (Revision Date: 5/21/15)	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:** **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition **(do <u>not</u> change or alter):** **RWGA Only**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. <u>Co-Payment:</u> A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. <u>Co-Insurance:</u> A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription <u>Deductible:</u> A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. <u>Premium:</u> The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. <u>APTC Tax Liability:</u> The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 0 - 400%, ACA plans must have a subsidy
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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Local Service Category:	**Hospice Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of end-of-life care provided by licensed hospice care providers to people living with HIV (PLWH) in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and having a life expectancy of 6 months or less residing in the Houston HIV Service Delivery (HSDA).
Services to be Provided:	Services must include but are not limited to medical and nursing care,

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

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/17/2024**
Recommendations:	Financial Eligibility: 300%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the people living with HIV (PLWH), when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between PLWH and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any PLWH seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing-impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible PLWH.
Financial Eligibility:	Income at or below 500% Federal Poverty Guidelines.
Eligibility for Service:	People living with HIV in the Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston HSDA **Linguistic Services Standards of Care**. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/06/2024**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/17/2024**
Recommendations:	Financial Eligibility: 500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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FY 2024 Houston EMA/HSDA Ryan White Part A Service Definition **Medical Nutritional Therapy** (Last Review/Approval Date: November 2021)	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Persons living with HIV residing within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).

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

	session lasting a minimum of 45 minutes.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	***Nutritional Supplements:*** Person living with HIV and documentation that the client is actively enrolled in primary medical care. ***Medical Nutritional Therapy:*** Person with HIV and documentation that the client is actively enrolled in primary medical care.
Agency Requirements:	None.
Staff Requirements:	The nutritional counseling services under this category must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years experience providing nutritional assessment and counseling to PLWH.
Special Requirements: **RWGA Only**	Must comply with Houston EMA/HSDA Part A/B Standards of Care, HHS treatment guidelines and applicable HRSA/HAB HIV Clinical Performance Measures. Must comply with the Houston EMA/HSDA approved Medical Nutritional Therapy Formulary.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/06/2024**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart and keep the service definition and the financial eligibility the same. Request that the provider increase awareness about the availability of supplemental nutrition drinks.	
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Local Service Category:	**Mental Health Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a family/couples, group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family/couple) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible person living with HIV. **Family/Couples Therapy/Counseling** is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to PLWH all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.

Service Unit Definition(s) **(TRG Only)**:	**Individual Crisis Intervention and/or Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Family/Couples Crisis Intervention and/or Therapy:** A unit of service is defined as a family/couples counseling session lasting a minimum of 90 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible PLWH attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session. A minimum of three (3) participants must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 500% Federal Poverty Guidelines.
Eligibility for Services:	For individual therapy session, person living with HIV or the affected significant other of a person living with HIV, resident of Houston HSDA. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. PLWH must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the PLWH is in crisis and cannot be provided immediate services from the other programs/providers. In this case, PLWH may be provided services, if the PLWH applies for the other programs /providers, until the other programs/providers can take over services. Medicaid/Medicare, Third Party Payer and Private Pay status of PLWH receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, PLWH must be either a person living with HIV or the significant other of person living with HIV. Affected significant other is eligible for services only related to the stress of caring for a person living with HIV.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current PLWH with

	emotional emergencies. PLWH eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential PLWH who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible PLWH may not be referred elsewhere in order that non-Medicaid/Medicare eligible PLWH may be added to this grant). Failure to serve Medicaid/Medicare eligible PLWH based on their reimbursement status will be grounds for the immediate termination of the provider's contract. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC PhD, Psychologist, or LMFT). At least two years' experience working with HIV disease or two years' work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years' experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Mental health services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws. Mental health services that are provided via telehealth must be in accordance with State of Texas mental health provider practice requirements, see Texas Occupations Code, Title 3 Health Professions and chapter 111 for Telehealth & Telemedicine.

	When psychiatry is provided as a mental health service via telehealth then the provider must follow guidelines for telemedicine as noted in Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the PLWH's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third-party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per PLWH in any single 24-hour period. Agency should develop services that focus on the most current Special Populations identified in the *Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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Local Service Category:	**Mental Health Services Targeting Special Populations**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition:	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a family/couples, group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family/couple) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible person living with HIV. **Family/Couples Therapy/Counseling** is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and affected family/partners living within the Houston HIV Service Delivery Area (HSDA). PLWH should also be a member of the following special populations: • Transgender persons (emphasizing those who are LatinX/Black and/or under the age of 25),

	• Individuals who exchange sex for money, and • Individuals born outside the US.
Services to be Provided:	Agencies are encouraged to have available to PLWH all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.
Service Unit Definition(s) **(TRG Only)**:	**Individual Crisis Intervention and/or Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Family/Couples Crisis Intervention and/or Therapy:** A unit of service is defined as a family/couples counseling session lasting a minimum of 90 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible PLWH attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session. A minimum of three (3) participants must attend a group session in order for the group session to be eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 500% Federal Poverty Guidelines.
Eligibility for Services:	For individual therapy session, person living with HIV or the affected significant other of a person living with HIV, resident of Houston HSDA. The PLWH should be a member of the following special populations: • Transgender persons (emphasizing those who are LatinX/Black and/or under the age of 25), • individuals who exchange sex for money, and • individuals born outside the US. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. PLWH must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the PLWH is in crisis and cannot be provided immediate services from the other programs/providers. In this case, PLWH may be provided services, if the PLWH applies for the other programs /providers, until the other programs/providers can take over services.

	Medicaid/Medicare, Third Party Payer and Private Pay status of PLWH receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, PLWH must be either a person living with HIV or the significant other of person living with HIV. Affected significant others are eligible for services only related to the stress of caring for a person living with HIV.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current PLWH with emotional emergencies. PLWH eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential PLWH who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible PLWH may not be referred elsewhere in order that non-Medicaid/Medicare eligible PLWH may be added to this grant). Failure to serve Medicaid/Medicare eligible PLWH based on their reimbursement status will be grounds for the immediate termination of the provider's contract. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Psychologist, or LMFT). At least two years' experience working with HIV disease or two years' work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years' experience in family therapy.

	Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	The agency must develop collaborative relationships with community partners that serve each of the identified special populations. These relationships should be documented via Memoranda of Understanding. MOUs will be submitted to TRG for review each year. Referrals should be tracked to evidence the success of these MOUs. Referrals will be reviewed by TRG on an annual basis. Staff should be adequately trained and/or experienced with each of the identified special populations. Training and/or experience should be documented. This documentation will be reviewed by TRG on an annual basis. Services are strongly encouraged to be community based where counseling can be provided in a safe and secure location. Services should be provided on days and at times that are conducive for participation of the identified special populations. All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Mental health services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws. Mental health services that are provided via telehealth must be in accordance with State of Texas mental health provider practice requirements, see Texas Occupations Code, Title 3 Health Professions and chapter 111 for Telehealth & Telemedicine. When psychiatry is provided as a mental health service via telehealth then the provider must follow guidelines for telemedicine as noted in Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the PLWH's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third-party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per PLWH in any single 24-

	hour period. Agency should develop services that focus on the most current Special Populations identified in the *Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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Local Service Category:	**Oral Health Care**
Amount Available:	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for people living with HIV (PLWH) 15 years of age or older must be based on a comprehensive individual treatment plan. Prosthodontics services to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance. If a provider cannot provide adequate services for emergency care, the PLWH should be referred to a hospital emergency room.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV residing in the Houston HIV Service Delivery Area (HSDA).

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

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

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

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Step in Process: **Council**		Date: **06/13/2024**
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 300%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
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FY 2024 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Oral Health/Rural** (Last Review/Approval Date: November 2021)	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – <u>Rural (North)</u>**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to eligible clients including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Persons living with HIV residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for

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

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 300%
1. Continue to provide implants.	
2. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
3.	

Local Service Category:	**Referral for Health Care: ADAP Enrollment Worker**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct people living with HIV (PLWH) to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include: • Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed. • Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible. AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program.
Services to be Provided:	Services include but are not limited to provision of education on available benefits programs applicable to the PLWH; completion of ADAP application including enrollment/recertification/six-month attestation; aid the PLWH in gathering all required supporting documentation to complete benefits application(s) including ADAP; provide a streamlined process for submission of completed ADAP applications and/or other benefits applications; assist in benefits continuation including six-month attestation and necessary follow-up; liaison with THMP and the PLWH throughout the ADAP application process
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct PLWH services or coordination of application process on behalf of PLWH.
Financial Eligibility:	Income at or below 500% of Federal Poverty Guidelines
Eligibility for Service:	People living with HIV in the Houston HDSA
Agency Requirements **(TRG Only)**:	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS. Agency must obtain and maintain access to TakeChargeTexas, the online system to submit THMP applications.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2.	
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Local Service Category:	**Referral for Healthcare: Incarcerated & Recently Released**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Referral for Health Care and Support Services (RFHC) directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA Ryan White HIV/AIDS Program (RWHAP)-eligible clients to obtain access to other public or private programs for which they may be eligible.
Local Service Category Definition:	Support of Referral for Healthcare-Incarcerated (RFHC-Incarcerated) that include identification of individuals at points of entry and access to services and provision of: • Referral services (including healthcare services) • Linkage to care • Health education and literacy training that enable PLWHs to navigate the HIV system of care • Benefits counseling This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the PLWH, provision of education regarding disease and treatment, education and skills building to increase PLWH's health literacy, completion of THMP/ADAP application and submission via TCT upload process, care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning. These services must focus on expanding key points of entry and documented tracking of referrals. Counseling, and referral activities are designed to bring people living with HIV into Outpatient Ambulatory Medical Care. The goal of RFHC-Incarcerated is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. RFHC-Incarcerated also provides the added benefit of educating and motivating PLWHs on the importance and benefits of getting into care.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV (PLWHs) incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources. RFHC for the Incarcerated is provided at Harris County Jail. HCJ's population includes both individuals who are actively progressing through the criminal justice system (toward a determination of guilt or innocence), individuals who are serving that sentence in HCJ, and individuals who are awaiting transfer to Texas Department of Criminal Justice (TDCJ). The complexity of this population has proven a challenge in service delivery. Some individuals in HCJ have a firm release date. Others may attend and be released directly from court.

	Therefore, RFHC for the Incarcerated has been designed to consider the uncertain nature of length of stay in the service delivery. Three tiers of service provision haven been designated. They are: • **Tier 0:** The individuals in this tier do **not** stay in HCJ long enough to receive a clinical appointment while incarcerated. The use of zero for this tier's designation reinforces the understanding that the interaction with funded staff will be minimal. The length of stay in this tier is traditionally less than 14 days. • **Tier 1:** The individuals in this tier stay in HCJ long enough to receive a clinical appointment while incarcerated. This clinical appointment triggers the ability of staff to conduct multiple interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days. • **Tier 2:** The individuals in this tier remain in HCJ long enough to get additional interactions and potentially multiple clinical appointments. The length of stay in this tier is traditionally 30 or more days. Service provision builds on the activities of the previous tier if the individual remains in HCJ. Each tier helps the staff to focus interactions to address the highest priority needs of the individual. Each interaction is conducted as if it is the only opportunity to conduct the intervention with the individual. Transitional social services should NOT exceed 180 days.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct PLWH services or coordination of care on behalf of PLWH.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Eligibility for Service:	People living with HIV incarcerated and recently released from the Harris County Jail.
Agency Requirements **(TRG Only)**:	Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who are identified by testing in HCJ. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU. Agency must obtain and maintain access to TakeChargeTexas (TCT), the online system to submit THMP applications.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services for the Incarcerated Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/17/2024**
Recommendations:	Financial Eligibility: None
1. Eliminate the service category due to the availability of alternative resources and to avoid a duplication of services.	
2.	
3.	

FY 2024 Houston EMA/HSDA Ryan White Part A Service Definition **Substance Abuse Services - Outpatient** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Use Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling individuals with HIV with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Persons living with HIV and substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *Current FY Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	Individuals living with HIV with substance abuse co-morbidities/disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical

	Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan annually no later than March 31st documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 500%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2.	
3.	

FY 2024 Houston EMA/HSDA Ryan White Part A Service Definition **Medical Transportation (Van Based)** (Revision Date: 05/10/2023)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Subrecipient must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Subrecipient must provide RWGA a copy of the agreement between Subrecipient and a licensed taxi vendor by March 31, 2023.** • All taxi voucher receipts must have the taxi company's name,

	the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Subrecipient will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report (CER). • A copy of the taxi company's statement (on company letterhead) must be included with the monthly CER. Supporting documentation of disbursement payments may be requested with the CER.
HRSA Service Category Definition: **RWGA Only**	**Medical transportation services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
Local Service Category Definition:	a. Urban Transportation: Subrecipient will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans and rideshare services to Ryan White Program-eligible individuals residing in Harris County. Clients residing outside of Harris County are ineligible for Urban transportation services. Exceptions to this requirement require prior written approval from RWGA. b. Rural Transportation: Subrecipient will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Houston EMA/HSDA counties other than Harris County. Clients residing in Harris County are ineligible for this transportation program. Exceptions to this requirement require prior written approval from RWGA. Essential transportation is defined as transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. The Subrecipient shall ensure that the transportation program provides taxi vouchers to eligible clients only in the following cases: • To access emergency shelter vouchers or to attend social security disability hearings; • Van service is unavailable due to breakdown or inclement weather; • Client's medical need requires immediate transport; • Scheduling Conflicts. **Subrecipient must provide clear and specific justification (reason) for the use of taxi vouchers and include the documentation in the client's file for each incident. RWGA must approve supporting**

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

	White Program eligible affected individuals residing inside Harris County will be eligible for services. b. Rural Transportation: Only persons living with HIV and Ryan White Program eligible affected individuals residing in Houston EMA/HSDA Counties other than Harris County are eligible for Rural Transportation services. Documentation of the client's eligibility in accordance with approved Transportation Standards of Care must be obtained by the Subrecipient prior to providing services. The Subrecipient must ensure that eligible clients have a signed consent for transportation services, client rights and responsibilities prior to the commencement of services. Affected significant others may accompany a person living with HIV as medically necessary (minor children may accompany their caregiver as necessary). Ryan White Part A/B eligible affected individuals may utilize the services under this contract for travel to Core Services when the aforementioned criteria are met and the use of the service is directly related to a person living with HIV. An example of an eligible transportation encounter by an affected individual is transportation to a Professional Counseling appointment.
Agency Requirements	Subrecipient must be a Certified Medicaid Transportation Provider. Subrecipient must furnish such documentation to Harris County upon request from Ryan White Grant Administration prior to March 1st annually. Subrecipient must maintain such certification throughout the term of the contract. Failure to maintain certification as a Medicaid Transportation provider may result in termination of contract. Subrecipient must provide each client with a written explanation of Subrecipient's scheduling procedures upon initiation of their first transportation service, and annually thereafter. Subrecipient must provide RWGA with a copy of their scheduling procedures by March 31, 2023, and thereafter within 5 business days of any revisions. **Subrecipient must also have the following equipment dedicated to the general transportation program:** • A separate phone line from their main number so that clients can access transportation services during the hours of 7:00 a.m. to 10:00 p.m. directly at no cost to the clients. **The telephone line must be managed by a live person between the hours of 8:00 a.m. – 5:00 p.m.** Telephone calls to an answering machine utilized after 5:00 p.m. must be returned by 9:00 a.m. the following business day. • A fax machine with a dedicated line. • All equipment identified in the Transportation Standards of Care necessary to transport children in vehicles. • Subrecipient must assure clients eligible for Medicaid transportation are billed to Medicaid. This is subject to audit by the County. The Subrecipient is responsible for maintaining documentation to evidence that drivers providing services have a valid Texas Driver's

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:__X__	If approved with changes list changes below:
1. Increase the financial eligibility for all transportation services to 500%.		
2. Ask the Recipient to make it possible for clients to receive a bus pass from any Ryan White funded agency where they are a client, not just their CPCDMS record holder.		
3.		

Step in Process: **HTBMTN Workgroup #3**		Date: **04/17/2024**
Recommendations:	Financial Eligibility: 400%	
1. Add text to the service definition to ensure all clients with mobility issues have access to appropriate transportation. Update the justification chart and set the financial eligibility for all transportation services the same.		
2.		
3.		

FY 2024 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Vision Care** (Last Review/Approval Date: November 2021)	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 16-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual

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

FY 2025 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:__X__ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition as is and the financial eligibility the same.	
2.	
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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-19-24							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, and Vision.* ***Workgroup #1*** ***Motion #1:** (Mica/Locks)* *Votes: Y=6; N=0;* *Abstentions = Arizpe, Franco, Hollis, Legasse, Ruggerio*	✔ Yes ___No	☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART	Epi (2020): An estimated 4,924 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 8,251, or 27% of all PLWH. Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2023): # clients served:	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definitions as is. Keep the financial eligibility the same: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%. Recommend that the Priority and Allocations

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		prescription, and clients cannot access LPAP until they are enrolled in Primary Care. <u>Continuum of Care</u>: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	*Primary Care: 10,282 (5.76% increase v. 2022)* *LPAP: 6,707 (3.9% increase v. 2022)* *Medical Case Mgmt: 3,893 (26.8% decrease v. 2022)* *EFA-Pharmacy: 3,533 (13% increase v. 2022)* *Outreach: 1,001 (0.7% increase v. 2022)* *Non-Medical Case Mgmt, or Service Linkage: 8,855 (5% increase v. 2022)* <u>Outcomes (FY2020)</u>: *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV	participants <u>Medical Case Management:</u> RW Part C and D <u>Service Linkage:</u> RW Part C and D, HOPWA, and a grant from a private foundation <u>EHE Funding</u>: RWGA received $4,585,790 in HRSA funding for 2023 EHE activities. Houston Health Department (HHD) received $2,642,329 under PS20-2010 for Integrated HIV Programs to Support Ending the HIV Epidemic. Several Houston area FQHCs continue to receive funding from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention	Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses activities of the EHE/Integrated Prevention and Care Services Plan and addresses certain Special Populations named in the Plan. Is this a duplicative service or activity? This service is funded locally		Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.

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			care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless,	(PCHP) Grant. Covered under QHP? ✔ Yes ___No	by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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			MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Public Clinic, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Rural and Vision* ***Workgroup #1*** ***Motion #1:** (Mica/Locks) Votes: Y=6; N=0; Abstentions = Arizpe, Franco, Hollis, Legasse, Ruggerio*	✔ Yes ___No	☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need.	Epi (2020): An estimated 4,924 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 8,251, or 27% of all PLWH. Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2023):	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definition as is. Keep the financial eligibility the same: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%. Recommend that the

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		Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	# clients served: *Primary Care: 10,282 (5.76% increase v. 2022)* *LPAP: 6,707 (3.9% increase v. 2022)* *Medical Case Mgmt: 3,893 (26.8% decrease v. 2022)* *EFA-Pharmacy: 3,533 (13% increase v. 2022)* *Outreach: 1,001 (0.7% increase v. 2022)* *Non-Medical Case Mgmt, or Service Linkage: 8,855 (5% increase v. 2022)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of	health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $4,585,790 in HRSA funding for 2023 EHE activities. Houston Health Department (HHD) received $2,642,329 under PS20-2010 for Integrated HIV Programs to Support Ending the HIV Epidemic. Several Houston area FQHCs continue to receive funding from HRSA's Ending the HIV Epidemic-	status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses activities of the EHE/Integrated Prevention and Care Services Plan and addresses certain Special Populations named in the Plan. Is this a duplicative service or activity?		Priority and Allocations Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.

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			clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage <u>Pops. with difficulty accessing needed services</u>: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth),	Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Rural, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy & Service Linkage (Includes OB/GYN) *See below for Vision* ***Workgroup #1*** ***Motion #1:** (Mica/Locks)* *Votes: Y=6; N=0;* *Abstentions = Arizpe, Franco, Hollis, Legasse, Ruggerio*	✔ Yes ___No	☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care	Epi (2020): An estimated 4,924 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 8,251, or 27% of all PLWH. Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definition as is. Increase the financial eligibility for PriCare to 400% and keep the financial eligibility the same for EFA=500%, MCM/SLW=

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
			Medical Case Mgmt: 50% of clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural	Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	or activity? This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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			Outreach: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Vision - Part A ***Workgroup #1*** ***Motion #1:** (Hollis/Locks) Votes: Y=6; N=0; Abstentions = Arizpe, Legasse*	✔ Yes ___No	☐ EIIHA ☐ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses.	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services:#5 Service Utilization (2023): # clients served: 2,099 *(21% decrease v. 2022)* Outcomes (FY2020): 750 diagnoses were reported for HIV-related ocular disorders, 97% of which were	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Care Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definition and the financial eligibility the same: 400%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	managed appropriately Pops. with difficulty accessing needed services: Females (sex at birth), Other/ multiracial, 18-24, Homeless, OOC				
Clinical Case Management - Part A ***Workgroup #1*** ***Motion #1:** (Mica/Locks) Votes: Y=7; N=0; Abstentions = Arizpe, Franco, Legasse, Ruggerio*	✔ Yes ___No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care, making CCM is a strategy for preventing unmet need. CCM	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services:*#3* Service Utilization (2023): # clients served: 787 *(22% decrease v. 2022)* Outcomes (FY2020): 56% of clients were in continuous care following receipt of CCM. 73% of clients utilizing CCM were virally	RW Part C EHE Funding: RWGA received $4,585,790 in HRSA funding for 2023 EHE activities. Houston Health Department (HHD) received $2,642,329 under PS20-2010 for Integrated HIV Programs to Support Ending the HIV Epidemic. Several Houston area FQHCs continue to receive funding from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #2 service need by PLWH - Results in desirable health outcomes for clients who access the service - Prevents unmet need by addressing co-morbidities related to substance abuse and mental health - Facilitates national, state, and local goals related to	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definition and keep the financial eligibility the same: none. Recommend that the Priority and Allocations

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		also addresses local priorities related to mental health and substance abuse co-morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH	suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	(PCHP) Grant. Covered under QHP? ___Yes ✔ No	- continuous HIV care and reducing unmet need - Addresses activities of the EHE/Integrated Prevention and Care Services Plan and addresses certain Special Populations named in the Plan. Is this a duplicative service or activity? This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only.		Committee increase the allocation to Medical Case Management and ask the Recipient to encourage agencies to use it to increase salaries to improve staff retention.

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Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion #1:*** *(Mica/Locks) Votes: Y=6; N=0; Abstentions = Arizpe, Franco, Legasse, Rowe, Ruggerio.*	___Yes ✔ No	☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 1 month of diagnosis. In 2018, 40% of the newly diagnosed in the EMA	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services:*#3* Service Utilization (2023): # clients served: 94 *(27% decrease v. 2022)* Outcomes (FY2020): Following Service Linkage, 49% of clients were in continuous HIV care, and 50% accessed HIV primary care for the first time Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $4,585,790 in HRSA funding for 2023 EHE activities. Houston Health Department (HHD) received $2,642,329 under PS20-2010 for Integrated HIV Programs to Support Ending the HIV Epidemic. Several Houston area FQHCs continue to receive funding from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service or activity? This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** In the service definition under Staff Requirements, remove the bachelor's degree requirement, change paid working experience to one year experience working with people living with HIV (PLWH) or a community health worker. Update the justification chart and keep and the financial eligibility the same: none.

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		were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2022, 9% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.			funded agencies/programs only.		

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Emergency Financial Assistance – Other - Part A ***Workgroup #3*** ***Motion #1:** (Boyle/Locks)* *Votes: Y=9; N=0;* *Abstentions = Arizpe, Palmer* ***Special Workgroup*** ***Motion #1:** (Mica/Stacy)* *Votes: Y=10; N=0;* *Abstentions = Escamilla*	___Yes ✔ No	☐ EIIHA ☐ EHE ☐ Unmet Need Continuum of Care (CoC) ☐ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA This service started 03/01/21.	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): N/A Service Utilization (2023): # clients served: 109 *(6% decrease v. 2022)*	This service was initially provided through a grant during COVID-19 epidemic. Covered under QHP? ___Yes ✔ No	Justify the use of funds: Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg #3 Motion:** Update the justification chart, keep the service definition the same, keep the financial eligibility the same: 400%. **Special Wg Motion:** Add durable medical equipment to the service definition, ask the Priority and Allocations Committee to assign it to Part B or State Services and ask Houston area Part B Recipient to bring

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							information to the Quality Improvement Committee on how the mechanics of delivering the service will work.
Food bank/Home Delivered Meals ***Special Workgroup*** ***Motion #1:** (Mica/Stacy) Votes: Y=8; N=0; Abstentions = Barrett, Carrington*	___Yes ✔ No	☐ EIIHA ☐ EHE ☐ Unmet Need Continuum of Care (CoC) ☐ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA		Covered under QHP? ___Yes ✔ No			**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Revive the service definition for the purpose of possibly providing Medically Tailored Meals.

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Health Insurance Premium and Co-Pay Assistance **- Part A, Part B, and State Services** ***Workgroup #2*** ***Motion #1:** (Galley/Sliepka)* *Votes: Y=8; N=0;* *Abstentions = Martin, Palmer*	✔ Yes __No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing financial barriers to HIV care for those who are eligible for public or private health insurance. Currently, 37% of RW clients have some form of health insurance, and 9% have Marketplace coverage. This service will assist those clients to	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *#7* *% of RW clients with health insurance: 38%* *% of RW clients with Marketplace coverage: 10%* Service Utilization (2023): # clients served: 2,660 *(12.9% increase v. 2022)* Outcomes (FY2020): 73.5% of health insurance assistance clients were virally suppressed Pops. with difficulty accessing needed services: Other / multiracial, HL, 25-49,	No known alternative funding sources exist for this service, though consumers between 100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs. Covered under QHP? __Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Supports federal health insurance marketplace participants Is this a duplicative service or activity? No, there is no known	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart, keep the service definition the same, keep the financial eligibility the same: 0 - 400%, ACA plans must have a subsidy.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		remain in HIV care via all insurance resources; This will also be utilized to assist federal health insurance marketplace participants. Continuum of Care: Health Insurance Assistance facilitates maintenance/ retention in care and viral suppression by increasing access to non-RW private and public medical and pharmaceutical coverage. The savings yielded by securing non-RW healthcare coverage for PLWH increases the amount of funding available to provide other needed services throughout the Continuum of Care.	Transgender, Homeless, MSM, Rural		alternative funding for this service as designed		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Hospice ‡ ***Workgroup #3*** ***Motion #1:** (Boyle/Locks)* *Votes: Y=9; N=0;* *Abstention = Kelly*	✔ Yes __No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis. This, in turn, may prevent PLWH from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. Hospice	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020):N/a Service Utilization (2023): # clients served: 16 *(44.8% decrease v. 2022)* Chart Review (2019): 92% of charts had records of palliative therapy as ordered and 100% had medication administration records on file. Records indicated that bereavement counseling was offered to client's family in 10% of applicable cases. Pops. with difficulty accessing needed services: N/a	Medicaid, Medicare Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses activities of the EHE/Integrated Prevention and Care Services Plan and addresses certain Special Populations named in the Plan. Is this a duplicative service or activity? This service is funded locally by other public sources for	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care? N/A	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart, keep the service definition the same, keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		ensures clients with co-morbidities remain in HIV care. As a result, this service also addresses local priorities related to mental health and substance abuse co-morbidities. Continuum of Care: Hospice services support re-linkage and maintenance/retention in care for PLWH by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis, preventing PLWH from falling out of care.			those meeting income, disability, and/or age-related eligibility criteria		
Housing ***Special Workgroup #2*** ***Motion #1:** (Mica/Locks)* *Votes: Y=8; N=1;*	___Yes ✔ No	☐ EIIHA ☐ EHE ☐ Unmet Need Continuum of Care (CoC) ☐ CoC RW eligible consumers		Covered under QHP? ___Yes ✔ No			**05/14/24 – the QI committee approved the HTBMN workgroup recommendation**

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Abstentions = Stacy ***Special Workgroup #3*** ***Motion #1:** (Locks/Tates)* *Votes: Y=7; N=0;* *Abstentions = Kelly, Rowe*		☐ CoC all PLWH in EMA/HSDA					**Wg Motion:** Revive the service definition for the purpose of providing temporary assisted living. **Wg Motion:** Ask staff to conduct a resource inventory of facility based medical respite programs and underutilized hospice services.
Linguistic Services‡ ***Workgroup #3*** ***Motion #1:** (Mica/Rowe)* *Votes: Y=3; N=5;* *Abstentions = Arizpe, Kelly, Palmer* ***Motion #2:** (Kelly/Boyle)*	___Yes ✔ No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA Unmet Need: Facilitating entry	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020):N/a Service Utilization (2023): # clients served: 52 *(8.7% decrease v. 2022)*	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH,	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion #1:** Eliminate the financial eligibility. *Motion failed.*

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Votes: Y=9; N=0; Abstention = Palmer		into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this service facilitates entry into care and helps prevent lapses in care for monolingual PLWH. Continuum of Care: Linguistic Services support linkage to care, maintenance/retention in care, and viral suppression by eliminating language barriers and facilitating effective communication for non-Spanish monolingual PLWH.	Pops. with difficulty accessing needed services: N/a	___Yes ✔ No	thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the EHE/ Integrated Prevention and Care Services Plan Is this a duplicative service or activity? No, there is no known alternative funding for this service as designed	There is no waiting list at this time; however, the need for this service has the potential to exceed capacity due to new cohorts of languages spoken in the EMA/HSDA Does this service assist special populations to access primary care? Yes	**Wg Motion #2:** Update the justification chart, keep the service definition the same, keep the financial eligibility the same: 500%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Medical Nutritional Supplements and Therapy - Part A ***Workgroup #2*** ***Motion #1:** (Mica/Galley)* *Votes: Y=9; N=0;* *Abstention = Palmer*	✔ Yes ___No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA Unmet Need: The most commonly cited reason for referral to this service by a RW clinician is to mitigate side effects from HIV medication. Currently, 8% of PLWH report that side effects prevent them from taking HIV medication. This service category eliminates potential barriers to HIV medication adherence by helping to alleviate side effects. In addition, evidence of an ART prescription is a criterion for met	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *#10* Service Utilization (2023): # clients served: 478 *(7.7% decrease v. 2022)* Outcomes (FY2020): 83% of medical nutritional therapy clients with wasting syndrome or suboptimal body mass improved or maintained their body mass index. 83% of Medical Nutritional Therapy clients were virally suppressed Pops. with difficulty accessing needed services: Females (sex at birth), Black/AA, 25-49,	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *Some QHPs may cover prescribed supplements	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #9 service need by PLWH - Has limited or no alternative funding source - Results in desirable health outcomes for clients who access the service - Removes barriers to HIV medication adherence, thereby facilitating national, state, and local goals related to viral load suppression Is this a duplicative service or activity? Alternative funding for this service may be available through Medicaid.	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definition and the financial eligibility the same: 400%. Request that the provider increase awareness about the availability of supplemental nutrition drinks.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		need. Continuum of Care: Medical Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	Homeless				
Mental Health Services‡ (Professional Counseling) **- Untargeted and Special Populations** ***Workgroup #2*** ***Motion #1:** (Mica/Sliepka)* *Votes: Y=9; N=0;* *Abstention = Palmer*	✔ Yes ___No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA Unmet Need: Of 29% of 2016 Needs Assessment participants who reported falling out of care for >12 months since first	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *#8* Service Utilization (2023): # clients served: 222 *(3.5% decrease v. 2021)* Chart Review (2019): 96% of clients had treatment	RW Part D (targets WICY), Medicaid, Medicare, private providers, and self-pay Some services provided by MHMRA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #7 service need by PLWH - Facilitates national, state, and local goals related to retention in care and preventing unmet need - Addresses activities of the EHE/Integrated Prevention	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist	**05/14/24 – the QI committee approved the HTBMN workgroup recommendation** **Wg Motion:** Update the justification chart and keep the service definition and the financial eligibility the same: 500%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		entering care, 9% reported mental health concerns caused the lapse. Over half (57%) of participants recorded having a current mental health condition diagnosis, and 65% reported experiencing at least one mental/emotional distress symptom in the past 12 months to such an extent that they desired professional help. Mental Health Services offers professional counseling for those with a mental health condition/concern, and, as a result, may help reduce lapses in HIV care. Mental Health Services also address local priorities related to mental health co-morbidities. Continuum of Care: Mental	plans reviewed and/or modified at least every 90 days. 100% of charts reviewed contained evidence of appropriate coordination across all medical care team members Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, RR, Rural, Homeless		and Care Services Plan and addresses certain Special Populations named in the Plan. Is this a duplicative service or activity? This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.	special populations to access primary care?	

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		Health Services facilitate linkage, maintenance/retention in care, and viral suppression by helping PLWH manage mental and emotional health concerns that may act as barriers to HIV care.					
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup #2*** ***Motion #1:** (Mica/Galley)* *Votes: Y=9; N=0;* *Abstention = Kelly* ***Motion #2:** (Mica/Galley)* *Votes: Y=9; N=0;* *Abstention = Kelly* ***Motion #3:** (Sliepka/Galley)*	✔ Yes ___No	☐ EIIHA ☐ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA Continuum of Care: Oral Health services support maintenance in HIV care by increasing access to care and treatment for HIV-related and general oral health diagnoses. Untreated oral health	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *#4* Service Utilization (2023): # clients served: 3,062 *(.29% increase v. 2022)* Outcomes (FY2019): Oral Health Care – Rural Target: 99% of client charts had evidence of vital signs assessment, 92% had	In FY12, Medicaid Managed Care expanded benefits to include oral health services Covered under QHP*? ___Yes ✔ No *Some QHPs cover pediatric dental; low-cost add-on dental coverage can be purchased in Marketplace	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #4 service need by PLWH. Is this a duplicative service or activity? This service is funded locally by one other public sources for its Managed Care clients only	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? Yes, clients report waiting lists for this service Does this service assist special populations to	**05/14/24 – the QI committee approved the HTBMN workgroup recommendations** **Wg Motion #1:** Continue to provide implants for Part A. **Wg Motion #2:** Update the justification chart and keep the service definition and the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Votes: Y=9; N=0; Abstention = Kelly		diagnoses can create poor health outcomes and may act as a financial barrier to HIV care.	evidence of hard and soft tissue examinations, 94% had evidence of receipt of periodontal screening, and 99% had evidence of oral health education. Oral Health Care – Untargeted: 99% had chart evidence for vital signs assessment at initial visit, 99% had updated health histories in their chart, 89% had a signed dental treatment plan established or updated within the last year, and 75% had chart evidence of receipt of oral health education including smoking cessation. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial,			access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendations** **Wg Motion #3:** Update the justification chart and keep the Part B service definition and the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
			White, 25-49, OOC, RR, MSM				
Council Support	___Yes ✔ No						
Project LEAP	___Yes ✔ No						
Blue Book	___Yes ✔ No						
Referral for Health Care – ADAP Enrollment Workers (AEW)‡ ***Workgroup #1***	___Yes ✔ No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *#6*	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - State Services-Rebate (SS-R) funding is intended to ensure service	Can we make this service more efficient? Placement of ADAP Enrollment Workers at each Ryan White primary care site will make this service more	**05/14/24 – the QI committee approved the HTBMN workgroup recommendations**

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
***Motion #1:** (Mica/Hollis) Votes: Y=7; N=0; Abstentions = Arizpe, Franco, Legasse, Ruggerio*	at Ryan White Care Sites will fund one FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP applications, as well as appropriate re-certifications and attestations.	Unmet Need: Assistance submitting complete and accurate ADAP applications and re-certifications reduces unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medication coverage. Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression	Service Utilization (2023): # clients served: 5,596 **due to issues with the data system, service utilization was not available for 2022.* Chart Review (2019): 59% of AEW client had charts documented evidence of benefit applications completed as appropriate within 2 weeks the eligibility determination date. 59% had evidence of assistance provided to access health insurance or Marketplace plans. 73% had evidence of completed secondary reviews of ADAP applications before submission to THMP. Pops. with difficulty accessing	Enrollment Workers at Ryan White primary care sites. Covered under QHP? ___Yes ✔ No	continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. Is this a duplicative service or activity? No	efficient and accessible than placement at a single site. Can we bundle this service? N/a – this would be the only use of SS-R funding in the Houston EMA/HSDA Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart and keep the service definition and the financial eligibility the same: 500%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
			needed services: Other / multiracial, White, 50+, MSM, Homeless, Transgender, Rural, RR				
Referral for Health Care – Incarcerated‡ ***Workgroup #3*** ***Motion #1:** (Kelly/Mica)* *Votes: Y=10; N=0;* *Abstention = Rowe*	___Yes ✔ No In 2022, this service transitioned from Early Intervention Services to Referral for Health Care and Support Services to better align with the scope of services provided. No data is available.	☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA	Epi (2020): Current # of living HIV cases in EMA: 30,988	EHE Funding: RWGA received $4,585,790 in HRSA funding for 2023 EHE activities. Houston Health Department (HHD) received $2,642,329 under PS20-2010 for Integrated HIV Programs to Support Ending the HIV Epidemic. Several Houston area FQHCs continue to receive funding from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - Addresses activities of the EHE/Integrated Prevention and Care Services Plan and addresses certain Special	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care? Yes	**05/14/24 – the QI committee approved the HTBMN workgroup recommendations** **Wg Motion:** Eliminate the portion of the service category that addresses the needs of incarcerated individuals due to the availability of alternative resources and to avoid a duplication of services.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
				___Yes ✔ No	Populations named in the Plan. Is this a duplicative service or activity? Yes, effective 01/23/24, the contracted provider decided not to pursue the funded positions. In the current system, incarcerated PLWH and are receiving care from the public clinic which currently has two funded positions working directly with individuals while incarcerated to develop a discharge plan and link them to care and support (including MAI). The Minority AIDS Initiative (MAI) is funded to provide post-release coordination and they have some ability to coordinate		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
					while individuals are incarcerated.		
Substance Use Disorder Treatment – Part A ***Workgroup #2*** ***Motion #1:** (Mica/Galley)* *Votes: Y=9; N=0;* *Abstention = Palmer*	✔ Yes ____No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care. Therefore, Substance Abuse Treatment services can directly prevent or reduce unmet need. Substance Abuse Treatment	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: *#12* Service Utilization (2023): # clients served: 21 *(110% increase v. 2022)* Outcomes (FY2019): 50% of clients accessed primary care at least once after receiving Substance Abuse Treatment services and 89% were virally suppressed.	RW Part C, Medicaid, Medicare, private providers, and self-pay. Some services provided by SAMHSA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Removes potential barriers to early entry into HIV care, thereby contributing to EIIHA goals - Prevents unmet need by addressing the #2 cause cited by PLWH for lapses in HIV care - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendations** **Wg Motion:** Update the justification chart and keep the service definition and the financial eligibility the same: 500%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		also addresses local priorities related to substance abuse co-morbidities. Continuum of Care: Substance Abuse Treatment facilitates linkage, maintenance/retention in care, and viral suppression by helping PLWH manage substance use that may act as barriers to HIV care.	Pops. with difficulty accessing needed services: Black/AA, 18-24, RR, Homeless		- Addresses activities of the EHE/Integrated Prevention and Care Services Plan and addresses certain Special Populations named in the Plan. Is this a duplicative service or activity? This service is funded locally by other public and private sources for (1) those meeting income, disability, and/or age-related eligibility criteria, and (2) those with private sector health insurance.		
Case Management – Non-Medical - State Services‡ (Targeting Substance Use Disorders)	___Yes ✔ No	☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank of all types of case	This service was previously funded under SAMHSA. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health	Can we make this service more efficient? No Can we bundle this service?	**05/14/24 – the QI committee approved the HTBMN workgroup recommendations**

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
Workgroup #2 ***Motion #1:*** *(Galley/Robert)* *Votes: Y=9; N=0;* *Abstention = Palmer*		☒ CoC all PLWH in EMA/HSDA EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling	management w/in funded services: *#3* Service Utilization (2023): # clients served: 209 (20.8% increase v. 2022) Pops. with difficulty accessing needed services: *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	___Yes ✔ No	outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service or activity? This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only	No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart and keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2022, 9% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup #3*** ***Motion #1:** (Mica/Ligons)* *Votes: Y=9; N=0;* *Abstention =Palmer*	___Yes ✔ No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA Unmet Need: Lack of transportation is the *fourth* most	Epi (2020): Current # of living HIV cases in EMA: 30,988 Need (2020): Rank w/in funded services: #9 Service Utilization (2023): # clients served: *Van-based: 573* *(39.4% decrease v. 2022)*	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing HIV primary care - Removes potential barriers	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**QI Motion:** Add text to the service definition to ensure all clients with mobility issues have access to appropriate transportation and increase the financial eligibility for all transportation services to 500%. Ask the Recipient to

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity? Is this service culturally appropriate for clients living with HIV?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted.
		commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care. Continuum of Care: Transportation supports linkage, maintenance/retention in care, and viral suppression by helping PLWH attend HIV primary care visits, and other vital services.	*Bus pass: 1,201 (10% decrease v. 2021)* Outcomes (FY2020): 67% of clients accessed primary care at least once after using van transportation; and 37% of clients accessed primary care after using bus pass services. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, Homeless, OOC, RR	EHE funding provides ridesharing with no financial eligibility. Covered under QHP*? ___Yes ✔ No	to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need Is this a duplicative service or activity? This service is funded locally by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.	Does this service assist special populations to access primary care?	make it possible for clients to receive a bus pass from any Ryan White funded agency where they are a client, not just their CPCDMS record holder. **Wg Motion:** Add text to the service definition to ensure all clients with mobility issues have access to appropriate transportation. Update the justification chart and set the financial eligibility for all transportation services the same: 400%.

‡ Service Category for Part B/State Services only.

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-24 ***In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than 5:00 p.m. on May 1, 2023. This form is available by calling the Office of Support: 832 927-7926***	
Ambulatory/Outpatient Primary Medical Care – Pediatric (incl. Medical Case Management and Service Linkage)	Service available from alternative sources.
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Food Pantry/Home Delivered Meals (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Home and Community-based Health Services (facility-based)	Category unfunded due to many years of underutilization.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Legal Assistance	Vendor returned funds; service is still provided through alternative funding sources.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

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TARGETING FOR FY 2025 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

Stage 1-2‡HIV Prevalence	Stage 3‡HIV Prevalence	All Stages‡ HIV Prevalence	Geographic Targeting	Other Targeting	N/A or No Targeting	Service Category
			X*	X**		Ambulatory/Outpatient Medical Care
			X*	X		Case Management Services - Core
				X		Case Management Services - Non-Core
					X	Emergency Financial Assistance - Other
					X	Emergency Financial Assistance - Pharmacy Assistance
					X	Health Insurance Assistance
					X	Hospice Services
					X	Linguistic Services
					X	Local Pharmacy Assistance Program
					X	Medical Nutritional Therapy
					X	Mental Health Services
					X****	Outreach Services - Primary Care Retention in Care
			X***		X	Oral Health
					X	Referral for Health Care - ADAP Enrollment Workers
					X	Substance Use Disorder Treatment
			X	X		Transportation Services
					X	Vision

* Geographic targeting in rural area only.

** In an effort to provide a baseline that reflects actual client utilization for community based organizations base this percentage on the FY 2023 final expenditures that targeted African Americans, Whites and Hispanics

*** Geographic targeting in the north only

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

‡ The three stages of HIV are 1: acute HIV (early), 2: chronic HIV (asymptomatic), and 3: acquired immunodeficiency syndrome (symptomatic, formerly referred to as AIDS).

Source: https://hivinfo.nih.gov/understanding-hiv/fact-sheets/stages-hiv-infection

Operations Committee Report

FY 2024 vs. FY 2025 Council Support Budget Comparison

(Operations Committee approved 05-13-24)

Budget Item	FY 2024 Amount	FY 2025 Amount	Difference	Notes
Salaries	$287,978	$280,658	- $ 7,320	Lower salaries for the manager and the health planner
Employee Fringe	146,986	145,255*	- 1,731	*NOTE: he County has not released the cost of benefits for the next fiscal year.
Equipment	4,000	4,500	+ 500	Inflation
Rental Fees	12,000	30,000	+ 18,000	The County is having difficulty finding a building that meets the Council's space needs. The FY25 budget is for 12 months and includes an increase in the cost of rent.
Moving Costs	2,500	0	- 2,500	
Resource Guide	31,000	15,000	- 16,000	The Blue Book will be published in FY24. The FY25 funds will be used to publish mini Blue Books in English and Spanish for soon-to-be released inmates.
Reimbursement for Volunteer Expanses	19,000	20,000	+ 1,000	Inflation, cost of mileage
Interpreter Services	10,000	15,000	+ 5,000	Increase to accommodate mono-lingual Spanish speakers attending RW meetings
Storage Unit for 35,000 Blue Books	3,000	3,600	+ 600	Inflation
TOTALS			- $ 2,451	

FY 2024 Budget Total	$ 589,534
FY 2025 Budget Total	- 587,083
Difference	$ 2,451

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Houston Ryan White Planning Council
FY 2025 Council Support Budget
March 1, 2025 - February 28, 2026
(As of 05-14-24)

		Subtotal	Total
PERSONNEL		**$280,658**	
RWPC Director (TBD) ($7000/mo. X 12 mos. x 100%) Responsible for overall functioning of planning council, supervises all support staff.	$84,000		
RWPC Health Planner (TBD) ($6333/mo. X 12 mos. x 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$76,000		
RWPC Coordinator (D. Beck) ($5284/mos. x 12 mos. x 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$63,407		
Consumer Engagment (R. Avila) ($4771/mox. X 12 mos. x 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$57,251		
FRINGE		**$145,255**	
Social Security @ 7.38%	$20,713		
Health Insurance (4 x $19,075/FTE)	$76,300		
Retirement @ 15.30%	$42,941		
Workers Compensation @ 0.88%	$2,470		
Unemployment Insurance @ 0.10%	$281		
Incentives/allowances	$2,550		
EQUIPMENT			
Replace obsolete computers and tablets and purchase equipment needed to allow Ryan White volunteers and students access to virtual meetings	$4,500	**$4,500**	

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Houston Ryan White Planning Council
FY 2025 Council Support Budget
March 1, 2025 - February 28, 2026
(As of 05-14-24)

		Subtotal	Total
TRAVEL		**$8,270**	
Local Travel: $0.69/mile for Planning Council Support Staff	$2,000		
Out of EMA travel: Two out of town trips for either Office of Support staff and/or Ryan White volunteers to attend HIV related conferences.	$6,270		
SUPPLIES General consumable office supplies including materials for Council members & public meetings.	$6,000	**$6,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$142,400**	
Rental Fees for Office & Meeting Rooms Rental agreement for office and meeting space space for RW volunteers, 45 students & staff ($2,500/mos. X 12 mos. = $30,000/year)	$30,000		
Resource Guide (mini Blue Books for Inmates)	$15,000		
Reimbursement for Volunteer Expenses: Reimbursement for meals, childcare, travel, gift cards/incentives & other eligible expenses resulting from participation in Council approved/HRSA grant required activities.	$20,000		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$5,000		
Communications (telephone and computer): For local and long distance phone expenses, equipment and internet charges.	$3,000		
Council Education: For speakers & training costs for ongoing training to insure that key decision-makers receive necessary information. This includes a January Orientation and a mid-year Council meeting to be held off-site in Harris County.	$5,500		

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Houston Ryan White Planning Council
FY 2025 Council Support Budget
March 1, 2025 - February 28, 2026
(As of 05-14-24)

		Subtotal	Total
Project LEAP Student Reimbursement: Total of 45 participants (15 students/course) for three 17-week courses including travel, childcare, incentives & other expenses resulting from participation in required consumer training activities in English and Spanish related to the Ryan White grant.	$7,000		
Project LEAP Education: Training costs for three 17- week courses including facilitation & speaker fees, translators & educational materials in English and Spanish.	$15,000		
Consumer Education: Training costs for up to 5 workshops including speaker fees, translators and educational materials.	$2,800		
Interpreter Services: For Spanish-speaking & sign-language interpretation services during Council meetings, public hearings, focus groups and more.	$15,000		
Fees and Dues: Registration costs for attending meetings, trainings & conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council, Project LEAP & other educational materials into Spanish.	$5,000		
Storage Unit for HIV Resource Directories: Storage for 30,000 directories @ $300/month	$3,600		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$6,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used by Council staff.	$9,000		
TOTAL			**$587,083**

Read AI

- Platform created for “teams” usage
- Is a charge for the software, various subscription levels.
    - There is a free version, but limited to 1 hr. duration of recording
- meeting notes with automated AI summaries
- AI creates
    - Meeting Summary
    - Chapters & Topics
    - Action Items
    - Transcription 2.0
    - Playback & Highlights (requires top level subscription)
    - Recommendations

Considerations:

- AI will create the items above driven by algorithms in its code.
    - NO human intervention
- Duplication of the recording of the meeting can lead to a “he said/she said” situation, since the meetings are already being recorded.
    - These recordings are available upon request, whereas this second recording is proprietary to the person who is doing the recording. Availability would depend upon the grace of the recorder.
    - This has legal implications for the Council/County.
    - There are no limits/constrains upon AI currently in this country. (Use of AI in spam, voice mimicking, etc.)

Recommendation:

- Since this would be a duplication of an established process the Council already has in place and due to the potential for confusion over what the Council did/did not do or say and the legal implications of dueling minutes, I would strongly recommend that the Council strongly consider the implications of allowing additional records of its proceeds.

June 13, 2024

Council Handouts

ITEM	DOCUMENTS
May 2024 Summary Report from Joint Integrated Plan	1
Director's Report: Ryan White Office of Support	2
Manager's Report: Ryan White Grant Administration	3

Ending the HIV Epidemic/Integrated HIV Prevention and Care Planning Body

Summary Reports from Committees and Workgroups

May 2024

For more information about the groups listed below, please contact Diane Beck, RWOoS by telephone at 832 927-7926 or by email at: Diane.Beck@harriscountytx.gov. All Committees & Workgroups meet virtually only, unless otherwise noted, and can be accessed by Zoom at: https://us02web.zoom.us/j/8899837982 Meeting ID: 889 983 7982

Join us for the next Leadership Team Meeting at 4 pm on Thursday, June 27, 2024. All are welcome

Aging and HIV Workgroup, 05/15/24, Diane Beck, RWOoS
Daniel Castellanos, DrPH, vice president of research and innovation at the Latino Commission on AIDS, presented a program on integrating HIV and aging care. Participants at the well-attended meeting agreed that aging services described in the presentation would be a great starting point for identifying those that needed to be added to HIV primary care. In July, Glenn Urbach, LMSW, the Ryan White grant administration program manager, will provide a service definition for case management targeting aging services. The workgroup will discuss modification of Ryan White standards of care. **Next meeting: Noon, Wednesday, July 17, 2024**

College Workgroup, Sha'Terra Johnson, TRG
Merging this group, which has yet to meet, with the Youth Workgroup is expected to launch it successfully in July. The co-chairs of the Leadership Team approved this change, allowing the two groups to meet together virtually. **Next Meeting: 6 p.m., Tuesday, July 2, 2024**

Consumer and Community Engagement Workgroup, 05/20/24, Cydney Clay, HHD
The group decided to integrate the College Workgroup into the Youth Workgroup and start an inventory of HIV services available on local college and university campuses. Road 2 Success community educational events are on hold until RWOoS can provide sandwiches. **Next meeting: 11 a.m., Monday, July 22, 2024**

Education and Awareness Committee,* 05/21/24, Tori Williams, RWOoS
After reviewing the goals and activities assigned to this committee, all convened agreed that it would be more efficient to merge this group with the Treat Committee. **Next Meeting: Noon, Friday, August 9, 2024**

Housing Workgroup, 05/23/24, Tori Williams, RWOoS
The workgroup has committed to two projects. The first will be working with Project LEAP students to produce one to two pamphlets for unhoused individuals. Potential topics are emergency housing resources and housing rights and resources. The second project will be collecting needs assessment data related to housing services in the greater Houston area. The most helpful will be the needs assessment, currently in the request-for-proposals stage, which is being conducted by the HOPWA program. The aim is to have two phases—phase 1, collecting needs assessment data, and, phase 2, creating an action plan. The hope is that phase 1 will be completed in the fall of 2025. **Next Meeting: 2 p.m., Friday, July 12, 2024**

Monitoring, Quality Assurance, and Evaluation Committee,* 05/09/24, Ama Williams, HHD
The committee did not meet in May so that members assigned to specific EHE/Integrated Planning committees and workgroups could attend May meetings and present evaluation plans at the next committee meeting. **Next meeting: 2 p.m., Thursday, July 11, 2024**

Needing In-Person Engagement Workgroup, 05/08/2024, Tori Williams, RWOoS
Members reviewed a plan to work with the AIDS Education and Training Center to create a three-part video series that includes HIV basics; information tailored to those who work with specific priority populations; and the

process for referring clients to local HIV prevention, testing and care services. The first series will be created in 2024 for case managers who work with the unhoused. There are approximately 1,000 case managers working with this group in the greater Houston area. In 2025, the series will be specifically designed for mental health workers, and in 2026, the series will be designed for staff who work with individuals impacted by coercive violence. **Next meeting: 10 a.m., Wednesday, July 17, 2024 (Note unusual day and time.)**

Prevention and Policy Committee, 05/14/24, Eliot Davis, HHD
Houston Health Department Deputy Assistant Director Marlene McNeese, MBA, and HHD Bureau of HIV/STI and Viral Hepatitis Prevention staffer Eliot Davis, LMSW, are assembling a report with updates on all EHE goals and activities. The aim is to present the report at the June Leadership Team meeting. In the meantime, the committee will gather information about the drawbacks of distributing condoms in Texas jails and prisons in order to understand both sides of the issue. Staff will provide a copy of the Prison Rape Elimination Act to the committee. FYI: Windham School District provides educational programs to students housed in correctional facilities across Texas. Some members suggested that the HHD website could provide more HIV prevention information about PEP and PrEP, as well as information about re-entry programs. Members also discussed sending PEP and PrEP information to therapists who work with those who have committed a sexual offense. **Next meeting: Noon, Tuesday, July 9, 2024**

Professional Health Care Engagement Workgroup, 04/29/24, Tori Williams, RWOoS
This workgroup met for the first time, and Josh Mica, Chair of the Houston Ryan White Planning Council, welcomed new co-chair, Evelyn Malone-Hicks, president of the Association of Nurses in AIDS Care, Houston Chapter. Together, they make a great team! (Thank you, Treat Committee Co-Chair Pete Rodriguez, for introducing Evelyn to the Houston EHE/Integrated Planning initiative.) After reviewing the workgroup goals, the group considered three proposed projects: (1) undertaking a series of videos to train case managers for the unhoused, mental health workers and those who work in shelters with individuals impacted by coercive violence; (2) training social workers and physicians, including physicians in private practice, in rural areas; and (3) educating front desk staff and other frontline workers how to create warm and knowledgeable relationships with clients living with HIV from the first visit. The members are to review the three projects and come to the next meeting with ideas and suggestions so that the group can select projects to implement in 2024. **Next meeting: 2 p.m., Monday, June 24, 2024. (Note unusual day and time.)**

Quality of Life and Social Determinants Committee
Steven Vargas, co-chair of the Research, Data, and Implementation Committee, and Josh Mica, Chair, Houston Ryan White Planning Council, recently agreed to co-chair this committee, which hasn't met since 2022. Soon, they will meet with Tori to plan next steps. In the meantime, the workgroups under the committee have been meeting and working on their goals and activities. **Next meeting: To be announced**

Racial and Social Justice Workgroup, 05/21/2024, Richon Ohafia, RWGA
After introductions, members reviewed agenda topics and participated in a presentation by Richon Ohafia, MPH, Ryan White Grant Administration, Health Equity Specialist, on definitions integral to racial and social justice. Discussions followed. Members are reviewing the AIDS United stigma index in preparation for the next meeting. Richon will provide a follow up presentation on Intersectionality at the July meeting. **Next meeting: 6 p.m., Tuesday, July 16, 2024—a hybrid meeting**

Research, Data, and Implementation Committee,* 05/09/24, Aryana Butler, HHD
The committee did not meet in May so that members assigned to specific EHE/Integrated Planning committees and workgroups could attend these May meetings and present evaluation plans at their next Committee meeting. **Next meeting: 2 p.m., Thursday, July 11, 2024.**

Respond Committee, 05/22/24, Sha'Terra Johnson, TRG
The May meeting was postponed until Eliot Davis has an opportunity to give an update on all EHE goals and activities at the June Leadership Team meeting. His presentation will provide guidance to the committee on next steps. **Next meeting: 1 p.m., Wednesday, July 24, 2024**

Status-Neutral Systems and Diagnose Committee, 05/08/24, Cydney Clay, HHD
Members evaluated each goal and discussed who would be responsible for evaluating that organizations were meeting their goals. Revisited the use of one overall survey to prevent repetitive links and prevent confusion. Reviewed each activity and determined that certain activities pertaining to policy can be switched out with the Prevention and Policy Committee. Committee members also discussed potentially scheduling a joint meeting with the Prevention and Policy Committee. **Next Meeting: 3 p.m., Wednesday, July 10, 2024**

Treat, Education and Awareness Committee,* 05/10/24, Tori Williams, RWOoS
After reviewing projects that the five education workgroups are developing, the Treat Committee co-chairs suggested ways to pull some of the workgroups together to streamline the structure, increase membership on each workgroup and simplify the Joint Planning Body structure as a whole. Co-chairs each selected workgroups to join at the next meeting and to support personally. The committee also reviewed Goal 2D, which was identified as outdated, and requested that staff gather data on availability of free phones available to those who are unhoused. If most of the unhoused can get phones, Goal 2D can be eliminated. **Next Meeting Date: Noon, Friday, August 9, 2024**

Youth and College Workgroup,* 05/07/2024, Rod Avila, RWOoS
The workgroup welcomed three additional members who heard about the Youth Workgroup from the Latino HIV Task Force (Thank you, Gloria!). Underway are two initiatives. One will create a monthly program combining the efforts of three or four groups serving vulnerable young adults identified as formerly or currently unhoused, to develop a monthly, in-person (possibly hybrid) dinner and educational discussion meeting. The educational component will focus on HIV prevention and care, mental health, substance use, housing, employment and other topics. Twice a year, the group will be asked for input about designing medical and support services for youth. Decisions about food, presenters and more—particularly naming the program—will be made by a steering committee of elected consumers from each of the youth groups participating. In this way, the program will also teach leadership skills. A second initiative will develop a resource pamphlet for vulnerable young adults. **Next Meeting: 6 p.m., Tuesday, July 2, 2024**

*** Committee and Workgroup Changes:** The College Workgroup is merging with the Youth Workgroup under the name Youth and College Engagement Workgroup. The Education and Awareness Committee is merging with the Treat Committee under the name Treat, Education, and Awareness Committee. The Monitoring, Quality Assurance, and Evaluation Committee and the Research, Data, and Implementation Committee were merged previously.

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. (a U.S. Department of Health and Human Services initiative)
HHD, Houston Health Department
HOPWA, Housing Opportunities for People with AIDS
PeP, post-exposure prophylaxis
PrEP, pre-exposure prophylaxis
RWGA, Ryan White Grant Administration
RWOoS, Ryan White Office of Support
TRG, The Houston Regional HIV Resource Group.

The Houston EMA Ryan White Planning Council Report
May 2024

Submitted 06-06-24

Chief Elected Official - Updates

- I believe that the Judge's Office will soon announce the Director's pending retirement and the resulting job opening. When that happens, the Office of Support will distribute the job description and instructions on how interested individuals can apply. Because there has been a long delay in releasing the job announcement, the current Director will work full time through at least September 2024. In the meantime, members of the Operations Committee went through a process of scoring applications from members who wished to serve and selected the following individuals as members of the 2024 Personnel Subcommittee: Cecilia Ligons, Co-Chair, Crystal R. Starr, Co-Chair, Skeet Boyle, Ronnie Galley, Kathryn Kase, Legal Counsel to the County Judge, Josh Mica, Bill Patterson, Pete Rodriguez and Bruce Turner. Tori Williams will staff the Subcommittee.

Ryan White Office of Support - Updates

- Data collection for the 2024 HIV Care Needs Assessment is now over. The data is being entered into the analysis software and Beth will be able to start analyzing the data in early July. As you know, the Priority and Allocations Committee needs the data to prioritize the FY 2025 service categories. In the meantime, the Priority and Allocations Committee is developing the FY 2025 allocations. Since allocations are more closely aligned with expenditure reports and other data, this will not be a problem.
- Staff is still working with the Harris County Engineering Department to find permanent office space on County property. At the moment, there seem to be very few County buildings that provide sufficient handicapped parking, close access to a bus stop or meeting space. In the meantime, Ryan White Grant Administration has generously offered additional funds so that the Council can remain at the church until the end of the FY24 grant year. And, the FY 2025 budget includes funds to cover an additional 12 months of rental fees.
- The Houston Health Department has recently announced that they have hired Mr. Cory Garrett to be the EHE Coordinator. For several years, Cory was the liaison between HHD and the Hip Hop community during the HIP HOP for HIV Awareness Testing event. More recently, he has coordinated art in the streets, especially with students. Tori is setting up an appointment to meet with Mr. Garrett and several HHD staff members to discuss the division of duties for the EHE/Integrated Planning body since the Office of Support has been doing most of the coordination and clerical work associated with the planning body.
- Regarding the Joint Planning body, it is important to note that HHD will be providing the community with an update on all EHE goals and activities within the Joint Plan. This update will impact most of the committees and workgroups associated with the Plan and is scheduled to be a hybrid meeting at 4 pm on Thursday, June 27, 2024. Watch your email for meeting reminders which include the in-person location and Zoom access information.
- Also, please watch your email for notices regarding Ryan White Planning Council Public Hearings. The Affected Community Committee just hosted a hearing to review the changes to the FY 2025 service definitions and soon, there will be a second hearing to present the FY 2025 allocations. Diane has been pre-recording the presentations, splicing them together and sending out the link to the YouTube videos, which are also on the Council website. The presentations are in English and in Spanish and we get significantly more viewers than we ever got when the hearings were held in person. Many thanks to Diane and all of the Ryan White volunteers who organize and record the public hearings.

Barbie Robinson, MPP, JD, CHC
Executive Director
1111 Fannin
Houston, Texas 77002

Harris County Public Health
Building a Healthy Community

Ericka Brown, MD, MBA, FACHE
Director Community Health and Wellness Division
1111 Fannin
Houston, Texas 77002

Houston EMA Ryan White Part A, MAI & EHE
Administrative Agency Report
June 6, 2024

Part A Updates

- **FY 2024 Notice of Award:** On May 29th, RWGA received its FY24 RW/A Full Notice of Award
    - FY 24 RW/A = $24,712,917 (FY23 = $24,342,151) (2% increase)
    - FY 24 MAI = $2,417,008 (FY23 = $2,382,116) (2% increase)
        - Represents an increase of $405,658 (2% overall increase)
- **FY 2023 Annual Progress Report & FY 2023 Expenditures Report:** both reports were submitted to HRSA in May.
- **FY 2023 Contract Status:**
    - RWGA has processed all the final expenditure reports from sub-recipients
    - Final UOB balance/carryover request of HRSA-$539,192/98% of FY23 award
    - Sub-recipients will be notified of carryover availability allocation requests in June

EHE Updates

- **Subrecipient TA Meeting:** RWGA hosted an EHE subrecipient technical assistance training and an all-day retreat on May 31st in partnership with BCM.
- **2024 HRSA Comprehensive Site Visit:** RWGA submitted its Corrective Action Plan addressing the six citations found during its site visit in January.

Open Positions

- Grants Management Project Coordinator position has been posted online. We're currently reviewing applicants and arranging the first round of interviews.
- Financial Analyst position has been moved to the Office of Financial Services and reclassified as a Grant Analyst. The position will still be 100% dedicated to the RW/A and EHE grants.

Glenn Urbach, Manager
HCPH/Ryan White Grant Administration Section
1111 Fannin, Houston, TX 77002
(713) 274-5790/glenn.urbach@phs.hctx.net