Intro Packet

Item / Document Title	Color/Size
General Information (white paper, unless otherwise indicated)	
Workgroup Agenda	**Pink**
Workgroup Guidelines	**Pink**
Workgroup Schedule & Timeline of Critical 2012 Ryan White Planning Council Activities	
Conflict of Interest Description from HRSA	
Conflict of Interest Description from RWPC	
HRSA-defined Core Medical Services (text from reauthorization bill)	
Services to be RFP'd if funded in FY 2013	
FY 2012 Part A, Part B and State Services Funded Service Categories	
Part A, Part B and State Services Financial Eligibility by Service Category for 2010/2011/2012	
Recommended HIV/AIDS Targeting for FY 2012 Service Categories	
AIDS Incidence, HIV (non-AIDS) Prevalence & AIDS Prevalence (From the Part A FY 2012 HRSA Grant Application)	
AIDS: Summary of Houston/Harris County Cases (Houston DHHS Bureau of Epidemiology)	
Policy and Procedures for Ryan White Part A and Medicaid/Medicare Eligibility Verification	
Barriers to Services Cited in the 2011 Houston Area HIV/AIDS Needs Assessment	
National HIV/AIDS Strategy: Implementation Update, July 2011	
Unmet Need Information (packet cover purple)	**Purple**
Unmet Need Estimate & Assessment (From the 2011 Houston Area HIV/AIDS Needs Assessment)	
Unmet Need Estimate & Assessment (From the Part A FY 2012 HRSA Grant Application)	
Unmet Need, 2009-2011 Texas Statewide Plan (DSHS)	
Unmet Need Dashboard (DSHS)	
Early Identification of Individuals with HIV/AIDS-EIIHA (packet cover orange)	**Orange**
HRSA PowerPoint Presentation on EIIHA	
EIIHA Strategy and Matrix (From the Part A FY 2012 HRSA Grant Application)	
Funding and Utilization Documentation (packet cover lime)	**Lime**
2012 Federal Poverty Guidelines	
Assessment of Populations with Special Needs From the Part A FY 2012 HRSA Grant Application	
FY 2010 Minority AIDS Initiative (MAI) Final Report, RWGA – January 2012	
Procurement Reports for Part A, Part B and State Services 2011-12	
Homeless Programs get $2.8 Million-chron.com (03/14/12) Award Report & Public Comment	
Comparison of 2010-2012 HOPWA Funding in Texas	
SAMSHA Grant Awards for the Houston EMA/HSDA – October 26, 2011	

Houston Area HIV Services Ryan White Planning Council

"HOW TO BEST MEET THE NEEDS" WORKGROUP

A Subcommittee of the Quality Assurance Planning Committee

Agenda

I. Call to Order

REMIND EVERYONE TO PUT THEIR CELL PHONES ON VIBRATE

A. Moment of Reflection

B. Welcome and Review Workgroup

1. Purpose

The Ryan White Planning Council is responsible for planning the organization and delivery of HIV services, specifically in the areas of outpatient medical care, case management and comprehensive treatment services, for the Houston EMA which includes Harris, Fort Bend, Montgomery, Chambers, Liberty and Waller counties. The Council also makes recommendations regarding Part B and State Services funds for services in the Houston HSDA which includes the six counties of the EMA as well as Austin, Colorado, Walker and Wharton counties. Each year, the Planning Council reviews and refines its service definitions in preparation for the next funding cycle which begins March 1st of the next year for Part A funds, August 1st for Minority AIDS Initiative funds, April 1st for Part B and September 1st for DSHS State Services funding. The purpose of this workgroup is to review specific service category definitions and make recommendations as needed to improve service delivery and effectiveness.

2. Guidelines (see *Workgroup Guidelines* located in this Packet)

All meetings are audio taped by the Office of Support for use in capturing the motions. The audiotape is public record. If you state your name or HIV/AIDS status it will be on public record.

II. Individual Introductions & Declaration of Conflict of Interest (COI)

A. Conflict of Interest:

Conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. To illustrate, conflict of interest occurs when a planning council member has a monetary, personal, or professional interest in a planning council decision or vote.

1. All workgroup participants introduce themselves and declare their COI.
2. Workgroup participants list their COI on the *2012 Conflict of Interest Declaration* form which is being passed around.

B. If there are multiple participants from the same agency, state which person will vote for that agency. Voting cards will be given out to attendees who will vote on recommendations.

III. Role of the staff representative from:

A. Office of Support

Provides guidance on HRSA and County policy that relates to Council processes and work products in order to ensure the Council accomplishes all required and necessary goals and objectives.

(Continued on back)

B. Ryan White Grant Administration

Provides the Council with accurate, timely, aggregate service category specific data and other information needed for the How to Best Meet the Need process and assure all services are in compliance with HRSA rules and regulations.

C. The Resource Group

Provide guidance on HRSA and State policy in order to ensure the Council accomplishes all required and necessary goals and objectives related to Part B and State Services funding.

IV. Determine How the Service Categories Should be Reviewed

A. By the whole workgroup or by small subgroups?

1. Small subgroups report back to the whole group at the end of the meeting; the whole workgroup will then review, make any necessary changes and approve recommendations.

2. If an additional meeting is necessary for one or more subgroups, **a motion is necessary to authorize subgroups to send their recommendations directly to the Quality Assurance Committee as opposed to bringing the workgroup back together to review and approve them.**

V. Background and Information Regarding the Service Categories to be Reviewed

A. Presentation of Needs Assessment data by the Office of Support

B. Presentation of CPCDMS data by Ryan White Grant Administration

VI. Review the Current Service Category Definition

A. Suggest Changes to the Service Definition: (**Please use the *How To Best Meet the Need FY 2013 Justification for Each Service Category* chart to document how the 2011 Needs Assessment or other documents were used in making this decision. See *How To Best Meet the Need FY 2012 Justification for Each Service Category* chart for last year's justification documentation*)***

1. Discuss suggested change(s);
2. Review the current Financial Eligibility;
3. Motion to approve the service category and financial eligibility as presented or with suggested changes;

C. Additional discussion;

D. Vote on the Motion.

***** REPEAT [V. and VI.] FOR EACH SERVICE CATEGORY *****

VII. If an additional meeting is necessary for one or more subgroups: Select a member of the subgroup to present recommendations to Quality Assurance at the meeting on Thursday, May 17, 2012 at 10:00 a.m. in room 532.

VIII. Announcements/Other

IX. Adjournment

Ryan White Part A, Part B and State Services
***"How to Best Meet the Need"* Workgroup Schedule**
(as of 03-12-12)

TRAINING FOR ALL PARTICIPANTS:
1:30 p.m. ~ Thursday, April 12, 2012
2223 West Loop South, Room 416

Information and workgroup packets will be available at this meeting.

After the orientation meeting, packets will be available from the Office of Support:
2223 W. Loop South, Suite 240, Houston, TX 77027; or call 713 572-3724.

Workgroup #1 ***includes the service categories:***

- Ambulatory/Outpatient Medical Care (including Local Pharmacy Assistance, Medical Case Management & Service Linkage)
  - **Adult: targeted to African Americans, Hispanic & White; Rural**
  - Pediatrics
- Clinical Case Management
- Non-Medical Case Management (Service Linkage)
- **Vision Care**
- Early Intervention Services‡

Thursday, April 19, 2012 - 1:00 p.m.
2223 West Loop South, Room 532

Workgroup #2 ***includes the service categories:***

- Professional Counseling (Mental Health) ‡
- Oral Health – Untargeted‡ & Rural
- Substance Abuse Treatment/Counseling
- Health Insurance Premium & Co-pay Assistance‡
- Hospice
- Medical Nutritional Therapy (including Nutritional Supplements)
- Linguistic Services‡

Monday, April 23, 2012 - 1:00 p.m.
2223 West Loop South, Room 532

Workgroup #3 ***includes the service categories:***

- Transportation (**van-based-Untargeted & Rural**)
- Food Pantry (Rural)‡
- **Legal Assistance**
- Home & Community-based Health Services (Adult Day Treatment)‡

Wednesday, April 25, 2012 - 2:00 p.m.
2223 West Loop South, Room 532

Workgroup #4 ***includes the service categories:***

- Blue Book

Tuesday, May 8, 2012 - 10:00 a.m.
2223 West Loop South, Room 240

Part A service categories in BOLD type are due to be RFP'd for FY 2013.

‡ Service Category for Part B/State Services only; Part B and State Services service categories are RFP'd every year.

Timeline of Critical 2012 Ryan White Planning Council Activities

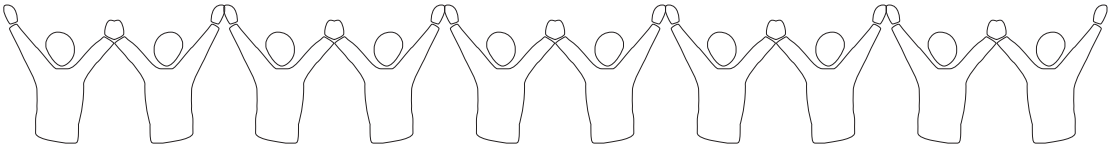
Thurs. April 12	11:30 a.m. The Planning Council meets. One item on the agenda will be to approve the *2012 Houston Area Comprehensive HIV Prevention and Care Services Plan.*
	1:30 – 4 p.m. Training for the How to Best Meet the Need (HTBMN) process. Those encouraged to attend are community members as well as individuals from the Quality Assurance (QA), Priority & Allocations (P&A) and Affected Community Committees. P&A Committee receives their priority setting notebooks.
Thurs. April 19	1 – 4 p.m. HTBMN Workgroup - Outpatient Primary Medical Care, Vision, all Case Management, Local Pharmacy Assistance Program and Early Intervention Services.
Mon. April 23	1 – 4 p.m. HTBMN Workgroup - Mental Health, Substance Abuse, Oral Health, Hospice, Health Insurance, Linguistics & Medical Nutritional Therapy.
Wed. April 25	2 – 5 p.m. HTBMN Workgroup - Transportation, Food, Legal Assistance and Home and Community-based Health Services (Adult Day Treatment).
Thurs. April 26	12:30 p.m. P&A Committee meets to allocate Part A unspent funds.
Tues. May 8	10 a.m. HTBMN Workgroup meets for recommendations on the Blue Book. The Operations Committee reviews the FY 2013 Council Support Budget.
Thurs. May 17	10 a.m. QA Committee meets to approve the FY13 HTBMN results and review subcategory allocation requests. Draft copies are forwarded to the Priority and Allocations Committee.
Mon. May 21	2012 Comprehensive HIV Prevention and Services Plan due to HRSA.
Tues. May 22	7 p.m. Public Hearing on the FY13 HTBMN results.
Wed. May 23	10 a.m. Special QA Committee meeting to review public comments regarding the HTBMN results.
Thurs. May 24	P&A Committee meets to recommend the FY13 service priorities for Ryan White Parts A and B.
Thurs. June 7	12 noon. Steering Committee meets to approve the FY13 How to Best Meet the Need results.
June 7 – 13	Special P&A Committee meetings to draft the FY13 allocations for RW Part A and B and State Services funding.
Fri. June 8	5 p.m. Deadline for submitting New Idea Forms. Please contact the Office of Support at 713 572-3724 to request a copy of the forms.
Thurs. June 14	11:30 a.m. Council approves the FY13 HTBMN results.
Thurs. June 21	10 a.m. QA meets to review the results of the assessment of the administrative mechanism.
Thurs. June 21	The P&A Committee meets to approve the FY13 allocations.
Tues. June 26	7 p.m. Public Hearing on the FY13 service priorities and allocations.
Wed. June 27	12:15 p.m. Special meeting of P&A to review public comments regarding the FY13 service priorities and allocations.
Thurs. July 5	12 noon Steering Committee approves the FY13 service priorities and allocations.
Thurs. July 12	11:30 a.m. Council approves the FY13 service priorities and allocations.
Wed. July 18	Tentative: First class for Project LEAP
Thurs. July 19	If necessary, the P&A Committee meets to address problems Council sends back regarding the FY13 priority & allocations. They also allocate unspent funds.
Thurs. Aug. 2	THIS IS THE LAST CHANCE TO APPROVE ANYTHING NEEDED FOR THE FY 2013 GRANT. (Mail out date for the August Steering Committee meeting is July 26, 2012.)
Fri. Sept. 7	5 p.m. Deadline for submitting New Idea Forms. Please contact the Office of Support at 713 572-3724 to request a copy of the forms.
September	Begin planning for the 2014 HIV/AIDS Needs Assessment.
Thurs. Sept. 13	Tentative: 11:30 a.m. Project LEAP presents results of their Needs Assessment to the Planning Council.
October	Review and possibly update the Memorandum of Understanding between all Part A stakeholders.
Thurs. Oct. 11	11:30 a.m. Council meeting to recognize all external committee members.
Tues. Oct. 16	1 p.m. Consumer Workgroup to review FY13 Standards of Care and Outcome Measures.
Oct/Nov	Workgroups meet to review FY13 Standards of Care and Outcome Measures for all service categories.
	Review the evaluation of 2012 Project LEAP. HTBMN workgroup to make recommendations for 2013 Project LEAP.
Thurs. Nov. 8	11:30 a.m. Project LEAP Graduation and Planning Council meeting.
Tues. Nov. 20	9:30 a.m. Commissioners Court to receive the World AIDS Day Resolution.
Nov. 27 – 29	HRSA Conference in Washington DC
Sat. Dec. 1	World AIDS Day.
Thurs. Dec. 13	11:30 a.m. Council meeting to elect the 2013 Council officers.

FY 2013 How to Best Meet the Need Process
Workgroup Guidelines

1. **All meetings are audio taped by the Office of Support for use in capturing the motions. The audiotape is public record. If you state your name or HIV/AIDS status it will be on public record.**
2. All work group participants must familiarize themselves with the Ryan White Planning Council's Conflict of Interest Policy. (This will be reviewed at the beginning of each work group meeting.)
3. **All work group participants are required to sign-in on the Conflict of Interest sheet indicating services with which they have a conflict of interest.**
4. Work Groups will use Robert's Rules of Order as a guideline for conducting business. Therefore, Work Group Chairs will ask for motions, a second to a motion, and a vote on all work group recommendations. The staff from the Office of Support will record all recommendations.
5. **According to the bylaws of the Ryan White Planning Council, "Only one voting member per agency will be permitted to vote. " Therefore, agencies sending more than one representative to a particular work group must declare at the beginning of the meeting which participant will be casting the vote throughout the meeting.**
6. The participant selected to represent the agency can vote on any recommendation unless the individual has a conflict of interest with the recommendation. (See the Ryan White Planning Council's Conflict of Interest Policy for further clarification.)
7. **All recommendations made by the "How to Best Meet the Need" Work Groups are sent to the Quality Assurance Committee for review, possible revision, and possible approval. Recommendations that are not approved by the Quality Assurance Committee are not forwarded to the Steering Committee or full Council.**

6 Section VI

Conflict of Interest



Introduction

Conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. To illustrate, conflict of interest occurs when a planning council member has a monetary, personal, or professional interest in a planning council decision or vote.

CARE Act Title I legislative provisions on conflict of interest for the planning council as a whole are limited to restrictions on planning council involvement in the management of grant funds and participation in the selection of particular entities as recipients of those funds. In addition, planning council membership requirements in the Amendments of 2000 for representation by "unaligned" consumer members require attention to conflict of interest.

Because the potential for conflict of interest is inherent in all of the activities of the planning council, HAB/DSS has broader expectations and requirements regarding minimizing and managing conflict of interest in the general functioning of the planning council. Each of these areas is discussed below.

Legislative Background

CARE Act legislative provisions on conflict of interest prohibit three types of activities:

- Planning council involvement in the management of grant funds.
- Planning council participation in the selection of particular entities as recipients of those funds.
- A financial or governance relationship with funded providers on the part of "unaligned" consumer members of the planning council.

CARE Act legislative provisions governing these restrictions are as follows:

Section 2602(b)(1) requires that candidates for planning council membership "be selected based on locally delineated and publicized criteria" and that "such criteria shall include a conflict-of-interest standard for that is in accordance with paragraph (5)."

Section 2602(b)(5)(A) (the "paragraph 5" referenced above) addresses conflict of interest for the planning council as a whole. It requires that "The planning council... may not be directly involved in the administration of a grant...[and] may not designate (or otherwise be involved in the selection of) particular entities as recipients of any of the amounts provided in the [Title I] grant."

Section 2602(b)(5)(B) addresses conflict of interest for individual members of the planning council. It states that "An individual may serve on the planning council...only if the individual agrees that if the individual has a financial interest in an entity, if the individual is an employee of a public or private entity, or if the individual is a member of a public or private organization, and such entity or organization is seeking [Title I funding], the individual will not, with respect to the purpose for which the entity seeks such amounts, participate (directly or in an advisory capacity) in the process of selecting entities to receive such amounts for such purpose."

As explained in the Conference Report accompanying the CARE Act Amendments of 1996, it is the intent of the legislation that the planning council "provide guidance to the grantee regarding the types of organizations that may best meet each service priority established by the planning council" and "help to guide the grantee in how best to meet the established service priorities." It is not intended "that the planning council select which particular organizations receive funding, either by specific direction or by narrowly describing a type of organization. The legislation clearly states that such a planning council role is prohibited."

Regarding conflict of interest by "unaligned" consumer representatives on planning councils,

Section 2602(b)(5)(C) of the Act requires that consumer representatives be individuals "who are receiving HIV-related services" from Title I funded providers; but "who are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity."

HAB/DSS Expectations

Below are HAB/DSS expectations and requirements for addressing conflict of interest—overall and in specific areas.

General Requirements

CARE Act conflict-of-interest provisions reinforce the distinction between the planning council's responsibility to set priorities and the grantee's responsibility to procure particular services. Specifically, the law prohibits the planning council as a whole from being directly involved in either the administration of a grant or participating in the selection of particular entities to receive Title I funds. This means that planning councils may not:

- Name, recommend, or approve particular entities for funding
- Be involved in the management of the contracts that govern the procurement of services, or
- Participate or otherwise be involved in the review of funding applications or selection of providers of services.

Such activities are responsibilities of the grantee and/or the administrative agent of the grantee. They include developing requests for proposals (RFPs), conducting technical assistance and bidders' conferences, conducting the application review process, negotiating contracts, awarding funds, developing reimbursement and accounting systems, and conducting program and fiscal monitoring.

Because planning council members may include representatives of the Title I grantee, use of CARE Act funds by the grantee may pose conflict of interest issues. Use of Title I funds by the Title I grantee for delivery of particular services (*e.g.*, medical care through a health department clinic) should be based on direction from the planning council and/or an objective review process. While local rules on procurement of services may allow the grantee to use funds it administers for its own services, HAB/DSS expects that such use will be subject to a public process if other entities in the community could provide the same services. Such a process is in keeping with the spirit of the CARE Act, which bases the appropriate and efficient use of scarce resources on input from community and organizational representatives who are directly affected by the HIV epidemic.

Planning Council Support and Program Support

While the legislation prohibits planning councils from participating or otherwise being involved in selecting particular entities for funding, they may be involved in selecting particular entities and individuals to carry out activities directly related to planning council functions and responsibilities. These activities include:

- General planning council administrative duties
- Developing and carrying out needs assessments
- Studying barriers to care
- Conducting planning activities
- Evaluating the administrative mechanism
- Capacity development
- Technical assistance
- Program evaluation, and
- Assessment of service delivery patterns.

In making determinations about who will carry out these activities, planning councils should be keenly attuned to potential conflicts of interest (real or perceived). HAB/DSS expects that planning councils and grantees will work together to ensure that high quality planning council support is available and that conflict of interest will be minimized through a mutually agreeable process. The planning council must use an open, public process to contract for planning council support services—preferably a competitive RFP process under the direction of the grantee. If a planning council's procedures allow planning council members or the agencies they represent to compete in this process, the planning council must define specific parameters and processes to manage real or perceived conflicts of interest. A planning council member who has a financial interest in, is an employee of, or is a member of that entity should not be involved or otherwise participate in the selection process.

Conflict of Interest and How Best to Meet Priorities

The CARE Act Amendments give planning councils the responsibility not only to set priorities, but also to establish how best to meet those priorities. The intent of this legislative provision is to establish a role for the planning council in guiding the grantee in identifying the types of organizations and service delivery mechanisms that best meet each service priority established by the council. Types of organizations may include, for example, outpatient clinics, community-based organizations that serve affected populations and historically underserved communities, and other types of entities that have been identified as effective in serving identified populations. Planning councils may also identify certain population groups that need to be served, geographic areas in which services should be delivered, and particular State or local government programs that the planning council feels best meet the needs of people living with HIV disease (*e.g.*, a State AIDS Drug Assistance Program [ADAP] or health department clinic).

The language developed by the planning council regarding how best to meet each service priority may not name particular providers as recipients of funds. Nor may the planning council participate or otherwise be involved with drafting specific contract proposal review criteria, reviewing funding applications, and selecting service providers. The grantee, not the planning council, is responsible for developing and implementing an RFP and contract award process. The grantee is obligated to ensure that the outcome of that process meets the priorities established by the council, including directions from the planning council regarding how best to meet the priorities and the dollar amounts allocated to each priority area.

HAB/DSS recognizes that in some EMAs and for some service categories with a small provider pool, language on how best to meet the priority may result in only a few or a single provider applying for funds. As long as the planning council does not name a particular provider, however, the council is not in violation of the conflict of interest requirements in the Act. A planning council's designation of the State ADAP program and/or a local health department program as the best way to meet a service priority does not violate conflict of interest requirements.

Monitoring Contracts and Redistribution of Funds

The planning council is prohibited from being involved in grant administration, and therefore, may not be involved in monitoring the fiscal or program performance of individual contractors. These activities are the responsibility of the grantee. The planning council may, however, provide the grantee with guidance on the types of information that should be included in the monitoring process and the methods of analysis.

Planning councils cannot name, recommend, or otherwise be involved in the approval of particular providers if a grantee redistributes program funds based on monitoring of individual contracts. However, the planning council must be informed of the changes to service priority allocations that result from any redistribution of program funds by the grantee. As with the initial disbursement of funds, the outcome of the redistribution must be consistent with the priorities and resource allocations of the planning council.

The grantee must also share information with the planning council so that both can monitor spending on each of the service categories identified as priorities by the planning council. The planning council should be able to readily evaluate the level of expenditure, number of people

served, and other aggregate information for particular service categories and target populations. If money is not being spent in a timely fashion, or target populations are not being served, the planning council can reallocate funds to another service category. The grantee and the planning council must work together to share appropriate information and ensure that any changes to the planning council priorities are reflected in the grantee's disbursement (or re-disbursement) of funds.

Managing Conflict of Interest

HAB/DSS expects planning councils to include in their bylaws and operating procedures provisions for handling conflict of interest in carrying out all planning council activities. Provisions should define conflict of interest and outline ways to manage it. These areas are described below.

Defining Conflict of Interest

Conflict of interest can be defined as *an actual or perceived interest by the member in an action that results or has the appearance of resulting in personal, organizational, or professional gain*. This actual or perceived bias in the decision-making process is based on the dual role played by planning council members who are aligned with other organizations as an employee, a Board member, a member, or in some other capacity. Most State and local governments have conflict of interest standards in place. Planning councils may wish to refer to them and assess whether they are applicable or can be adapted to the needs of the planning council.

Areas Where Conflict of Interest Can Happen

Although the legislation does not define conflict of interest beyond its relationship to the selection of particular entities, the potential for conflict of interest is present in all CARE Act processes: needs assessment, comprehensive planning, priority setting, allocation of funds, and evaluation. Because the activities of the planning council are so central to the allocation and disbursement of resources within an EMA, the actions of any one member or a group of planning council members can actually be—or be perceived to be—based on individual rather than common interest. It is the responsibility of the planning council as a whole to define conflict of interest, and to specify those actions to which it applies and the types of relationships covered by it.

Following are conflict of interest considerations for specific areas:

Membership. In most instances, conflict of interest does not refer to persons living with HIV disease (PLWH) whose sole relationship to a Title I-funded provider is as a client receiving services or serving as an uncompensated volunteer. However, PLWH, like other planning council members, should not be involved in decisions that can affect entities in which they have a financial interest or a governance responsibility. Examples of financial interest include being officers, employees, or paid consultants to Title I provider agencies or to the administrative agency that administers that Title I grant.

Many members wear "multiple hats" and thus need to clearly identify the perspective they are representing in their membership. A good example of this is the member who is an employee of a funded provider, is a PLWH, and is a member of a community of color.

Expectations should be clearly defined for members who represent a community. A good planning process gathers diverse perspectives. However, the role of a representative should be communicated clearly, including a job description stating how the representative is expected to communicate with members of the community they represent. This would help deal with a problem where PLWH either come with a personal agenda or advocate for a particular service provider.

Leadership. An actual or perceived conflict of interest can occur when planning councils are chaired solely by a representative of the grantee. Therefore the 2000 CARE Act Amendments stipulate that councils cannot be chaired solely by an employee of the grantee. It can, however, be co-chaired by a grantee representative along with another member of the council.

Needs Assessment. An actual or perceived conflict of interest can occur in the conduct of a needs assessment, particularly with respect to its implementation in planning, priority setting, and resource allocation. Conflict of interest can emerge at decision points of the needs assessment process such as the following:

- How to conduct a needs assessment
- Which groups to survey
- What questions to ask
- How to phrase the questions
- How to interpret the results
- How to review external data, such as epidemiologic data
- Which data to use, and
- Which results to implement.

A good needs assessment contains input from consumers and providers, as well as players beyond the currently funded providers. As such, examples of conflict of interest regarding their input into a needs assessment process might include the following:

- A provider convinces the council to overemphasize the input of its own clients
- A provider representative determines which agency clients (*e.g.*, the happy ones!) should be targeted for the needs assessment, and
- The needs assessment is limited to soliciting the opinions of planning council members and no one else.

Priority Setting and Resource Allocation. Examples of conflict of interest in the priority-setting process include the following:

- Failure to use the council's criteria to set priorities, and instead advocating for one's own interests.
- A choice to fund services that do not match the needs identified in the needs assessment.
- Priorities that are set based on who was the most vocal at the priority-setting meeting.

When setting priorities, planning councils should look at the big picture—the continuum of care—rather than focus on individual categories of funding. An overall plan minimizes the chances for a single advocacy group to dominate. The setting of priorities should flow from the results of

the needs assessment, not from the individual interests of the members. Funding decisions should reflect changes in the local epidemic and in meeting the service gaps and unmet needs of PLWH in their region. In justifying priorities, planning councils should discuss the availability of other funding sources to lessen the need for Title I funding of a particular service and reduce duplication of effort. Priorities set by the council should seem reasonable to an objective viewer.

Comprehensive Planning. In comprehensive planning, conflict of interest can lead to problems such as the following:

- Inadequate planning for underserved populations and subpopulation groups
- Lack of follow-through with the results of needs assessments, and
- An ineffective planning process that results in an ineffective service delivery system not responsive to a changing epidemic.

For effective planning, develop a structure for planning that includes specific steps in the development of a plan and a timeline for implementation. A clearly defined planning process prevents persons or organizations with conflicts of interest from directing the process in a biased or unfair way and helps ensure that a plan is followed.

Evaluation. Planning councils are responsible for evaluating their own planning process and their cost-effectiveness and efficiency in meeting the needs identified by their needs assessment. The results of this evaluation should be used to improve the council's ability to plan and deliver high quality, cost-effective services to meet the needs of PLWH in their communities. However, conflict of interest can influence:

- The extent to which evaluation is conducted
- How it is conducted
- Who can conduct it
- What the results are, and
- How the results will be interpreted and used.

Conflict of interest can lead to a stagnant process where the *status quo* is maintained with no real evaluation of the planning council's efficiency and effectiveness.

Techniques for Managing Conflict of Interest

HAB/DSS expects planning councils to employ a variety of strategies to minimize conflict of interest and its potential adverse effects, such as keeping members self-aware of the potential for conflict of interest and using procedures that can minimize or address conflicts. Examples are as follows:

- **Disclosure Forms**. Many groups require members to complete forms that identify any conflicts. The form might include all of the following:
  - Relationships the member has to an organization that could benefit from an action by the planning council, including the nature of the conflict (*i.e.*, the person or organization that can benefit from the action)
  - The relationship that causes the potential conflict of interest
  - The duration of the conflict of interest, and
  - What actions will be used to resolve a conflict of interest.

Members might be required to declare their potential conflicts of interest annually, semi-annually, or even at every meeting. Sometimes disclosure is specifically required any time discussion or decision making involves an entity or situation in which the member has a real or perceived conflict of interest. Disclosure forms should be updated routinely to maintain accurate information.

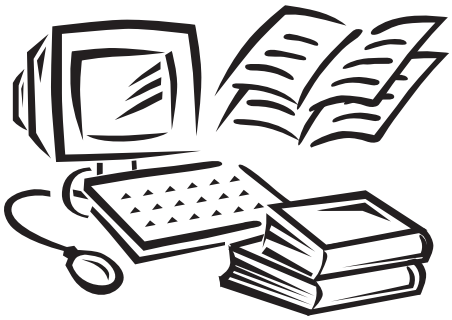
- **Reminders of Conflict of Interest**. Among other actions that may be useful in increasing planning council member awareness of conflict of interest are the following reminders:
  - Provide a matrix of members and their conflicts of interest at every meeting
  - Provide members with the planning council's mission statement to remind them of the purpose of their work, and
  - Require members to sign a declaration of commitment to the purposes of the planning council.
- **Input During Meetings**. Orderly processes that can reduce conflict include allowing for regular input from planning council and community members at meetings. Requests for time to comment on concerns should be submitted in advance of meetings and the time allocated should be limited, while allowing for diverse expression and full debate.
- **Other Forums for Input**. Input beyond the planning council membership can include consumer caucuses, provider caucuses, support groups, and ad hoc committees to get input at each step of the process.
- **Clear Processes with Open Participation**. Processes that are well defined and open to the public protect the interests of all planning council members. Included in those processes should be avenues for broad and balanced input from a variety of sources. The needs assessment process, for example, must include input from providers and consumers and should not be dominated by a particular group. Similarly, comprehensive planning activities should be based on a clear structure and process that identifies action steps, timelines, and specific roles and responsibilities. Perhaps most important, the setting of priorities must flow from the results of the needs assessment and comprehensive planning process.
- **Memorandum of Understanding Between Planning Council and Grantee**. This document can outline duties of each entity and the roles of particular staff so that expectations are clear.
- **Member Term Limits and Staggered Terms**. This can allow for new voices to be heard.
- **Conflict of Interest Standards**. Successful resolution of conflict of interest situations requires adoption of conflict of interest standards and their routine application in planning council decisions. Such standards should be outlined in the planning council's bylaws. The planning council needs to decide what it considers to be a fair and practical method to manage and resolve conflict of interest issues, recognizing that no solution is perfect. Conflict of interest cannot be fully prevented or resolved; it can be managed consistently and fairly. Specific standards include the following:
  - Prohibit those with a potential conflict of interest from voting on issues relating to a particular organization or category of service.
  - Ask anyone with a potential conflict of interest to leave the room during the discussion of that category of service or organization as well as while a vote is being taken.

- Assign a co-chair or a committee to review all conflict of interest concerns. Authorize any planning council member to make a request for review of a perceived conflict of interest; define the process of review in writing, establishing timelines so that any review is undertaken in an expeditious manner; and establish policies for dealing with members who engaged in a conflict of interest and/or refused to cooperate in a conflict of interest review.

- **Grievance Procedures**. In cases where a conflict of interest evolves into a dispute, the planning council may need to turn to grievance procedures to resolve the situation (see the chapter on Grievance Procedures).

R E F E R E N C E S

Health Resources and Services Administration, HIV/AIDS Bureau. *TA Topics #1: Managing the Conflict of Interest Challenge*. Rockville, MD: U.S. Department of Health and Human Services, November 1994.



HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL

EST. JUL. 15, 1998 REV DECEMBER 13, 2007 POLICY No. 800.01

CONFLICT OF INTEREST

PURPOSE

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

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

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

AUTHORITY

The CARE Act Amendments of 2000 through 2006 Sec.2602(b)(1);Sec.2602(b)(5)(A); Sec.2602(b)(5)(B);Article VIII,Sec8.01 of the Bylaws of the Houston Area HIV Health Services (RW) Planning Council 2001.

DEFINITION(S)

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

PROCESS

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

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

RWPC members must complete a COI Disclosure Form annually and/or as needed, describing the relationship of the person to each organization that can benefit from an action by the RWPC. This information, in the form of a matrix of members and their conflicts of interest, will be provided to all

members of the RWPC. Additionally all RWPC members will identify conflicts of interest during a discussion and/or vote and abstain from voting on issues pertaining to that conflict. All RWPC members are encouraged to request a review of potential COI of another member during a RWPC meeting.

The Secretary of the RWPC has responsibility for addressing actions to resolve COI when they occur (see RWPC Policy500.01). When the Secretary has a COI, monitoring voting for COI and processing inquiries related to COI will fall to the role of the Council Vice Chair, if the Council Vice Chair has a COI the responsibility will fall to the Council Chair. If still unresolved then the responsibility will fall to the Chair of the Operation Committee.

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

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

COI INQUIRY/INTRODUCTION/PROCEDURE:

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

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

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

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

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

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

Step 3: The member will briefly express his/her complaint and propose, as a motion, a solution. The motion is the actual question of privilege or a request to inquire about a COI.

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

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

As soon as the interrupting question of privilege is disposed of, the assembly resumes consideration of the

question that was interrupted.

METHOD OF DISCLOSURE:

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

RESOLUTION OF CONFLICT OF INTEREST:

Ryan White Planning Council's "APPROPRIATE STEPS FOR CONFLICT RESOLUTION" five-step process will be followed. (See RWPC Steps to Conflict Resolution Form).

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

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

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B and State Services in the Houston EMA/HSDA as of 03-03-12							
Ambulatory/Outpatient Medical Care:							
Adult – Part A (Includes OB/GYN) *See below for Pediatric and Vision Care.*	✔ Yes ___No					Bundled with: Local Pharmacy Asst, Medical Case Mgmt, Nutritional Counseling, Service Linkage, Treatment Adherence	
Pediatrics	✔ Yes ___No					Bundled with: Medical Case Mgmt, Nutritional Counseling, Service Linkage, Treatment Adherence	
Vision	✔ Yes ___No						

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Adult - Part B	✔ Yes ___No					Bundled with: Local Pharmacy Asst. Medical Case Management Nutritional Counseling Treatment Adherence	
Case Management - Medical ***(Clinical only)*** Part A State Services	✔ Yes ___No					Bundled with: Client Advocacy Referral	
Case Management – Non-Medical (Service Linkage at HIV testing sites)	___Yes ✔ No					Bundled with: Client Advocacy Referral	

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Early Intervention Services‡ (Incarcerated)	✔ Yes ___No						
Food Bank - Rural‡	___Yes ✔ No						
Health Insurance Co-payments & Co-insurance‡	✔ Yes ___No						

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Home and Community-based Health Services: Facility-based‡ (Adult Day Care)	___✔___Yes ___No						
Hospice Services (Complimentary core service)	___✔___Yes ___No						
Legal Assistance Part A State Services-Rural	___Yes ___✔___No					Bundled with: Child Welfare Services Permanency Planning	

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Linguistic Services ‡	___Yes __✔__No						
Medical Nutritional Therapy (Nutritional Counseling & Nutritional Supplements)	__✔__Yes ___No						

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Mental Health‡ (Professional Counseling)	✔ Yes ___No						
Oral Health (Dental)**:** Untargeted‡ Rural (North)	✔ Yes ___No						
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							
Planning Council Support	___Yes ✔ No						

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	**Is this a core service?** If no, how does this service support access to core services and support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	**Documentation of Need** (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	**Identify non-Ryan White/ non-State Services Funding Sources** (Alternative Funding Sources)	**Justify the use of Ryan White Part A, Part B and State Services funds for this service**	**a. Can we bundle the service?** **b. Is this a duplicative service or activity?** **c. Make service delivery more efficient?** **d. Has a recent capacity issue been identified?**	**Recommendation(s)**
Project LEAP	___Yes __✔__No						
Blue Book	___Yes __✔__No						
Substance Abuse Treatment	__✔__Yes ___No						

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, Comp Plan, Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Transportation (Van-based, bus passes & gas vouchers)	___Yes __✔__No						

(over)

‡ Service Category for Part B/State Services only.

FY 2013 How to Best Meet the Need Justification for Each Service Category

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 03-01-12 *(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 p.m. on June 8, 2012**. This form is available by calling the Office of Support: 713 572-3724)*	
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.
Emergency Financial Assistance	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.)
Food Pantry (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.
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.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
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.

FY 2012 How to Best Meet the Need Justification for Each Service Category — Council Approved 06/09/2011

Service Category	Is this a core service? If no, how does this service support access to core services and support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA:* Early Identification of Individuals unaware of their HIV/AIDS status; and **Unmet Need:* PLWHA aware of their HIV+ status but not in medical care.	Documentation of Need (Examples: from the 2011 Needs Assessment, 2009 Comp Plan (CP), Outcome Measures, State of Emergency, etc.)	Identify non-Ryan White/ non-State Services Funding Sources (Alternative Funding Sources)	Justify the use of Ryan White Part A, Part B and State Services funds for this service	a. Can we bundle the service? b. Is this a duplicative service or activity? c. Make service delivery more efficient? d. Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B and State Services in the Houston EMA/HSDA as of 03-03-11							
Ambulatory/Outpatient Medical Care:							
Adult – Part A (Includes OB/GYN) *See below for Pediatric and Vision Care; Part B.*	✔ Yes ___No	**Primary Care** is the EIIHA linkage component. **Medical Case Management** gets and keeps clients in other core medical services. **Local Pharmacy Assistance Program** does not get people into care, but it helps keep them in care. These clients are captured in the statewide network. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17%	• **See FY 2012 Data Summary Chart and charts from Ryan White Grants Admin. (RWGA) for more data than provided below.** • **Number of new clients with no RW services in the 12 months prior to the FY10 grant year start: 2,387.** • **For all FY10 Outcome Measures: See FY 2012 Data Summary Chart.** **Primary Care:** *2010 Client Utilization:* Primary Care (total): # clients served 7,035 Avg expend/client: $1,451 **Medical Case Management:** *2010 Client Utilization:* # served 5,626	**Primary Care:** Medicaid/Medicare **Medical Case Mgmt**: Part C and D **Non-Medical Case Mgmt**: Part D **Local Pharmacy Assistance Program**: This service compliments the state ADAP program, the State Pharmacy Assistance Program, the public clinic's pharmacy program, Medicare Pt. D and the RW Health Insurance Program.	**Primary Care**: This is a HRSA defined core service. RW is used as the funding of last resort. 2011 Needs Assessment shows Primary Care is the highest reported need. **Medical Case Mgmt**: This is a HRSA defined core service. **Local Pharmacy Assist Program:** 2011 NA shows high need for service. Access to medications helps maintain health status. This program cannot be accessed unless the client is receiving primary care.	**a-** Bundled with: Medical Case Management, Non-Medical Case Mgmt, Local Pharmacy Assistance, Nutritional Counseling, Treatment Adherence **b-** No **c-** No **d-** No, all providers currently meet the national standard of 3rd next appointment availability of 15 days. ***FOR MOST SERVICE CATEGORIES PLEASE NOTE:*** In April 2010, the Program Coordinator for the CDC funded Opt Out Testing Program stated that, "since August 2008, opt out testing in Harris County Hospital District facilities alone found 400 new HIV	• Accept the service category definition as presented. • Keep the financial eligibility at the current level for each service category: - Primary Care: 300% - Med Case Mgmt: none - LPAP: 300% non-HIV, 500% HIV meds

‡ Service Category for Part B/State Services only.

		Race/Eth: White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	Avg expend/client: $455 **Non-Medical Case Mgmt**: *2010 Client Utilization:* # served 4,925 Avg expend/client: $150 **Local Pharmacy Assistance Program:** *2010 Client Utilization:* # served 3,080 Avg expend/client: $925			positive individuals and 810 HIV positive individuals who had already tested positive. Most of the 810 individuals were not in care “.	
Pediatrics	✔ Yes ___No	Primary Care is the EIIHA linkage component. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	09 CP: A1, A2, B1, B2 , B3, C1, E2, F1, F2 90 children (ages 0-12) were served For all FY10 Outcome Measures: See FY 2012 Data Summary Chart.	Children’s Health Insurance Program Medicaid provides most of the primary medical care for pediatric clients. RW funds are used for medical case mgmt.	This is a HRSA defined core service. RW is used as the funding of last resort.	**a-** Bundled with: Medical Case Management Nutritional Counseling Treatment Adherence **b-** No **c-** No **d-** No	• Accept the service category definition as presented and keep the financial eligibility at 300%.
Vision	✔ Yes ___No		*2010 Client Utilization:* # served 1,474 Avg expend/client: $101 For all FY10 Outcome Measures: See FY 2012	No other resource for HIV related vision care.	HRSA defined core medical service. The standards of care requires that clients must be checked for HIV-related pathology.	**a-** Bundled with: Primary Care **b-** No **c-** No **d-** No	• Accept the service category definition as presented and keep the financial eligibility at 300%.

‡ Service Category for Part B/State Services only.

			Data Summary Chart.				
Adult - Part B	✔ Yes ___No	Primary Care is the EIIHA linkage component. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	See documentation under Adult-Part A on page 1.	**Primary Care:** Medicaid/Medicare **Medical Case Mgmt**: Part C and D **AIDS Pharmaceutical Assistance Program**: This service compliments the state ADAP program, the State Pharmacy Assistance Program, Medicare Pt. D and the RW Health Insurance Program.	**Primary Care**: This is a HRSA defined core service. RW is used as the funding of last resort. 2011 Needs Assessment shows Primary Care is the highest reported need. **Medical Case Mgmt**: This is a HRSA defined core service. **Local Pharmacy Assist Program:** 2011 NA shows high need for service. Access to medications helps maintain health status. This program cannot be accessed unless the client is receiving primary care.	**a-** Bundled with: Medical Case Management AIDS Pharmaceutical Assist Nutritional Counseling Treatment Adherence **b-** No **c-** No **d-** No	• Accept the service definition as presented and keep the financial eligibility at the current level for each service category: - Primary Care: 300% - APA: 300% non-HIV, 500% HIV meds - Med Case Mgmt: none
Case Management - Medical ***(Clinical only)*** Part A/Part B	✔ Yes ___No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:**	See *Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs*, published by the US Dept. of Health and Human Services, CDC and HRSA, Aug. 2008 *2010 Client Utilization:* # served 870 Avg expend/client: $529	Part C and D	This is a HRSA defined core service.	**a-** Bundled with: Client Advocacy Referral **b-** No **c-** No **d-** No	• Accept the service category definition for Part A and B as presented. • Keep the financial eligibility at none.

‡ Service Category for Part B/State Services only.

		White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	11 NA: See data summary chart. 09 CP: A1, A2, B1, B2 , B3, C1, E2, F1, F2. For FY10 Outcome Measures: See FY 2012 Data Summary Chart.				
Case Management – Non-Medical (Service Linkage at HIV testing sites)	___Yes __✔__No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	According to the CDC, as of 2006 approximately 21% of individuals infected with HIV are unaware of their status. See *Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs*, published by the US Dept. of Health and Human Services, CDC and HRSA, Aug. 2008 *2010 Client Utilization:* # served 236 Avg expend/client: $926 For FY10 Outcome Measures: See FY 2012 Data Summary Chart.	Pt C and D and HOPWA	This service is a bridge which gets clients into care. Helps find people who are out of care including those who have fallen out of care.	**a-** Stand alone service but located at testing sites and includes Client Advocacy & Referral **b-** No **c-** No **d-** No	• Accept the service category definition as presented. • Keep the financial eligibility at none.
Early Intervention Services ‡ (Incarcerated)	__✔__Yes ___No	Testing and medical care/medications are provided in the jail/prison.	*2010 Client Utilization:* # served 863 Avg expend/client: $193	This service no longer receives general revenue dollars.	The incarcerated population has a high prevalence rate and cannot access other services. EIS provides continuity of care before and after release.	**a-** No **b-** No **c-** No **d-** No	• Accept service definition as presented. • Keep the financial eligibility at none.
Food Bank - Rural ‡	___Yes __✔__No	By definition the service does not link clients to care but it indirectly links people back into care by targeting the	*2010 Client Utilization* # served 95	See list of food pantries in the EMA/HSDA compiled from the United Way database, April 12, 2011.	Food Pantry eligibility is limited to those in rural areas. Convicted felons are not	**a-** No **b-** Yes, but local pantries may not have food to meet the needs of	• Update service category definition to be a voucher only program and keep the

‡ Service Category for Part B/State Services only.

		recently released and others. Client must see the doctor before receiving this service. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%			allowed to access food stamps. Also, many food pantries are zip code specific.	HIV+ individuals. **c-** No **d-** No	financial eligibility at 125%.
Health Insurance Co-payments & Co-insurance	__✔__Yes __No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:**	*2010 Client Utilization:* # served 872 Avg expend/client: $1,723 For FY10 Outcome Measures: See FY 2012 Data Summary Chart.	A few other agencies provide this service.	Ensures access to medication, supports core services and provides inpatient care. Saves Ryan White money by keeping people out of Ryan White funded care system.	**a-** Can't bundle **b-** No **c-** Supports access to primary medical care by extending existing health insurance coverage. **d-** No	• Accept service definition as presented and keep the financial eligibility at 500%.

‡ Service Category for Part B/State Services only.

		White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%					
Home and Community-based Health Services: Facility-based‡ (Adult Day Care)	__✔__Yes __No	Not applicable. Must have a doctor's order in order to receive this service. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	*2010 Client Utilization:* # served 58 Avg expend/client: $4,302	Medicaid/Medicare reimbursable for those who are authorized@ $12.50/day and HOPWA funding is available.	Saves money by keeping people out of more expensive, possibly RW funded, care facilities. The social support leads to medication adherence.	**a-** No **b-** No **c-** N/A **d-** No	• Accept the service category definition as presented and keep the financial eligibility at 300%.
Hospice Services Part A/Part B	__✔__Yes __No	Not applicable.	*2010 Client Utilization:* # served 69 Avg expend/client: $6,129 For FY10 Outcome Measures: See FY 2012 Data Summary Chart.	Medicare/Medicaid will pay for home-based hospice services.	HRSA defined core service. Represents an option on the last track of the continuum of care. Other providers cannot take homeless and are limited	**a-** No **b-** No **c-** No **d-** Occasional waiting list	• Accept service definitions for Part A and Part B as presented and keep the financial eligibility at 300%.

‡ Service Category for Part B/State Services only.

					by the number of indigent clients they can take.		
Legal Assistance Part A State Services-Rural	__Yes ✔ No	This service links clients with non-RW benefits which means they may not need RW funded medical care. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	*2010 Client Utilization:* # served 382 Avg expend/client: $996 For FY10 Outcome Measures: See FY 2012 Data Summary Chart.	Other legal aid services are available, but not HIV-specific.	A gap would be created if Part A or SS funds were to be withdrawn.	**a-** Bundled with: Child Welfare Services Permanency Planning **b-** No **c-** No **d-** No	• Accept the service category definitions for Part A and State Services with one change: under Local Service Category Definition, replace 'comprehensive' with 'Ryan White eligible' and keep the financial eligibility at 300%.
Linguistic Services ‡	__Yes ✔ No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30%	*2010 Client Utilization:* # served 34 Avg expend/client: $824	Lutheran Social Services and DSHS will provide limited funding, but no other significant funding source.	Absence of this service would increase the cost of primary care to the provider because it is a required service in order to obtain conformed consent. Also, it would limit access to core services for some clients.	**a-** No **b-** No **c-** No **d-** The AA is unaware of a waiting list but at times the services exceed the amount of the allocation.	• Accept the service category definition as presented and keep the financial eligibility at 300%.

‡ Service Category for Part B/State Services only.

		55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%					
Medical Nutritional Therapy: Nutritional Counseling & Nutritional Supplements	✔ Yes ___No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	*2010 Client Utilization:* # served 890 Expend/client: $246 For FY10 Outcome Measures: See FY 2012 Data Summary Chart.	Nutritional counseling and supplements have few to no alternative resources.	Nutritional counseling and supplements are directly tied to treatment adherence.	**a-** Nutritional supplements and counseling are bundled **b-** No **c-** No **d-** No	• Accept the service category definition as presented and keep the financial eligibility at 300%.
Mental Health (Professional Counseling)	✔ Yes ___No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:**	*FY 2010 Client Utilization:* # served: 336 Expend/client: $751	Medicare, Medicaid, private insurance and self pay. Some MHMRA funding.	HRSA defined core service. Primary care chart review data shows that 50% of clients had a mental health co-morbidity.	**a-** No **b-** No **c-** No **d-** No	• Accept the service category definition as presented and keep the financial eligibility at 300%.

‡ Service Category for Part B/State Services only.

		2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%					
Oral Health (Dental)**:** Untargeted Rural (North)	___✔___Yes ___No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	*2010 Client Utilization:* # served: 2,735 Expend/client: $651 For FY10 Outcome Measures: See FY 2012 Data Summary Chart. *FY10 Outcome Measures:*	There is a dental reimbursement under Pt F but not in Houston.	HRSA defined core service. Not funded elsewhere specifically for PLWH/A.	**a-** No **b-** No **c-** No **d-** Yes, clients from the Beaumont and Galveston HSDAs utilize the local provider	• Accept the service category definition as presented and keep the financial eligibility at 300%.
Substance Abuse Treatment	___✔___Yes ___No	Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care:	*2010 Client Utilization:* # served: 37 Expend/client: $1,779 For FY10 Outcome	Medicare, Medicaid, private insurance and self pay. Some state and federal dollars. SAS =	HRSA defined care service. Chart review data continues to show high percent of clients	**a-** No. **b-** NA **c-** NA **d-** No, but the number	• Accept the service category definition as presented and keep the financial eligibility at

‡ Service Category for Part B/State Services only.

		PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **Age:** 2-12: <1% 13-24: 05% 25-44: 48% 45-54: 30% 55+: 17% **Race/Eth:** White: 26% Black: 51% Latino: 21% **Mode:** MSM: 48% IDU: 14% Het: 31% Other: 7%	Measures: See FY 2012 Data Summary Chart.	$42,000.	using this service use primary care.	of clients fluctuates greatly.	300%.
Transportation Van-based	___Yes ___✔___No	Bus passes are provided to newly diagnosed so they can access primary care. Through 2009, approx. 20,945 living with HIV/AIDS (12,075 PLWA & 8,870 PLWH); 66% estimated to be in care: PLWA: 61%; PLWH: 55% 39% not in care (unmet need): PLWA: 34%; PLWH: 45% **SEE ABOVE FOR AGE, RACE/ETH and MODE.**	*FT10 Client Utilization:* # served: 598 Expend/client: $683 FY 10 Bus Passes: # served: 1,725 Expend/client: $101 Units/client: n/a FY10 Gas Vouchers: For all FY10 Outcome Measures: See FY 2012 Data Summary Chart. *FY10 Outcome Measures:*	Pt D targets women and children and youth	Cost effective. High Outcome Measures.	**a-** Not practical to bundle **b-** No **c-** NA **d-** No	• Accept the service category definition as presented and keep the financial eligibility at 300%.

(over)

‡ 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 03-01-11 *(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 p.m. on June 17, 2011**. This form is available from the Office of Support at: 713-572-3724)*	
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.
Emergency Financial Assistance	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.)
Food Pantry (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.
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.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
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.

The HIV/AIDS Program: Legislation

Core Services

More money will be spent on direct health care for Ryan White clients. Under the new law, grantees receiving funds under Parts A, B, and C (formerly called Titles I, II and III) must spend at least 75 percent of funds on "core medical services."

The Administration and Congress want to make sure that grantees target Federal funds to pay for essential medical care. That care includes

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;
- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Previously, no core set of medical services was specified in the statute.

Remaining funds may be spent on support services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. The law outlines support services as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

Services in the FY 2013 RFP for RW Part A and MAI

At a minimum, assuming the services are still prioritized by the RWPC, the following Service Categories will be in the FY 2013 RFP for Part A and MAI services:

- **Comprehensive Community-Based Primary Medical Care** including Local Pharmacy Assistance Program (LPAP), Medical Case Management and Service Linkage targeted to African American, Hispanic and White;
- **Comprehensive Community-Based Primary Medical Care** including Local Pharmacy Assistance Program (LPAP), Medical Case Management and Service Linkage targeted to Rural;
- **Vision Care**
- **Transportation (Van-Based)** – Untargeted and Rural (combined, single contract for both)
- **Legal Assistance**

FY 2012 Part A Funded Service Categories

** = HRSA-defined core service

Part A Funded Service Categories:

**Ambulatory/Outpatient Medical Care (includes Pediatrics, OB/GYN and Vision care)
**Case Management – Medical (including treatment adherence services)
Case Management – Non-medical (community based)
**Hospice Services
Legal Assistance
**Local Pharmacy Assistance Program
**Medical Nutrition Therapy
**Oral Health (Rural)
Program Support (Project LEAP, Case Management Training and Blue Book)
Planning Council Support
**Substance Abuse Services
Transportation

HRSA Services NOT Funded by Part A:

Child Care Services (in home reimbursement and at primary care sites)
**Early Medical Intervention (HE/RR)
Food Bank/Home Delivered Meals
**Health Insurance Assistance
**Home and Community-based Health Services – Facility Based
**Home and Community-based Health Services – In Home
Housing Assistance (Emergency rental assistance)
Housing Related Services (Housing coordination)
**Mental Health Services
Minority Capacity Building
Linguistic Services
Outreach Services
Psychosocial Support Services (Counseling/Peer)
Rehabilitation Services
Volunteerism/Buddy Companion Services

FY 2012 Part B/State Services Funded Service Categories

** = HRSA-defined core service

Part B/State Services Funded Service Categories:

**Ambulatory/Outpatient Medical Care (Rural)
**Case Management – Medical (Rural)
**Early Medical Intervention (Incarcerated)
Food Pantry (Rural)
**Health Insurance Assistance
**Home and Community based Health Services – Facility Based
**Hospice Services
Linguistics Services
Legal Assistance
**Mental Health
**Oral Health Care (untargeted and prosthodontics)

HRSA Services NOT Funded by Part B/State Services:

Case Management – Non-Medical
Child Care Services (in home reimbursement and at primary care sites)
**Early Medical Intervention (HE/RR)
Food Pantry (untargeted)
Home Delivered Meals
Housing Assistance (Emergency rental assistance)
Housing Related Services (Housing coordination)
**Local Medication Program
**Medical Nutrition Therapy (Nutritional Counseling and Nutritional Supplements)
Minority Capacity Building
Outreach Services
Psychosocial Support Services (Counseling/Peer)
Rehabilitation Services
**Substance Abuse Services
Transportation (Rural)
Volunteerism/Buddy Companion Services

FY 2012 Service Categories for Part A, Part B and State Services
Houston EMA/HSDA Financial Eligibility for Services

Service Definition	FY10	FY11	FY12
Ambulatory Outpatient Medical Care	300%	300%	**300%**
Case Management	---	---	---
Early Intervention Services (Incarcerated)	---	---	---
Food Bank (Rural)	125%	125%	**125%**
Health Insurance Assistance	Pt A 300% Pt B 500%	Pt A 300% Pt B 500%	**Pt A 300%** **Pt B 500%**
Home and Community Based Health Services (Adult Day Treatment)	300%	300%	**300%**
Hospice Services	300%	300%	**300%**
Legal Assistance	300%	300%	**300%**
Linguistics (Interpreter) Services	300%	300%	**300%**
Local Pharmacy Assistance Program	300+500%	300+500%	**300+500%**
Medical Nutritional Therapy (including Nutritional Supplements)	300%	300%	**300%**
Mental Health Services	300%	300%	**300%**
Oral Health	300%	300%	**300%**
Substance Abuse Services	300%	300%	**300%**
Transportation	300%	300%	**300%**

Targeting for FY 2012 Service Categories
For Ryan White Part A, Part B and State Services Funding

(Quality Assurance Committee approved 05-19-11)

HIV Prevalence	AIDS Prevalence	HIV & AIDS Prevalence	Geographic Targeting	Other Targeting	N/A or No Targeting	Service Category
			X*	X**		Ambulatory/Outpatient Medical Care
				X		Case Management Services - Core
				X		Case Management Services – Non-Core
				X		Early Medical Intervention
			X*			Food Assistance (pantries, meals)
					X	Health Insurance
					X	Home and Community Based Services
					X	Hospice Services
			X*		X	Legal Assistance
					X	Linguistic Services
				X		Local Pharmacy Assistance Program
					X	Medical Nutritional Therapy
					X	Mental Health Treatment
			X***		X	Oral Health
					X	Substance Abuse Treatment
			X	X		Transportation Services
					X	Vision

* Geographic targeting in rural area only.

** In an effort to provide a base line that reflects actual client utilization, for community based organizations base this percentage on the FY 2010 final expenditures that targeted African Americans, Whites and Hispanics. In FY 2010 this was 37% African American; 36% Hispanic and 27% White. The administrative agent is directed to provide the committee with a report reflecting the resulting change.

*** Geographic targeting in the north only.

Attachment 3: Table 1 - HIV (non-AIDS) Prevalence, AIDS Prevalence and Three-Year AIDS Incidence

Houston EMA	**HIV Prevalence as of 12/31/2010**		**AIDS Prevalence as of 12/31/2010**		**AIDS Incidence 2008-2010**	
	***# People living with HIV*[1]**		***# People living with AIDS*[1]**		***# New AIDS cases reported*[1]**	
	Cases	**%**	**Cases**	**%**	**Cases**	**%**
Total	**8,965**	**100.0%**	**11,910**	**100.0%**	**2,610**	**100.0%**
Gender	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
Male	6,385	71.2%	9,028	75.8%	1,845	70.7%
Female	2,580	28.8%	2,882	24.2%	765	29.3%
Race/Ethnicity	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
White	2,254	25.1%	3,351	28.1%	432	16.6%
African American	4,709	52.5%	5,516	46.3%	1,419	54.4%
Hispanic	1,851	20.6%	2,861	24.0%	690	26.4%
Other	151	1.7%	182	1.5%	69	2.6%
Age	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
<2 years	7	0.1%	0	0.0%	0	0.0%
2-12 years	69	0.8%	3	0.0%	0	0.0%
13-24 years	787	8.8%	274	2.3%	225	8.6%
25-34 years	2,321	25.9%	1,535	12.9%	737	28.2%
35-44 years	2,623	29.3%	3,461	29.1%	845	32.4%
45-54 years	2,188	24.4%	4,321	36.3%	555	21.3%
55+ years	970	10.8%	2,316	19.4%	248	9.5%
Exposure*[2] *Category	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
MSM	4,658	52.0%	6,015	50.5%	1,172	44.9%
IDU	842	9.4%	1,451	12.2%	337	12.9%
MSM/IDU	338	3.8%	750	6.3%	116	4.4%
Heterosexual	2,943	32.8%	3,589	30.1%	973	37.3%
Pediatric	175	2.0%	87	0.7%	12	0.5%
Adult Other	9	0.1%	18	0.2%	0	0.0%

Data Source: Texas eHARS data as of July 2011

[1] The subtotal of estimates for each category may not match the EMA totals due to rounding.
[2] Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

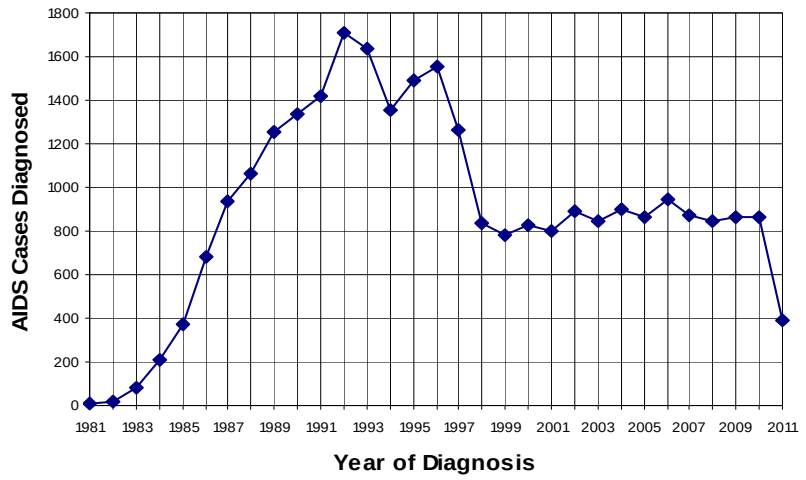
AIDS: Summary of Houston/Harris County Cases

Cumulative - Reported 1981 through 09/30/2011

Table 1: Reported AIDS Cases by Race/Ethnicity, Sex and Age at Diagnosis

Sex	White Non-Hispanic		Black Non-Hispanic		All Races/ Hispanic		Other/Unk Non-Hispanic		Total	
Males										
Age (Years)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
00-04	9	(0)	43	(1)	12	(0)	1	(0)	65	(0)
05-12	4	(0)	7	(0)	4	(0)		(0)	15	(0)
13-19	18	(0)	91	(1)	32	(1)	2	(1)	143	(1)
20-29	1626	(16)	1654	(21)	1019	(23)	39	(17)	4338	(19)
30-39	4751	(46)	2934	(37)	1986	(46)	104	(45)	9775	(43)
40-49	2833	(27)	2071	(26)	953	(22)	55	(24)	5912	(26)
Over 49	1156	(11)	1029	(13)	350	(8)	31	(13)	2566	(11)
Total	10397	(100)	7829	(100)	4356	(100)	232	(100)	22814	(100)
Percent of row total		(46)		(34)		(19)		(1)		(100)
Females										
Age (Years)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
00-04	4	(1)	40	(1)	18	(2)	1	(2)	63	(1)
05-12	2	(0)	10	(0)	3	(0)		(0)	15	(0)
13-19	14	(2)	95	(3)	14	(2)	3	(5)	126	(2)
20-29	162	(24)	941	(26)	190	(24)	10	(16)	1303	(26)
30-39	235	(35)	1299	(36)	278	(36)	24	(38)	1836	(36)
40-49	161	(24)	809	(23)	171	(22)	15	(23)	1156	(23)
Over 49	91	(14)	387	(11)	105	(13)	11	(17)	594	(12)
Total	669	(100)	3581	(100)	779	(100)	64	(100)	5093	(100)
Percent of row total		(13)		(70)		(15)		(1)		(100)
All Sexes										
Age (Years)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
00-04	13	(0)	83	(1)	30	(1)	2	(1)	128	(0)
05-12	6	(0)	17	(0)	7	(0)	0	(0)	30	(0)
13-19	32	(0)	186	(2)	46	(1)	5	(2)	269	(1)
20-29	1788	(16)	2595	(23)	1209	(24)	49	(17)	5641	(20)
30-39	4986	(45)	4233	(37)	2264	(44)	128	(43)	11611	(42)
40-49	2994	(27)	2880	(25)	1124	(22)	70	(24)	7068	(25)
Over 49	1247	(11)	1416	(12)	455	(9)	42	(14)	3160	(11)
Total	11066	(100)	11410	(100)	5135	(100)	296	(100)	27907	(100)
Percent of row total		(40)		(41)		(18)		(1)		(100)

Figure 1: Reported AIDS Cases by Diagnosis Year
1981- 09/30/2011



Note: AIDS cases for 2010 are expected to increase due to reporting delays.

Table 2: Reported AIDS Cases by City of Residence at Diagnosis

City	Cases	(%)
Houston	25877	(92.7)
Baytown	216	(0.8)
Bellaire	90	(0.3)
Humble	258	(0.9)
Katy	164	(0.6)
Pasadena	396	(1.4)
Spring	220	(0.8)
Other Cities*	686	(2.5)
Total	27907	(100.0)

*Includes Channelview, Crosby, Galena Park, Kingwood La Porte, Missouri City, Seabrook, South Houston, Tomball, Webster, & others.

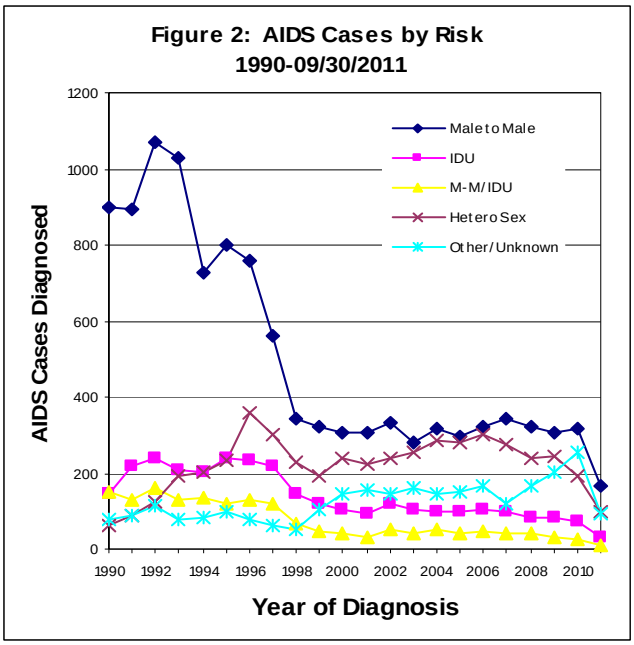
Table 3: Reported AIDS Cases by Mortality Status

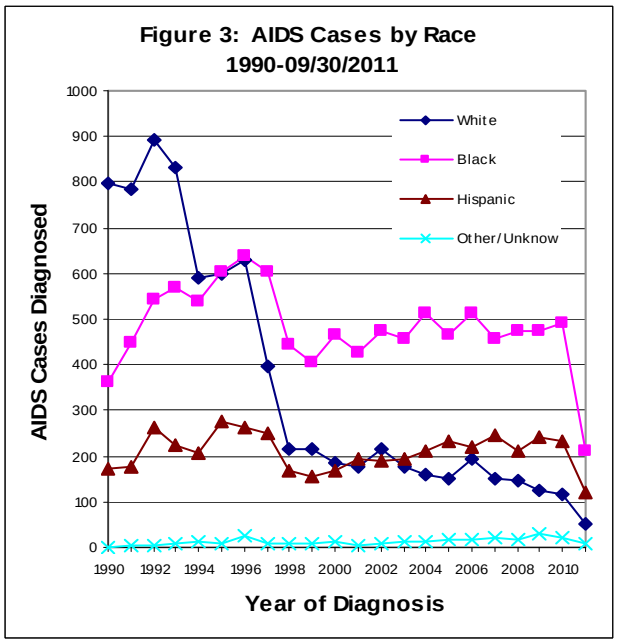
Status	Cases	(%)
Presumed living	11737	(42.1)
Deceased	16170	(57.9)
Total	27907	(100.0)

Bureau of Epidemiology Houston Department of Health and Human Services Contact Phone; (713) 794-9181

Table 4. Reported AIDS Cases by Race/Ethnicity, Sex and Identified Risk

Sex	White Non-Hispanic		Black Non-Hispanic		Any Race Hispanic		Other Unknown		Total	
Males										
Risk	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Male to Male Sex	8158	(78)	3522	(45)	2716	(62)	114	(49)	14510	(64)
Intravenous Drug Use (IDU)	436	(4)	1282	(16)	297	(7)	19	(8)	2034	(9)
Male to Male Sex & IDU	1103	(11)	731	(9)	267	(6)	18	(8)	2119	(9)
Hemophilia	24	(0)	9	(0)	15	(0)	2	(1)	50	(0)
Sex with Opposite Sex	219	(2)	1320	(17)	539	(12)	34	(15)	2112	(9)
Blood Transfusion	44	(0)	9	(0)	6	(0)	1	(0)	60	(0)
Mom with or at risk of HIV	7	(0)	53	(1)	14	(0)	1	(0)	75	(0)
Other/Undetermined	406	(4)	903	(12)	502	(12)	43	(19)	1854	(8)
Total	10397	(100)	7829	(100)	4356	(100)	232	(100)	22814	(100)
Percent of column total		(94)		(69)		(85)		(78)		(82)
Females										
Risk	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Intravenous Drug Use (IDU)	254	(38)	943	(26)	98	(13)	4	(6)	1299	(26)
Hemophilia		(0)		(0)	1	(0)		(0)	1	(0)
Sex with Opposite Sex	304	(45)	1983	(55)	521	(67)	40	(63)	2848	(56)
Blood Transfusion	22	(3)	8	(0)	10	(1)		(0)	40	(1)
Mom with or at risk of HIV	4	(1)	62	(2)	21	(3)	1	(2)	88	(2)
Other/Undetermined	85	(13)	585	(16)	128	(16)	19	(30)	817	(16)
Total	669	(100)	3581	(100)	779	(100)	64	(100)	5093	(100)
Percent of column total		(6)		(31)		(15)		(22)		(18)
All Sexes										
Risk	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Male to Male Sex	8158	(74)	3522	(31)	2716	(53)	114	(39)	14510	(52)
Intravenous Drug Use (IDU)	690	(6)	2225	(20)	395	(8)	23	(8)	3333	(12)
Male to Male Sex & IDU	1103	(10)	731	(6)	267	(5)	18	(6)	2119	(8)
Hemophilia	24	(0)	9	(0)	16	(0)	2	(1)	51	(0)
Sex with Opposite Sex	523	(5)	3303	(29)	1060	(21)	74	(25)	4960	(18)
Blood Transfusion	66	(1)	17	(0)	16	(0)	1	(0)	100	(0)
Mom with or at risk of HIV	11	(0)	115	(1)	35	(1)	2	(1)	163	(1)
Other/Undetermined	491	(4)	1488	(13)	630	(12)	62	(21)	2671	(10)
Total	11066	(100)	11410	(100)	5135	(100)	296	(100)	27907	(100)





Note: Totals for all categories presented may change due to reporting delays.

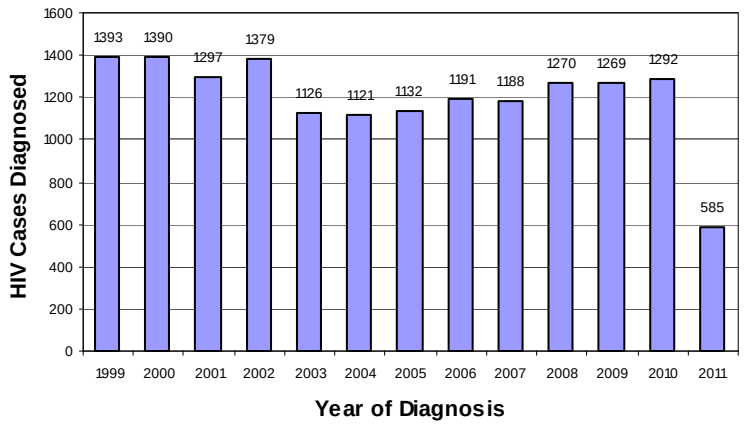
HIV: Summary of Adult* *Reportable* Houston/Harris County Cases

Cumulative - Reported 1999-09/30/2011

Table 5: Reported HIV Cases, Regardless of AIDS Status, by Race/Ethnicity, Sex and Age at Diagnosis

Sex		White Non-Hispanic		Black Non-Hispanic		Any Race Hispanic		Other Unknown		Total	
Males	**Age Group**	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
	13-19	47	(1)	354	(5)	107	(3)	2	(1)	510	(4)
	20-29	853	(23)	1972	(30)	1211	(33)	75	(30)	4111	(29)
	30-39	1404	(38)	2068	(32)	1381	(38)	110	(43)	4963	(35)
	40-49	954	(26)	1408	(22)	673	(18)	44	(17)	3079	(22)
	over 49	432	(12)	724	(11)	267	(7)	23	(9)	1446	(10)
	Total	3690	(100)	6526	(100)	3639	(100)	254	(100)	14109	(100)
	Percent of row total		(26)		(46)		(26)		(2)		(100)
Females	**Age Group**	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
	13-19	35	(6)	368	(9)	57	(7)	9	(10)	469	(9)
	20-29	153	(27)	1415	(35)	273	(33)	34	(37)	1875	(34)
	30-39	180	(32)	1175	(29)	251	(31)	27	(30)	1633	(30)
	40-49	125	(22)	672	(17)	146	(18)	13	(14)	956	(17)
	over 49	74	(13)	375	(9)	91	(11)	8	(9)	548	(10)
	Total	567	(100)	4005	(100)	818	(100)	91	(100)	5481	(100)
	Percent of row total		(10)		(73)		(15)		(2)		(100)
All	**Age Group**	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
	13-19	82	(2)	722	(7)	164	(4)	11	(3)	979	(5)
	20-29	1006	(24)	3387	(32)	1484	(33)	109	(32)	5986	(31)
	30-39	1584	(37)	3243	(31)	1632	(37)	137	(40)	6596	(34)
	40-49	1079	(25)	2080	(20)	819	(18)	57	(17)	4035	(21)
	over 49	506	(12)	1099	(10)	358	(8)	31	(9)	1994	(10)
	Total	4257	(100)	10531	(100)	4457	(100)	345	(100)	19590	(100)
	Percent of row total		(22)		(54)		(23)		(2)		(100)

Figure 4: Adult HIV Cases in Houston/Harris County (Reported 1999-09/30/11)



HIV became reportable in 1999. The year of diagnosis in Fig. 4 is the year of the earliest known test and may not be the same year as the reportable test. Reportable tests with diagnosis year before 1999 are not displayed in Fig. 4.

Editorial Note: Total for all categories presented may change due to reporting delays.

Table 6: Reported Adult HIV Cases by City of Residence at Diagnosis

CITY	Cases	(%)
Houston	18036	92.1
Baytown	141	0.7
Katy	146	0.7
Humble	307	1.6
Pasadena	248	1.3
Spring	172	0.9
Others*	540	2.8
TOTAL	19590	100.0

*Includes Bellaire, Channelview, Clear Lake City, Crosby, Cypress, Galena Park, Highlands, Huffman, Dear Park, Kingwood, La Porte, Seabrook, South Houston, Tomball and others.

Table 7: Reported Adult HIV Cases by Mortality Status

Status	Cases	(%)
Presumed Living	16384	83.6
Deceased	3206	16.4
Total	19590	100.0

*Adult cases defined as 13 years of age and older.

Table 8: Reported HIV Cases, Regardless of AIDS Status, by Race/Ethnicity, Sex and Identified Risk

Sex	White Non-Hispanic		Black Non-Hispanic		Any Race Hispanic		Other Unknown		Total	
Males										
Risk	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Male to Male Sex	2701	(73)	2808	(43)	2169	(60)	150	(59)	7828	(55)
Intravenous Drug Use (IDU)	164	(4)	684	(10)	146	(4)	15	(6)	1009	(7)
Male to Male Sex & IDU	277	(8)	352	(5)	117	(3)	12	(5)	758	(5)
Sex with Opposite Sex	143	(4)	1242	(19)	490	(13)	27	(11)	1902	(13)
Other/Undetermined	405	(11)	1440	(22)	717	(20)	50	(20)	2612	(19)
Total	3690	(100)	6526	(100)	3639	(100)	254	(100)	14109	(100)
Percent of column total		(87)		(62)		(82)		(74)		(72)
Females										
Risk	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Intravenous Drug Use (IDU)	151	(27)	577	(14)	50	(6)	6	(7)	784	(14)
Sex with Opposite Sex	264	(47)	2347	(59)	569	(70)	59	(65)	3239	(59)
Other/Undetermined	152	(27)	1081	(27)	199	(24)	26	(29)	1458	(27)
Total	567	(100)	4005	(100)	818	(100)	91	(100)	5481	(100)
Percent of column total		(13)		(38)		(18)		(26)		(28)
All Sexes										
Risk	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Male to Male Sex	2701	(63)	2808	(27)	2169	(49)	150	(43)	7828	(40)
Intravenous Drug Use (IDU)	315	(7)	1261	(12)	196	(4)	21	(6)	1793	(9)
Male to Male Sex & IDU	277	(7)	352	(3)	117	(3)	12	(3)	758	(4)
Sex with Opposite Sex	407	(10)	3589	(34)	1059	(24)	86	(25)	5141	(26)
Other/Undetermined	557	(13)	2521	(24)	916	(21)	76	(22)	4070	(21)
Total	4257	(100)	10531	(100)	4457	(100)	345	(100)	19590	(100)

Figure 5: Reported Adult HIV cases in Houston/ Harris Co., By Identified Risk 1/1/1999-09/30/2011

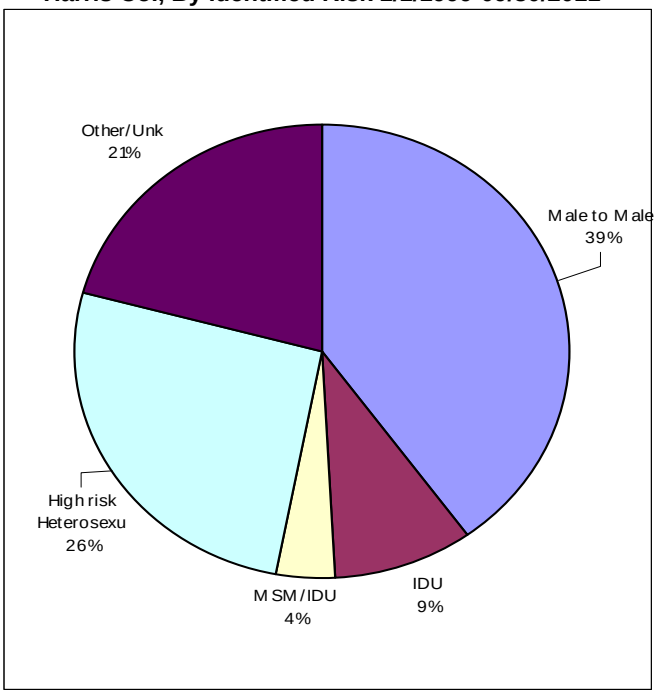
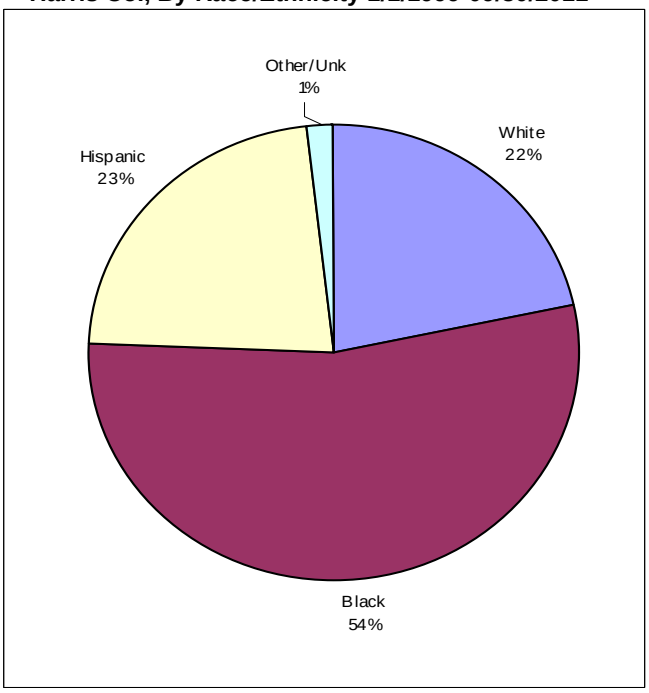


Figure 6: Reported Adult HIV Cases in Houston/ Harris Co., By Race/Ethnicity 1/1/1999-09/30/2011



Editorial Note: Totals for all categories presented may change due to reporting delays.

Notes on HIV and AIDS categories

HIV became a reportable condition in Texas in 1999 when positive HIV Western blots performed after 1998 became reportable. In the year 2000, the case definition was expanded to include any detectable HIV viral load performed after 1999. So Houston/Harris County began reporting HIV in 1999. During the investigation of a positive HIV report, an earlier HIV diagnosis date may be discovered. An HIV case may be reported in 1999, but the HIV diagnosis date may be an earlier date such as 1994. Thus, the sum of all HIV cases reported from 1999 forward (the total number in Table 5) does not equal the sum of the HIV cases diagnosed from 1999 forward (the sum of the cases shown in Fig. 4).

As reported in this quarterly report, HIV and AIDS categories are not mutually exclusive categories. If a person has a reportable HIV test after 1998, the person will be counted as an HIV case, regardless of AIDS status. If the same person subsequently develops AIDS, the person will continue to be counted as an HIV case, regardless of AIDS status, but in addition be counted as an AIDS case. Thus, one cannot add the HIV and AIDS cases together to compute the number of cases of HIV or AIDS.

Interstate Duplication Evaluation Project (IDEP)

In October 2004, the state health departments and the CDC evaluated and resolved interstate duplication of HIV and AIDS case reports submitted to the national database. Less than 1% of the HIV-only cases and less than 2% of the AIDS cases were found to be duplicates in the Houston/Harris Co. database as a result of the IDEP project. Now the state health departments together with the CDC periodically compare cases, and evaluate and resolve interstate duplication of reporting.

Harris County Public Health & Environmental Services, Ryan White Grant Administration

Policy and Procedures for Ryan White Part A and Medicaid/Medicare Eligibility Verification

REVISED DATE: 02/08/11 Site Visit Guidelines 7.2, 7.3, 7.4, 7.5

POLICY:

All persons seeking services must provide the following documentation in order to be eligible for services:

- HIV+ diagnosis[1]
- Verification of identity
- Verification of current residency within Houston EMA
- Verification of current household income

PROCEDURES:

1. **Duration of Eligibility:** All documentation accepted during eligibility verification must be current (i.e. no greater than 180 days from the day the client presents for registration or update). For purposes of this policy, the client's eligibility will expire six months (180 days) from the date the client's eligibility was established or updated by the agency. The CPCDMS Client Verification form will display the eligibility expiration date. (Proof of HIV+ diagnosis does not have an expiration date and does not need to be updated).

In addition, as Ryan White is the payor of last resort for those services that are reimbursable by Medicaid, Medicare or third party, the files of clients receiving Medicaid/Medicare eligible services must contain documentation of the agency's efforts to verify Medicaid/Medicare eligibility on a monthly basis. (In lieu of maintaining the information in individual client files, the agency may employ a tractable mechanism that assures Medicaid/Medicare verification at least monthly).

2. **HIV+ Diagnosis: (REQUIRED BY ALL AGENCIES)**

Acceptable documentation:

- A computer-generated HIV+ lab test with the individual's name pre-printed. Examples are:
    1. Antibody screening test {e.g. Reactive Enzyme Immunoassay (EIA) with confirmatory western blot or Indirect Immunofluorescence Assay test (IFA)} or

[1] For services available to non-HIV+ persons, documentation of the client's relationship to an HIV+ person and the HIV+ person's diagnosis must be provided.

2. HIV Nucleic Acid (DNA or RNA) detection test {e.g. Polymerase Chain reaction (PCR); HIV p24 Antigen test or HIV Isolation (viral culture)} or
3. HIV Testing Medical Report on HDHHS letterhead

- A statement or letter signed by a medical professional (acceptable signatories listed below) indicating that the individual is HIV+, including the individual's name and the phone number of the medical professional.
- A medical progress note, hospital discharge paperwork, or other document signed by a medical professional (acceptable signatories listed below) indicating that the individual is HIV+, including the individual's name and the phone number of the medical professional.
- An anonymous HIV test result containing identifying information sufficient to ensure a reasonable certainty as to the identity of the test subject, e.g. gender and date of birth (valid for only 60 days from the start of services at the agency).
- A Texas Department of Criminal Justice (TDJC) physician-completed Medical Certification Form (MCF)

Acceptable signatories:

- A licensed physician
- A licensed physician assistant
- A licensed nurse practitioner
- A registered nurse working under the supervision of a physician
- A licensed Master's level social worker (LMSW) working under the supervision of a physician
- An Advanced Practice Nurse

NOTE: Proof of HIV+ Diagnosis does not have an expiration date and does not need to be updated annually.

3. **Identity:** **(REQUIRED BY ALL AGENCIES)**

Acceptable documentation:

- Texas Driver's License
- Texas Identification Card
- Texas Department of Corrections identification card
- Employment badge with picture
- Student ID with picture
- U.S. immigration documents with picture
- Credit card with picture
- Metro picture ID
- U.S. naturalization, citizenship, passport or other Federal documents with picture
- Driver's license or identification card issued by another US state
- A government-issued ID from a country other than the U.S.
- Birth certificate (cannot be used by married women)
- Social Security card
- Medicaid/Medicare card
- VA ID Card

The following documentation is acceptable only for undocumented and/or homeless clients and clients recently released from or referred by the Harris County jail:

- Letter on company letterhead from a case manager, social worker, counselor or other professional from another agency who has personally provided services to the client
- Letter on company letterhead from the Harris County jail

4. **Residency:**

Residency documentation for minors is required for a parent or guardian with whom the minor resides.

Acceptable residency documentation: (must be current)

- Residency and Income Affidavit (see sample forms)
- Valid copy of "CPCDMS Client Verification" form (Agencies Online who are NOT Record Owners)
- Current lease in the name of the client or listing the client as an occupant
- Current Property tax documents
- Current utility/phone/cable bill in the name of the client
- Current credit card bill in the name of the client
- Current letter on company letterhead signed by the director of a recognized group home, care home or transitional living facility
- Any type of current business correspondence with the client's name and address pre-printed, e.g. auto registration, insurance, bank/brokerage statement, food stamp letter, Social Security letter, Medicaid letter
- Current pay stub with address
- Supporter statement with address and valid signature by client supporter

The following documentation is acceptable only for undocumented and/or homeless clients:

- Agency temporary affidavit signed and dated by the client (valid for only *60 days* from the start of services at the agency)
- Letter on company letterhead from a case manager, social worker, counselor or other professional from another agency who has personally provided services to the client

5. **Income:**

All clients must be screened for financial eligibility for Ryan White Part A funded services. Services should not be provided to clients whose household income exceeds the cap established by the Ryan White Planning Council for each service category.[2]
Documentation of income must be provided for all members of the client's household.[3] Income documentation for minors is required for the parent(s) or guardian(s) with whom the minor resides.

Acceptable income documentation (must be current):

- Valid copy of "CPCDMS Client Verification" form (Agencies Online who are NOT Record Owners)
- Payroll stub/copy of payroll check/bank statement showing direct payroll deposit

[2] see the US Dept. of Health and Human Services Poverty Guidelines for the current year and the "Ryan White Federal Poverty Guidelines" table.
[3] As per Federal definition, a same sex spouse or partner is not considered to be a household member.

- Letter from employer on company letterhead indicating weekly or monthly wages
- Unemployment benefits letter/copy of check
- IRS 1040 form (tax return)/W2 form/1099 form
- Social Security award letter
- VA benefits letter
- Private disability/pension letter on company letterhead
- Medicaid letter
- Child or spousal support order with judge's signature and date
- Food Stamp and/or Temporary Assistance for Needy Families (TANF) award letter

The following documentation is acceptable only for clients claiming no income:

- Agency temporary affidavit signed and dated by the client (valid for only 60 days from initial service date)
- Residency and Income Affidavit (see sample forms)
- Proof of application for Social Security (valid for 6 months only)
- Client living off savings: bank/investment account statements from 3 consecutive months showing withdrawals for living expenses
- Client being supported by someone else: statement signed and dated by the supporter, which includes the amount and type of support (room only, room and board, cash assistance, etc.) and the supporter's phone number for verification[4]
- Homeless client: letter on company letterhead from a case manager, social worker, counselor or other professional from another agency who has personally provided services to the client

6. **Medicaid/Medicare Eligibility Verification:**

The following service categories must provide verification of client ineligibility for Medicaid/ Medicare or third party coverage (to assure that Ryan White Part A is payer of last resort) for the dates that were provided:

Medicaid/Medicare or Third Party Reimbursable Service Categories

- Primary Medical Care (including pediatric and women's services)
- Psychiatry
- Local Pharmacy Assistance Program (LPAP)
- Dental (Youth/Minors)
- Rehabilitation/PT
- Substance Abuse Treatment
- Vision Services
- Transportation (Medicaid only)

Acceptable documentation to verify Medicaid/Medicare eligibility status:

- Verification of employment, i.e. payroll stub, copy of payroll check, bank statement showing direct payroll deposit, letter from employer on company letterhead indicating weekly or monthly wages no greater than 6 months old (to demonstrate Medicaid/Medicare eligibility status)
- Medicaid/Medicare rejection letter covering the dates of service
- Signed note in patient record showing date and time of call to Medicaid/Medicare (must be done monthly)
- Medifax slips or other automated system (must be done at least monthly)

[4] Ryan White Grant Administration recommends using the supporter statement provided in this manual

The following documentation is acceptable only for undocumented and/or homeless clients:

- Letter on company letterhead from a case manager, social worker, counselor or other professional (certifying Medicaid/Medicare eligibility status) from another agency who has personally provided services to the client, stating that the client is undocumented and/or homeless.

The Ryan White Grant Administration will, during site visits to agencies providing Medicaid/Medicare reimbursable services, record the social security numbers of "reviewed" client records only. This measure is intended for the sole purpose of assuring that Ryan White Part A is the payer of last resort, as directed/dictated by The Health Resources & Services Administration (HRSA).

After the Medicaid/Medicare eligibility status has been verified/established, all records of the Social Security Number are destroyed. All references to a client will be made by the use of the established 11-character code.

Services rendered under Ryan White Part A for days on which a client was eligible for Medicaid, Medicare, or another third party payer will be recouped by Harris County. The agency however, will not be cited for failing to use Ryan White as the payer of last resort if the above documentation showing the client is ineligible for Medicaid or Medicare is in the client file at the time of the site visit.

_____ _____

Approved by Manager **Date**
HCPHES – Ryan White Grant Administration

From the 2011 Houston Area HIV/AIDS Needs Assessment

Barriers to Core Services

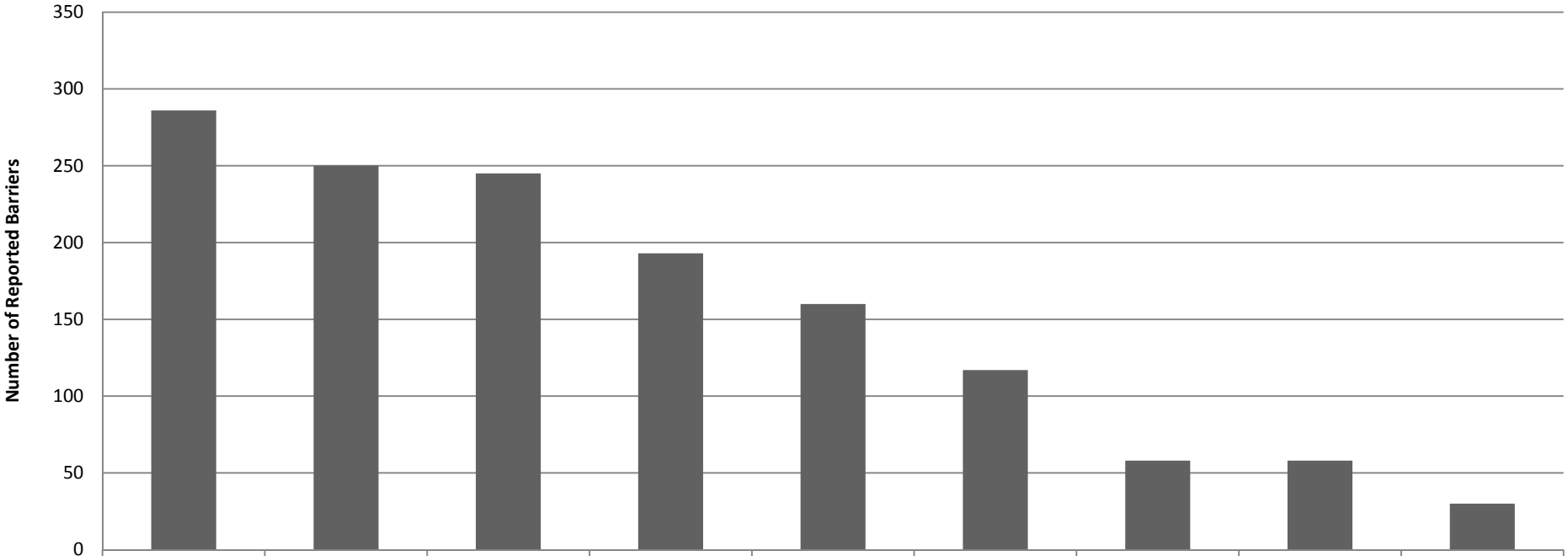
Introduction
Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

Barriers to Services
Survey respondents that reported "some difficulty" accessing a service were asked to identify the barriers. Respondents chose from a prepared list of 16 common barriers. The 4 most commonly reported barriers for core services were difficulty making or keeping appointments, long wait times, problems with paperwork and difficult getting to the services. The following table ranks the barriers reported for all core services.

Barrier	Number of respondents
It's hard to make or keep appointments.	183
I would have to wait too long to get the services	163
I had problems with paperwork	146
It's hard for me to get there	146
I don't know where to get the services	130
I don't know how to get the services	129
The services are not in my area	92
The people who run the services are not friendly	89
I was told I am not eligible for this service	82
The services cost too much	81
I don't think I'm eligible to get the services	52
I'm afraid someone will find out about my HIV	40
People at the agency don't speak my language	22
I'm not ready to face my HIV status	20
My Jail/prison history makes it hard to get services	16
There is no one to watch my kids if I go there	6

Respondents could also describe barriers not included on the list. There was no limit to the number of barriers allowed, so respondents were encouraged to list all barriers experienced when accessing the service.

Number of Reports of Barriers Per Core Service Category, All Respondents



	Dental	Medical	HIV Meds	Case Man	Nutr. Therapy	Mental Hlth Counseling	Substance Abuse Tx	Home Health	Hospice
Reports	286	250	245	193	160	117	58	58	30

- The chart above shows the number of barriers reported for each core service.
- Among all respondents, the three core services with the highest number of reported barriers were dentist visits (n=286), medical care services (n=250) and HIV medications (n=245).

The following table lists the specific barriers reported for each core service.

	Core Services									
Barriers	Medical	HIV Meds	Dental	Case Management	Nutritional Therapy	Substance Abuse Tx	Mental Health Counseling	Hospice	Home Health	**Total Count per Barrier**
It's hard to make or keep appointments.	**36**	17	**71**	**23**	15	4	15	0	2	**183**
I would have to wait too long to get the services	**48**	**31**	1	**27**	**23**	6	**21**	2	4	**163**
It's hard for me to get there	**37**	18	**36**	15	16	10	11	1	2	**146**
I had problems with paperwork	**23**	**45**	**38**	17	7	3	5	3	5	**146**
I don’t know where to get the services	13	18	**22**	19	**22**	9	14	3	10	**130**
I don't know how to get the services	10	12	**25**	**24**	**20**	5	17	6	10	**129**
The services are not in my area	13	11	**25**	8	16	5	7	4	3	**92**
The people who run the services are not friendly	16	6	17	18	9	4	11	4	4	**89**
I was told I am not eligible for this service	11	18	17	12	8	3	2	2	9	**82**
The services cost too much	11	**44**	7	5	7	0	5	0	2	**81**
I don't think I'm eligible to get the services	3	7	10	12	9	2	3	2	4	**52**
I'm afraid someone will find out about my HIV	11	6	6	6	2	3	3	2	1	**40**
People at the agency don't speak my language	11	4	1	2	2	0	1	1	0	**22**
I'm not ready to face my HIV status	4	5	5	1	1	3	0	0	1	**20**
My Jail/prison history makes it hard to get services	3	2	2	4	3	0	1	0	1	**16**
There is no one to watch my kids if I go there	0	1	3	0	0	1	1	0	0	**6**
Total Barriers per Core Service	**250**	**245**	**286**	**193**	**160**	**58**	**117**	**30**	**58**	**1397**

Barriers to Supportive Services

Introduction

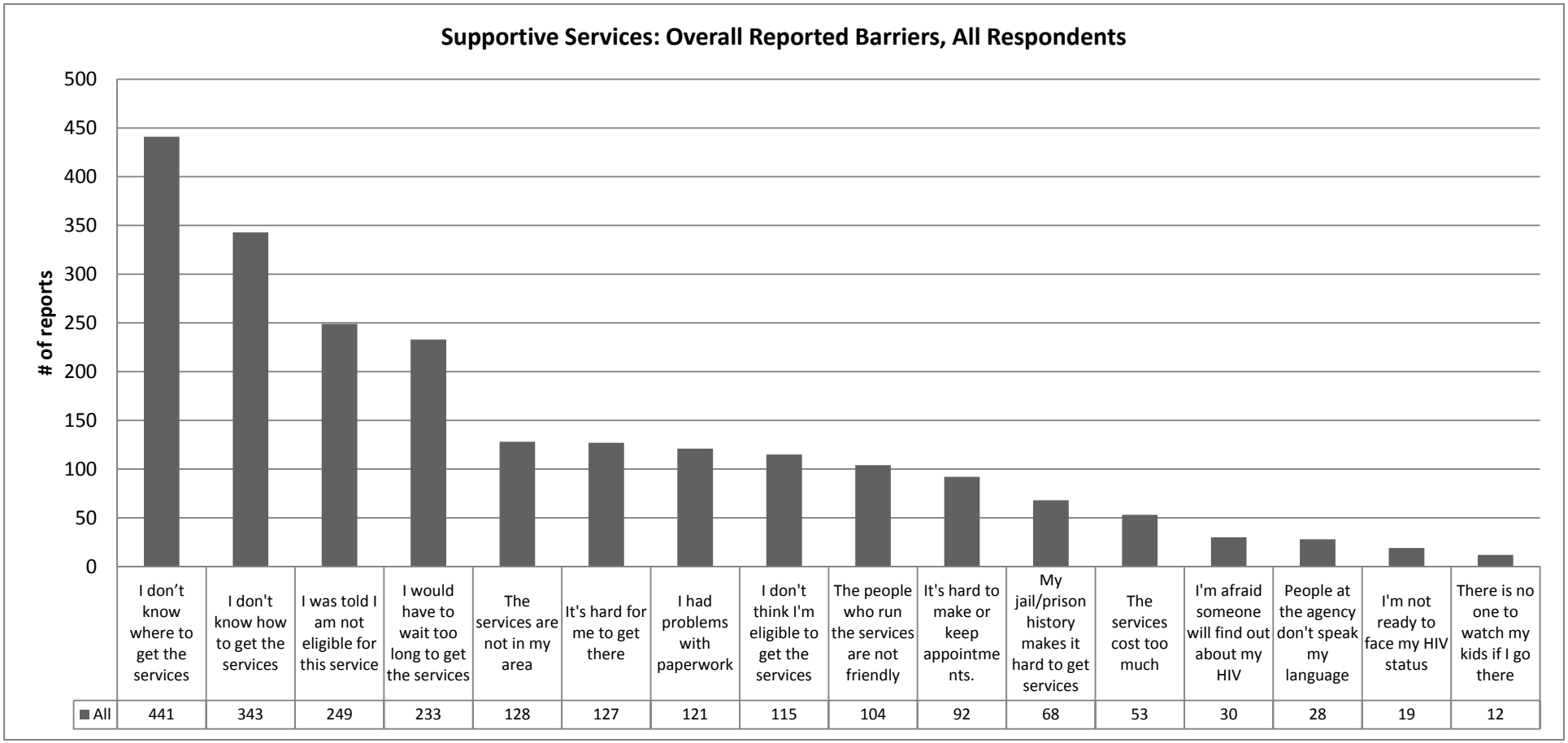
Survey respondents that reported "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

Barriers to Services

Survey respondents that reported "some difficulty" accessing a service were asked to identify the barriers. Respondents chose from a prepared list of 16 common barriers. The 4 most commonly reported barriers for supportive services were difficulty not knowing where to get services, not knowing how to get services, being told of ineligibility for services and long wait times. The following table ranks the barriers reported for all core services.

Barrier	Number of Reports	% of total Reports
I don't know where to get the services	441	20%
I don't know how to get the services	343	16%
I was told I am not eligible for this service	249	11%
I would have to wait too long to get the services	233	11%
The services are not in my area	128	6%
It's hard for me to get there	127	6%
I had problems with paperwork	121	5%
I don't think I'm eligible to get the services	115	5%
The people who run the services are not friendly	104	5%
It's hard to make or keep appointments.	92	4%
My jail/prison history makes it hard to get services	68	3%
The services cost too much	53	2%
I'm afraid someone will find out about my HIV	30	2%
People at the agency don't speak my language	28	1%
I'm not ready to face my HIV status	19	1%

Respondents could also describe barriers not included on the list. There was no limit to the number of barriers allowed, so respondents were encouraged to list all barriers experienced when accessing the service.



The chart above shows the number of reports of barriers for all supportive services. The barriers are ranked based on the full sample of respondents.

NATIONAL HIV/AIDS STRATEGY:

Implementation Update

JULY 2011

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Introduction

One year ago, President Obama fulfilled a commitment he made by releasing the *National HIV/AIDS Strategy for the United States* (NHAS). The NHAS was developed through an extensive process of public input and with the engagement of HIV leaders from across the Federal government. It provides a roadmap for guiding actions by public and private stakeholders working to respond to the domestic epidemic. The Strategy identifies key action steps and core metrics with quantitative targets that we will strive to achieve over a five year period, from 2010-2015. Key goals of the NHAS are to **reduce the number of new HIV infections**, **increase access to care and improve health outcomes for people living with HIV,** and **reduce HIV-related health disparities**.

Releasing the Strategy was only the beginning. The President also issued a *Presidential Memorandum* to ensure that ongoing efforts were made to implement the Strategy. This included directing the White House Office of National AIDS Policy (ONAP) to work with the Office of Management and Budget (OMB) to report annually on progress made in implementing the Strategy. Federal agencies developed detailed operational plans for implementing the Strategy with a series of priority actions to be taken over calendar year 2011. In early 2012, we intend to submit to the President and release to the public a report on progress by major public and private stakeholders to implement the Strategy. As we approach the first anniversary of the NHAS release, however, we developed this short overview to reflect on key milestones and progress that has been made in implementing the Strategy in its first year.

Various parts of the government have become more engaged in the implementation effort. The White House has hosted meetings on topics such as responding to HIV among women and girls and the implementation of the Strategy in Latino communities. HHS has conducted numerous consultations on re-engaging the LGBT community and how to work with state and local governments to develop state and local implementation plans. DOL held a meeting on expanding employment opportunities for people living with HIV and DOJ has prioritized HIV discrimination in its civil rights enforcement actions.

We are proud of the enthusiasm and support of our Federal partners, as well as so many community members, people living with HIV, funders, businesses, faith leaders and other stakeholders. While we have more goals to achieve, we believe that three notable features characterize the Administration's efforts to-date to implement the Strategy: 1) the Strategy at work throughout federal agencies, 2) making strategic new investments, 3) and making needed policy changes.

Key Progress

1. Strategy at Work throughout federal agencies

The Presidential Memorandum directed six lead agencies (Department of Health and Human Services (HHS), Department of Housing and Urban Development (HUD), Department of Justice (DOJ), Department of Labor (DOL), the Social Security Administration (SSA), and the Department of Veterans Affairs (VA) to develop Agency Operational Plans for implementing the Strategy within 150 days after the release of the Strategy. These plans were submitted to ONAP and OMB in December 2010. In February 2011, we released the Agency Operational Plans, which also included a White House overview report synthesizing the Agencies' work and describing the steps being taken by the Federal government to achieve the goals of the Strategy. The Agency Operational Plans provide a detailed description of key initiatives and highlight ways that agencies are working to improve coordination within and across agencies. The following are a selection of agency activities over the past year that supports the Strategy's goals:

Department of Health and Human Services (HHS)

- The **Centers for Disease Control and Prevention (CDC)** provided supplemental resources to all funded health jurisdictions to collect CD4 and viral load data as part of their core surveillance activities and improve the ability of health departments to use geospatial information to monitor and respond to the local epidemic. In addition, CDC provided funds to health departments to develop, monitor, and evaluate models for using CD4, viral load and other surveillance data to improve the effectiveness of local HIV prevention efforts and improve the health of people living with HIV by maintaining linkage and adherence to appropriate and timely medical care and prevention services.
- The **Centers for Medicare & Medicaid Services (CMS)** published a State Medicaid Director letter to remind states and stakeholders about the various Medicaid options that exist to increase access and improve care coordination for people with HIV/AIDS and to assist them in their efforts to take advantage of these options. The letter also assists states in efforts to cover pre-disabled people living with HIV through 1115 waivers. Specifically, the letter offers technical assistance and a waiver template designed to simplify and expedite the waiver application process.
- The **Food and Drug Administration (FDA)** approved a fourth generation HIV diagnostic assay that allows for earlier detection of HIV. The new test is also the first diagnostic test approved by FDA indicated for use in children as young as 2 years of age, and pregnant women. Additionally, in November 2010, FDA approved a new HIV test that provides results in as little as 60 seconds.
- The **Indian Health Service (IHS)** has recruited 8 new service units to the National Expanded HIV Testing Initiative – which allocates funding to participating sites, pairing collaborators with resources to achieve enhanced serostatus knowledge of the service population across new geographic areas of the United States. This brings the total participating sites to: 27 Federal, 15 Urban, and 4 Tribal sites.
- The **Health Resources and Services Administration (HRSA)** has taken several steps to better support community health centers in providing HIV care. The HIV/AIDS Bureau (HAB) will award

a total of $450,000 to develop residency training opportunities with a focus on HIV management and care at community health centers. The Bureau of Primary Health Care has developed project officer trainings and tools to increase health center understanding of guidelines and protocols for HIV care and treatment.

- The **National Institutes of Health (NIH)** announced 3 successful groundbreaking studies: 1) the use of a microbicide gel that reduces the risk of HIV infection in HIV-negative women; 2) the use of medications for HIV-negative gay men that prevents HIV infection; and 3) a study that showed that HIV positive individuals who start treatment early are 96% less likely to transmit to their uninfected partners. NIH also established a new research working group on AIDS and Aging to identify new research areas to address increasing neurological, metabolic, cardiovascular and other clinical complications of aging with HIV/AIDS.
- The **Office of Population Affairs (OPA)/Office of Family Planning (OFP)**, with Minority AIDS Initiative funds and Title X appropriations, provides support for targeted on-site HIV prevention services that include routine testing and prevention counseling as part of family planning clinical services.
- The **Substance Abuse and Mental Health Services Administration (SAMHSA)** launched the Minority AIDS Initiative Targeted Capacity Expansion (MAI –TCE): Integrated Behavioral Health/Primary Care Network Cooperative Agreements (approximately $14.3 million/up to 12 grantees). The expected outcomes for the program include reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas.

Department of Labor (DOL)

- DOL's **Office of Federal Contract Compliance Programs (OFCCP)** has launched a system for prioritizing and fast-tracking investigations of employment discrimination complaints based on HIV/AIDS status. Such cases will be reported and tracked in OFCCP's Case Management System (CMS). OFCCP has also developed public education materials on employment rights under Section 503 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act with emphasis on HIV/AIDS employment discrimination. These materials have been distributed to OFCCP's field offices and will also be distributed to stakeholders and community groups.

Department of Housing and Urban Development (HUD)

- HUD has conducted extensive stakeholder consultations on options to revise the HOPWA funding formula, to be based on living HIV cases and other pertinent factors. Over 500 comments were obtained through on-site meetings and the *HUD Ideas in Action* website. Analyses and management discussion of various funding formula options to better target HOPWA housing resources to the most impacted communities are ongoing. A legislative proposal will be submitted to Congress by the end of this year to modernize the program and reflect needs associated with current relevant data on persons living with HIV. HUD has also collaborated with DOL and presented best practice models through webinars reaching more than 400 grantee representatives.

Department of Justice (DOJ)

- DOJ continues to solicit and prioritize HIV-discrimination complaints, and currently has 11 active investigations, many opened as a result of active outreach efforts. The **Bureau of Prisons (BOP)** formalized a mechanism to track and ensure accountability of clinical HIV treatment interventions / recommendations, updated and released BOP HIV Clinical Practice Guidelines in June, 2011, and held a Medical Director's webinar update on the new HIV Clinical Practice Guidelines to all BOP clinical team members.

2. Making strategic new investments

Beginning with $30 million in new HIV prevention investments in July 2010 from the Prevention and Public Health Fund included in the Affordable Care Act, the Administration has supported targeted new investments for priority HIV/AIDS related activities. This included the Enhanced Community HIV Prevention Planning ECHPP initiative, along with expanded investments in HIV surveillance so that all states and local jurisdictions have the capacity to track community viral load, an important tool for monitoring changes in the numbers of new HIV infections. Additionally, we are establishing new programs targeting gay and bisexual men, the population that drives the HIV epidemic in the U.S.. Furthermore, we are continuing critical programs for other high-risk groups including black women and men.

In FY 2011, we were able to increase funding for the AIDS Drug Assistance Program (ADAP) by $50 million over the FY 2010 enacted level, and we increased HIV prevention funding at CDC by making targeted new investments, despite the agency receiving a significant cut in funding. The Administration was also successful at pushing back on policy riders that would have prevented Federal and DC funds from being used for syringe services programs. The VA also received increased investments in HIV care in FY 2011.

3. Making necessary policy changes

HHS has improved its tracking of HIV spending across Federal agencies on the basis of population factors such as race/ethnicity, gender, and HIV risk factors. This provides a baseline for expanding the targeting of resources to the populations at greatest risk and ensuring that key populations receive resources commensurate with their share of the epidemic.

The Office of the Assistant Secretary for Health has begun restructuring the Secretary's Minority AIDS Initiative Fund to enhance the effectiveness of prevention and care activities for high risk communities. The restructuring included the development of internal, competitive funding announcement with guidance to HHS agencies and staff divisions to align FY 2011 proposal submissions with NHAS priorities. The Fund is also using directed "carve out" funding in the current fiscal year to support five "scale up" projects to serve racial and ethnic minority populations in the 12 Cities Project. The Office is also establishing new metrics so that HHS will be better equipped to monitor the effectiveness of these essential resources.

CDC and HUD have committed to taking steps in 2011 to update funding formulas to award funding on the basis of living HIV/AIDS cases. Previously, funds were allocated using cumulative AIDS cases or historical funding precedents. HUD will develop a legislative proposal before the end of this year to effect this change. On June 30th, CDC released their new funding announcement for state and local

health departments using the new formula beginning in January 2012. This type of change can be challenging as it results in shifts of resources from one location to another. At the same time, it is necessary to ensure that resources are allocated fairly and in proportion to the current burden of HIV, which will help assure that our efforts have the largest impact. CDC established a floor of funding to ensure that all states and territories receive a minimum level of funding. This new funding formula will be phased in over three years.

Priorities for the Coming Year

The success of the Strategy doesn't lie in the hands of the Federal government alone. One of the most encouraging developments over the last year has been the manner in which the NHAS has served to steer a conversation about HIV in the direction of the strategic steps that individuals, communities and the Nation need to take to achieve the Strategy's goals. In various state and local jurisdictions across the country, agencies have either developed their own Strategy implementation plans, or they have started the process of doing so. Additionally, numerous HIV services and advocacy organizations have held meetings and community dialogues about what the Strategy means for their own communities. These actions are critically important and must continue.

The focus of the next phase of the Strategy implementation must include a renewed emphasis on:

- **Building and strengthening new collaborative partnerships at the state, tribal, and local level**

  Part of the reason for the broad support for the Strategy was due to the high level of community engagement in its development. We plan to continue with our community engagement efforts over the coming year. Also, we will seek ways to facilitate and support dialogues that must take place at the state and local level.

- **Bringing new people into the fight against HIV in the United States and building a Community Action Toolkit**

  We're empowering communities to implement the Strategy where they are. Through community organizing tools and online resources, everyday people can take ownership of the Strategy and apply it to their local communities.

  Implementing the Strategy is a monumental effort. Although many individuals and organizations have committed to making the Strategy's goals real, there is a need to bring in a broader range of community groups and organizations to help re-invigorate the effort. Besides enthusiasm and more 'boots on the ground', bringing in new people will help us create innovative solutions to old problems as well as help us engage broader audiences.

- **Defining common metrics for measuring our progress**

  As important as implementation of the Strategy is, it is only good if we know whether what we are implementing is working. A process has begun at the Federal level to identify suitable targets to help us gauge our progress in implementing the Strategy. There are challenges with establishing targets. For instance, should Federal, state and local targets be uniform? Should targets be uniform across low and high prevalence States? These and other issues are being carefully considered and will take time to develop to ensure that our measures are appropriate and available across Federal and local and state levels, as well as most reflective of the goals of the Strategy.

- **Streamlining efforts to minimize administrative burden while ensuring accountability for public resources.**

  ONAP plans to work with OMB and our Federal partners to consider new ways to minimize reporting burden for state and local governments and to collect consistent and reliable data across Federal agencies.

Conclusion

We are grateful to the many community partners, including those living with HIV/AIDS, who are working with us to implement the *National HIV/AIDS Strategy for the United States* and meet the aggressive, but reasonable targets that we established. As we have somberly reflected on the last thirty years of fighting this epidemic in the U.S., we thank all people who remain committed to helping us make the vision of the Strategy a reality.

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