

HOUSTON AREA HIV SERVICES  
RYAN WHITE PLANNING COUNCIL



*We envision an educated community where the needs of all HIV/AIDS infected and/or affected individuals are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system. The community will continue to intervene responsibly until the end of the epidemic.*

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

AGENDA

12 noon, Thursday, April 11, 2013  
Meeting Location: 2223 W. Loop South, Room 416  
Houston, Texas 77027

- I. Call to Order
  - A. Welcoming Remarks and Moment of Reflection
  - B. Adoption of the Agenda
  - C. Adoption of the Minutes
  - D. Training : The How To Best Meet the Need Process
- II. Public Comments and Announcements
- III. Reports from Committees
  - A. Affected Community Committee

Greg Monk, Chair  
Ryan White Planning Council

Michael Bass and Cecilia Ross,  
Co-Chairs,  
Quality Assurance Committee

Morénike Giwa, Secretary

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

Teresa Presley Pruitt &  
Nadine Wallace, Co-Chairs

*Item: Committee Training: How To Best Meet the Need*  
*Recommended Action: FYI: The Committee received training in the How To Best Meet the Need process so that members can fully participate in this process in April and May 2013.*

*Item:* Houston Area Comprehensive HIV Prevention And Care Services Plan for 2012 - 2014

*Recommended Action:* FYI: See the attached update on the development of a nondiscrimination statement. The committee is gathering feedback from local stakeholders and from needs assessment activities before they will make a recommendation regarding action on this item.

*Item:* 2013 Committee Meeting Schedule

*Recommended Action:* FYI: See the attached 2013 Committee meeting schedule.

*Item:* National Youth HIV/AIDS Awareness Day: April 10

*Recommended Action:* FYI: See the attached description of National Youth HIV and AIDS Awareness Day which will be Wednesday, April 10, 2013.

B. Comprehensive HIV Planning Committee

Chris Escalante &  
Steven Vargas, Co-Chairs

*Item:* 2013 Joint Epidemiological Profile

*Recommended Action:* FYI: The Special Populations and Co-Infections sections of Chapter 6 have been drafted. New data on HIV and Hepatitis co-infection were received in March, and an additional section will be added. Grammar, formatting, and readability edits are being completed by staff now, and a complete draft of Chapter 6 will be provided to the Steering Committee and Council for review and approval at their May meetings. In the meantime, the portions of the document that were approved by the Council in March will be used for the How To Best Meet the Need process in April.

*Item:* Activity Planning for Year 2 of the Comprehensive HIV Plan

*Recommended Action:* FYI: The committee discussed implementation of assigned Year 2 activities from the Comprehensive HIV Plan and completed Activity Worksheets. Activities assigned to the Comprehensive HIV Planning Committee for Year 2 are:

- Engage broad-based Houston Area health, social service, and community coalitions in order to engage new and non-traditional partners in supporting the HIV prevention and care mission
- Establish or maintain formal partnerships between the Houston Area HIV Planning Bodies and agencies or individuals representing Special Populations; and through these partnerships, seek technical assistance and training on how the needs of Special Populations can be advanced
- Support ongoing statewide efforts for increased integration of HIV prevention and care as outlined in the *Texas HIV/STD Prevention Plan*, *Texas Jurisdictional Plan*, and *Texas Program Collaboration, Service Integration Plan (PCSI)*

All are to be conducted in collaboration with the HIV Prevention Community Planning Group (CPG).

*Item:* Update: 2014 HIV/AIDS Needs Assessment Process  
*Recommended Action:* FYI: The workgroup to design the consumer survey for the 2014 Needs Assessment convened by conference call on March 21, 2013 to finalize the survey. The Needs Assessment Group (NAG) will meet on April 2, 2013 to approve the consumer survey & sampling plan. The committee will approve both products at their April meeting.

*Item:* Other Special Studies from 2012  
*Recommended Action:* FYI: Analysis of the SIRR Provider Survey conducted in 2012 is complete, and the results will be presented and discussed at the April 10, 2013 Comprehensive HIV Planning Committee meeting.

C. Quality Assurance Committee

Cecilia Ross and  
Michael Bass, Co-Chairs

*Item:* Criteria for Determining the FY 2014 Service Categories  
*Recommended Action:* Motion: Approve the attached Chart which lists the criteria to be used to determine the Ryan White Part A, MAI, Part B and *State Services* FY 2014 service categories.

*Item:* Assessment of the Administrative Mechanism  
*Recommended Action:* Motion: Approve the attached *2013 Assessment Checklist* for the assessment of the local Ryan White HIV/AIDS Program administrative mechanism.

*Item:* 2012 Ryan White Part A Chart Reviews  
*Recommended Action:* FYI: See the attached copy of the Ryan White Part A 2012 Chart Reviews for the following services:

- Primary Care
- Vision Care

*Item:* 2013 How To Best Meet the Need Training and Workgroup Meeting Schedule  
*Recommended Action:* FYI: See the attached workgroup meeting schedule for the 2013 How To Best Meet the Need process. All are encouraged to see Georgette Monaghan to sign up to participate in a training or workgroup. Workgroup meeting packets will be available at the How To Best Meet the Need training meeting at 1:30 pm on Thursday, April 11, 2013.

*Item:* Navigator Program  
*Recommended Action:* FYI: The attached Idea Form regarding a Navigator Program has been forwarded to the How To Best Meet the Need Workgroup on Monday, April 15, 2013 with a possible follow up workgroup on Thursday, April 18, 2013.

- D. Priority and Allocations Committee  
*Item:* Ryan White Part A/MAI Procurement Report  
*Recommended Action:* FYI: See the attached Ryan White Part A/MAI Procurement Report (dated 03/11/13) and the 4<sup>th</sup> Quarter, final FY 2012 Service Utilization Report (dated 03/28/13).

Gabriel Gonzalez and  
Bruce Turner, Co-Chairs

*Item:* Ryan White Part B & State Services Procurement Reports  
*Recommended Action:* FYI: See the attached Ryan White Part B and State Services Procurement Reports.

*Item:* FY 2014 Guiding Principles & Criteria  
*Recommended Action:* Motion: Approve the attached FY 2014 Guiding Principles and Criteria.

*Item:* FY 2014 Priority Setting Process  
*Recommended Action:* Motion: Approve the attached FY 2014 Priority Setting Process.

*Item:* 2013 Policy for Addressing Unobligated & Carryover Funds  
*Recommended Action:* Motion: Approve the attached 2013 Policy for Addressing Unobligated and Carryover Funds.

*Item:* FY 2013 Congressional Budget  
*Recommended Action:* FYI: See the attached chart which shows examples of the potential impact of Sequester-related reductions in Houston's RW award.

- E. Operations Committee  
*Item:* Council Member Statement of Confidentiality  
*Recommended Action:* Motion: Approve the attached Statement of Confidentiality form and ask all members to sign the form and turn it into Tori at the end of the April 2013 Council meeting.

Kevin Moore and  
David Watson, Co-Chairs

*Item:* Office of Support Staff Policies and Procedures  
*Recommended Action:* FYI: See the attached Office of Support Staff Policies and Procedures.

- V. Report from the Office of Support

Tori Williams, Manager  
Office of Support

- VI. Report from Ryan White Grant Administration

Charles Henley, Manager,  
Ryan White Grant Admin., HCPHS

- |       |   |  |
|-------|---|--|
| VII.  | Report from The Resource Group  | Patrick Martin, Program<br>Development Director,<br>The Resource Group |
|       |   |  |
| VIII. | New Business  |  |
| A.    | Spotlight on the Operations Committee   | David Watson &<br>Kevin Moore, Co-Chairs                               |
| B.    | Ryan White Part C Urban   | Nancy Miertschin   |
| C.    | HOPWA   | Melody Barr  |
| D.    | Community Prevention Group (CPG)  | Steven Vargas  |
| E.    | Update from Task Forces:  |  |
|       | <ul style="list-style-type: none"> <li>• African American</li> <li>• Latino</li> <li>• MSM</li> <li>• Transgender</li> <li>• Youth</li> <li>• Hepatitis C</li> <li>• Syphilis</li> <li>• Urban AIDS Ministry</li> </ul> | Amber David<br>Jerry Garza<br>Bruce Turner                             |
| F.    | AIDS Trial Network  | Steven Vargas  |
| G.    | Legislative Updates   |  |
| H.    | Texas HIV/AIDS Coalition  | Morénike Giwa  |
| I.    | SPNS Grant: HIV and the Homeless Program  | Januari Leo  |
| J.    | Medical Updates   | Januari Leo or Bruce Turner<br>Nancy Miertschin<br>Ben Barnett, MD     |

VIII. Announcements

IX. Adjournment

**HOUSTON AREA HIV SERVICES  
RYAN WHITE PLANNING COUNCIL**



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

**MINUTES**

12 noon, Thursday, March 14, 2013

Meeting Location: 2223 W. Loop South, Room 532  
Houston, Texas 77027

<b>MEMBERS PRESENT</b>	<b>MEMBERS PRESENT</b>	<b>OTHERS PRESENT</b>
Greg Monk, Chair	Kevin Moore	Modelle Brudner, Liaison for County Judge Emmett
Ben Barnett, Vice-Chair	Teresa Presley Pruitt	Ramiro Hernandez
Morénike Giwa, Secretary	Leslie Raneri	Chevonne Potter, Bering Omega Community Svcs.
Roland Amboree	Cecilia Ross	Captain Yukiko Tani, HRSA
Ruth Atkinson	C. Bruce Turner	Juanita Farrow, HRSA Consultant
Melody Barr	Eric Twombly	Lolita Cervera, HRSA Consultant
Michael Bass	Steven Vargas	Pamela Smith, Gilead
Curtis Bellard	Nadine Wallace	
David Benson	David Watson	<b>STAFF PRESENT</b>
Bianca Burley	Tamika White	<i>Ryan White Grant Administration</i>
Ella Collins-Nelson	Larry Woods	Charles Henley
Amber David	<b>MEMBERS ABSENT</b>	Carin Martin
Chris Escalante	Rene de Buenrosto	Heather Keizman
Evelio Escamilla	Jerry Garza, excused	<i>The Resource Group</i>
Gene Ethridge	J. Hoxi Jones, excused	Patrick Martin
Herman Finley	Januari Leo, excused	<i>Office of Support</i>
Gabriel Gonzalez	Osaro Mgbere, excused	Tori Williams
Tracy Gorden	Nancy Miertschin, excused	Jen Hadayia
Paul Grunenwald	Terrence Redix	Georgette L. Monaghan
Nelson Lopez	Lena Williams-Ellis, excused	

**See the attached chart at the end of the minutes for individual voting information.**

**Call to Order:** Greg Monk, Chair, Ryan White Planning Council, called the meeting to order at 12:09 p.m. and welcomed three guests: Captain Yukiko Tani from HRSA and two HRSA consultants, Juanita Farrow and Lolita Cervera.

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

Adoption of the Minutes: **Motion #2:** *it was moved and seconded (Turner, Collins-Nelson) to adopt the February 14, 2013 minutes. Motion carried.* Abstentions: Presley Pruitt, Watson, White.

Council Training: Jennifer Hadayia, Health Planner, Office of Support provided summaries of the following Council documents:

- *2013 Houston Area Integrated Epidemiological Profile for HIV/AIDS Prevention & Care Services Plan*
- *Access to HIV Care Among Transgender & Gender Non-Conforming People in Houston.* Raneri suggested that a fact sheet summarizing the information learned in the study be developed and provided to providers. Turner asked that CPCDMS add an additional box for gender pronouns. Vargas felt that HRSA should also work on being inclusive of transgender individuals in their materials.

**Public Comments and Announcements:** Giwa read the guidelines regarding public comment. Chevonne Potter, Bering Omega Community Services, summarized the attached flyer regarding Home and Community Based Health Service – Day Treatment Program.

### **Reports from Committees:**

**Affected Community Committee:** Teresa Presley Pruitt, Co-Chair, reported on the following:

Committee Training: The Committee started its first meeting of the year with training on the purpose of the Council, information about Ryan White related public hearings and the perimeters for participating in local health fairs, see attached presentation.

2013 Committee Goals: See the attached 2013 Committee goals. The first status report on activities *related to the goals is due in April 2013.*

Houston Area Comprehensive HIV Prevention And Care Services Plan for 2012 - 2014: In February, all but one Ryan White Planning Council Standing Committee reviewed the Year 2 Implementation Checklist from the Comprehensive Plan, see attached checklist.

**Comprehensive HIV Planning Committee:** Steven Vargas, Co-Chair, reported on the following:

2013 Joint Epidemiological Profile: ***Motion #3:*** *Approve the 2013 Houston Area Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Services Plan. Motion carried unanimously.*

Year 1 Evaluation Report for the Comprehensive HIV Plan: ***Motion #4:*** *Approve the Year 1 Evaluation Report for the 2012 Comprehensive HIV Prevention and Care Services Plan (dated 02/20/13), see attached. Motion carried unanimously.*

Access to HIV Care Among Transgender People: ***Motion #5:*** *Approve the special study entitled Access to HIV Care Among Transgender and Gender Non-Conforming People in Houston (dated: 01/28/13), including the recommendations outlined in the memo. See attached document and recommendations. Motion carried unanimously.*

Update on the 2014 HIV/AIDS Needs Assessment Process: The workgroup to design the survey questions for the 2014 Needs Assessment held its first meeting on February 19, 2013. See the attached list of recommended changes for the 2014 survey.

Planning for Year 2 Implementation of the Comprehensive HIV Plan: See the attached Implementation Checklist for the Ryan White Planning Council for Year 2 of the Comprehensive HIV Prevention and Care Plan. All Planning Council Committees have been informed of their role in Year 2 implementation and will begin planning for their activities in March.

**Quality Assurance Committee:** Michael Bass, Co-Chair, gave the following reports:

2012 Part B and State Services Chart Reviews: See the attached copy of the Ryan White Part B and State Services funded 2012 Chart Reviews for the following services:

- Case Management
- Home and Community Based Services
- Hospice
- Mental Health
- Oral Health Care
- Outpatient Ambulatory Medical Care

Ryan White Grant Administration will present the 2012 Chart Reviews for Part A and MAI funded services at the March 21, 2013 Committee meeting.

FY 2014 How to Best Meet the Need Training and Workgroup Meeting Schedule: See the attached workgroup meeting schedule for the FY 2014 How to Best Meet the Need process. See Monaghan to sign up to participate in a training or workgroup. Workgroup meeting packets will be available at the How to Best Meet the Need Training meeting at 1:30 p.m. on Thursday, April 11, 2013. Williams stated that one new idea has been turned in for the navigator program and, if it is accepted by the Quality Assurance Committee, it will be sent to a How To Best Meet the Need workgroup for further discussion and consideration.

2013 Committee Goals: See the attached 2013 Committee goals.

**Priority and Allocations Committee:** Gabriel Gonzales, Co-Chairs, reported on the following:

2013 Proposed Idea Form and Criteria: ***Motion #6*** from the *Quality Assurance and the Priority and Allocations Committees: Approve the attached 2013 Proposed Idea Form and the 2013 Criteria for Reviewing Ideas for use after 03/14/13. Motion carried unanimously.*

2013 Committee Policies: The Committee will be reviewing and making recommendations on the following policies at their March 28, 2013 Committee meeting, see attached policies used in 2012:

- Guiding Principles & Criteria
- Priority Setting Process
- Policy for Addressing Unobligated & Carryover Funds

Please submit comments or questions about these policies to the Office of Support before March 28, 2013.

Reports from the Administrative Agent – Part B: See the attached reports:

- FY 12/13 Ryan White Part B Procurement Report (9/1/12 – 12/31/12)
- FY 12/13 Ryan White Part B Allocations Worksheet (9/1/12 – 12/31/12)
- 2012-2013 Ryan White Part B Service Utilization (9/1/12 – 12/31/12)
- FY 12/13 DSHS State Services Procurement Report (9/1/12 – 12/31/12)
- FY 12/13 DSHS State Services Service Utilization (9/1/12-8/31/12)

2013 Committee Goals: See the attached 2013 Committee goals.

**Operations Committee:** David Watson, Co-Chair, reported on the following:

2013 Mentor/Mentee Luncheon: See the attached evaluation results from the 2013 Mentor/Mentee Luncheon.

2013 Council Orientation: See the attached evaluation results from the 2013 Council Orientation.

2013 Council Training: See the attached list of Council training topics for 2013.

FY 2013 Project LEAP Service Definition: **Motion #7**: Approve the attached FY 2013 Project LEAP service definition (see underlined text for changes). **Motion carried unanimously.**

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

**Report from Ryan White Grant Administration:** Charles Henley, Manager, Ryan White Grants Administration, Harris County Public Health Service, summarized the attached report.

**Report from The Resource Group:** Patrick Martin, Program Development Director, The Resource Group, summarized the attached report.

### **New Business**

**HOPWA:** Barr stated that her office is planning for a 10% decrease, although HUD has told them it would be 5%. Two Public Hearings will be held for the City of Houston's Housing and Community Development Department 2013 Action Plan. The Hearings will be on April 3, 2013 at the West End Multi-Service Center, 170 Heights Boulevard and April 10, 2013 at the Third Ward Multi-Service Center, 3611 Ennis Street; both will begin at 6:00 p.m. The next HOPWA RFP's will be released in April for a 2-year grant cycle.

**Community Prevention Group (CPG):** David stated that members of the CPG worked in partnership with the City Health Department to hold their annual Orientation for new members.

### **Update from Task Forces:**

**African American:** David stated that the Task Force met the 2<sup>nd</sup> Friday of the month at the Kashmere Multi Service Center at noon. They are recruiting for membership on three committees: 1) Advocacy, 2) Media and 3) Action (testing). Finley added that the Task Force will be conducting outreach at the Sunnyside Multi Service Center on April 26, 2013.

**Latino:** Vargas stated that the Latino Task Force (LHTF) held its first quarterly evening meeting in conjunction with the Gilead Quarterly HIV Networking Dinner on Thursday, February 21, 2013. The event was well attended with representatives from area agencies, local pharmacies, and HIV advocates. Everyone benefited from a presentation by Dr. Ponce regarding Latinos and HIV care.

The LHTF will be walking in the upcoming Cesar Chavez Parade, and is looking for others interested in joining them. The parade will be held on Saturday, March 23, 2013. Walkers will meet in the Sellers parking lot located at the corner of Canal St. and Cesar Chavez at 9 am. The next meeting will be held on Friday, March 29, 2013, from 2 pm – 4 pm at the West End Multi-service Center located at 170 Heights Boulevard (between Washington & I-10), Houston, TX, 77007.

**Men Who Have Sex with Men (MSM):** Turner stated that this Task Force meets on the 3<sup>rd</sup> Monday of the month. They are sponsoring a testing event at the F-Bar on St. Patrick's Day. Follow up testing will occur quarterly at the F-Bar. In September, they will sponsor a Health Fair of some sort in conjunction with National Gay Men's HIV/AIDS Awareness Day. Turner has been in touch with other tasks force to find individuals interested in creating an Over Age 50 Task Force.

**Hepatitis C:** Vargas reported that this Task Force is planning a multi-day observance for National Hepatitis Awareness Month in May 2013. May 19th marks the 2<sup>nd</sup> Annual Hepatitis Testing Day, and HCV education and testing is being planned at multiple venues on multiple days. Legacy has committed to a May 17 observance with HCV education and testing, and AAMA has committed to the same for Monday, May 20. Other agencies are being sought to engage in this effort, so if interested in assisting, please consider attending an upcoming meeting, generally held the second Wednesday of the month.

**AIDS Trial Network:** Giwa gave the following report: For current trends in HIV research and science, please

visit the Conference on Retroviruses and Opportunistic Infections (CROI) website at: [www.retroconference.org](http://www.retroconference.org). For info on upcoming HIV research events, including national and regional meetings and trainings, please visit the HIV/AIDS Network Coordination website calendar at: [www.hanc.info](http://www.hanc.info). Regarding local Community Advisory Board (CAB) meetings: A) In March 2013: Texas Children's/Baylor CAB meeting: (This CAB represents Houston HIV research for the International Maternal Pediatric Adolescent AIDS Clinical Trials Group [IMPAACT], Ryan White Part D [HIV affected women, infants, children, youth, and caregivers], Pediatric HIV/AIDS cohort [PHACS], and the Adolescent Trials Network [ATN]). Next meeting: 11:30 am to 1 pm on March 26, 2013, Texas Children's Feign Center, 6701 Fannin Street. For more info or to RSVP: [TMAldape@texaschildrens.org](mailto:TMAldape@texaschildrens.org). B) In April 2013: Houston HIV/AIDS Cross-Network Community Advisory Board: (This CAB represents Houston HIV research for the AIDS Clinical Trials Group [ACTG], the HIV Vaccine Trials Network [HVTN], and the AIDS Malignancy Consortium [AMC]). Next meeting (free; meal provided): 5:30 pm to 6:30 pm, April 16, 2013 at Legacy – Montrose on the 4th floor, 1415 California Street. For more info or to RSVP: [PSimmons@legacycommunityhealth.org](mailto:PSimmons@legacycommunityhealth.org).

**Medical Updates:** Barnett, MD made some general comments about the recent item in the news describing a possible second person to be cured of HIV. An HIV+ pregnant woman in Mississippi gave birth to a baby who was found to be HIV+. The baby was put on HIV medication, then the mother and baby were lost to care. For five months the baby was not taking HIV medication and now there is no evidence of HIV infection in the child. The conclusion was that treating the baby within 30 hours of being born irradiated the infection and the baby was “cured”. The story is controversial. Was the baby exposed or was the baby actually infected? The reason why infected persons cannot be cured is because there are cells in the body that live forever and HIV get in these cells and are stored forever; these are called long term or latent memory cells. Neonates apparently do not have these memory cells therefore, HIV has no way to become latent. What does this mean for adults? If one can eliminate these latent reservoirs that exist in all of us, could a cure may be found? Regarding the story about bee venom killing HIV, this is just another molecule that blocks HIV, there are a lot of molecules that block HIV.

**Announcements:** Escalante stated that the topic there will be a meeting at the Transgender Center at 6 pm on March 14, 2013. The topic is HIV and Your Heart. Giwa pointed out a flyer on National Women and Girl's HIV Day. Also in the packet is information about World TB Day in Texas on March 24, 2013 and the first National Youth HIV Awareness Day on April 12, 2013. David stated that on Saturday, March 16, 2013 the Live Consortium will be hosting the 2013 African American Women HIV/AIDS Forum, see attached flyer. Wallace asked members to be aware of the National Kidney Walk on April 14, 2013.

**Adjournment:** The meeting adjourned at 1:58 p.m.

Respectfully submitted,

\_\_\_\_\_  
Victoria Williams, Manager

\_\_\_\_\_  
Date

Draft Certified by  
Council Chair: \_\_\_\_\_

Date \_\_\_\_\_

Final Approval by  
Council Chair: \_\_\_\_\_

Date \_\_\_\_\_

# DRAFT

## Council Meeting Voting Records for March 14, 2013.

C = Chair of the meeting LM = Left the meeting VP = via phone	<b>Motion #1</b>				<b>Motion #2</b>					<b>Motion #1</b>				<b>Motion #2</b>			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN		ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
MEMBERS									MEMBERS								
Roland Amboree		X				X			Kevin Moore		X				X		
Ruth Atkinson		X				X			Teresa Presley Pruitt		X						X
Ben Barnett		X				X			Leslie Raneri, 12:17	X				X			
Melody Barr, 12:12	X				X				Cecilia Ross		X				X		
Michael Bass		X				X			Bruce Turner		X				X		
Curtis Bellard		X				X			Steven Vargas		X				X		
David Benson		X				X			Nadine Wallace		X				X		
Bianca Burley, 12:13	X				X				Eric Twombly, 12:33	X				X			
Ella Collins-Nelson		X				X			David Watson		X						X
Amber David, 12:13	X				X				Tamika White		X						X
Chris Escalante		X				X			Larry Woods		X				X		
Evelio Escamilla		X				X											
Gene Ethridge		X				X			Rene de Buenrostro	X							
Herman Finley		X				X			Jerry Garza	X							
Morénike Giwa		X				X			J. Hoxi Jones	X							
Gabriel Gonzalez		X				X			Januari Leo	X							
Tracy Gorden		X				X			Osaro Mgbere	X							
Paul Grunenwald		X				X			Nancy Miertschin	X							
Nelson Lopez		X				X			Terrence Redix	X							
Greg Monk				C				C	Lena Williams-Ellis	X							

C = Chair of the meeting LM = Left the meeting VP = via phone	Motion #3			Motion #4				Motion #3			Motion #4			
	ABSENT	Epi Profile YES	Carried NO	ABSTAIN	Year 1-Comp YES	Carried NO		ABSTAIN	ABSENT	Epi Profile YES	Carried NO	ABSTAIN	Year 1-Comp YES	Carried NO
MEMBERS								MEMBERS						
Roland Amboree		X			X			Kevin Moore	X				X	
Ruth Atkinson		X			X			Teresa Presley Pruitt	X				X	
Ben Barnett		X			X			Leslie Raneri	X				X	
Melody Barr		X			X			Cecilia Ross	X				X	
Michael Bass		X			X			Bruce Turner	X				X	
Curtis Bellard		X			X			Steven Vargas	X				X	
David Benson		X			X			Nadine Wallace	X				X	
Bianca Burley		X			X			Eric Twombly	X				X	
Ella Collins-Nelson		X			X			David Watson	X				X	
Amber David		X			X			Tamika White	X				X	
Chris Escalante		X			X			Larry Woods	X				X	
Evelio Escamilla		X			X									
Gene Ethridge		X			X			Rene de Buenrostro	X					
Herman Finley		X			X			Jerry Garza	X					
Morénike Giwa		X			X			J. Hoxi Jones	X					
Gabriel Gonzalez		X			X			Januari Leo	X					
Tracy Gorden		X			X			Osaro Mgbere	X					
Paul Grunenwald		X			X			Nancy Miertschin	X					
Nelson Lopez		X			X			Terrence Redix	X					
Greg Monk			C				C	Lena Williams-Ellis	X					

C = Chair of the meeting LM = Left the meeting VP = via phone																	
	<b>Motion #5</b>				<b>Motion #6</b>					<b>Motion #5</b>				<b>Motion #6</b>			
	Transgender	Carried			Idea Form-QA	Carried				Transgender	Carried			Idea Form-QA	Carried		
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Roland Amboree		X				X			Kevin Moore		X				X		
Ruth Atkinson		X				X			Teresa Presley Pruitt		X				X		
Ben Barnett		X				X			Leslie Raneri		X				X		
Melody Barr		X				X			Cecilia Ross		X				X		
Michael Bass		X				X			Bruce Turner		X				X		
Curtis Bellard		X				X			Steven Vargas		X				X		
David Benson		X				X			Nadine Wallace		X				X		
Bianca Burley		X				X			Eric Twombly		X				X		
Ella Collins-Nelson		X				X			David Watson		X				X		
Amber David		X				X			Tamika White		X				X		
Chris Escalante		X				X			Larry Woods		X				X		
Evelio Escamilla		X				X											
Gene Ethridge		X				X			Rene de Buenrostro	X							
Herman Finley		X				X			Jerry Garza	X							
Morénike Giwa		X				X			J. Hoxi Jones	X							
Gabriel Gonzalez		X				X			Januari Leo	X							
Tracy Gorden		X				X			Osaro Mgbere	X							
Paul Grunenwald		X				X			Nancy Miertschin	X							
Nelson Lopez		X				X			Terrence Redix	X							
Greg Monk				C				C	Lena Williams-Ellis	X							

	Motion #7					
	ABSENT	YES	NO			
C = Chair of the meeting LM = Left the meeting VP = via phone						
MEMBERS	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSTAIN
Roland Amboree		X			Kevin Moore	
Ruth Atkinson		X			Teresa Presley Pruitt	
Ben Barnett		X			Leslie Raneri	
Melody Barr		X			Cecilia Ross	
Michael Bass		X			Bruce Turner	
Curtis Bellard		X			Steven Vargas	
David Benson		X			Nadine Wallace	
Bianca Burley		X			Eric Twombly	
Ella Collins-Nelson		X			David Watson	
Amber David		X			Tamika White	
Chris Escalante		X			Larry Woods	
Evelio Escamilla		X				
Gene Ethridge		X			Rene de Buenrostro	X
Herman Finley		X			Jerry Garza	X
Morénike Giwa		X			J. Hoxi Jones	X
Gabriel Gonzalez		X			Januari Leo	X
Tracy Gorden		X			Osaro Mgbere	X
Paul Grunenwald		X			Nancy Miertschin	X
Nelson Lopez		X			Terrence Redix	X
Greg Monk				C	Lena Williams-Ellis	X

## **Steps to Participate in the 2013 How To Best Meet the Need Process**

### **What is *How To Best Meet the Need*?**

It is defining the HRSA approved service categories so that they “best meet the needs” of our local community.

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. Each year, the Planning Council reviews and refines its service definitions in preparation for the **FY 2014** funding cycle which begins March 1, 2014. The purpose of each workgroup is to review specific service category definitions and make recommendations as needed to improve service delivery and effectiveness.

- Step 1: Determine the criteria to be used to select FY 2014 service categories. **March 21, 2013.**
- Step 2: Sign up for a How To Best Meet the Need workgroup.
- Step 3: Attend training on the documents that will be used to justify changes made to the current service definitions. **1:30 – 4 pm, Thurs., April 11, 2013 in Room 416.**
- Pick up packets of materials for the workgroup(s) you will be attending.
- Step 4: Attend your workgroup(s). At the workgroups you will:
- Introduce yourself and state your conflict of interest
  - Staff will explain their role in the process
  - The Administrative Agent will provide general information
  - The Office of Support will provide general information
  - Review each service definition and possibly recommend changes
  - Determine the financial eligibility for the service
- Step 5: Watch to see if changes are made to a service category of particular interest to you at the Quality Assurance Committee meeting. **10 am, Mon., May 16, 2013 Room 416.**
- Step 6: Attend the Public Hearing where the service definitions are presented to the public. **7 pm, Wed., May 29, 2013, City Annex, 900 Bagby St, downtown Houston.**
- Step 7: Watch to see if changes are made to a particular service category at the **June 6<sup>th</sup> Steering Committee or June 13, 2013 Council meetings.** Changes made to services are final only after the Council has approved the FY 2014 service definitions.

**March 1, 2014: Changes made to FY 2014 service categories take effect.**



**Comprehensive HIV Plan  
Strategy #3, Activity #1  
*Developing a Workable Universal  
Nondiscrimination Statement***

Rusty Wendt, MS, DrPH Candidate (UTSPH)  
Intern, Ryan White Planning Council Office of Support  
December 2012

*Updated March 2013*



**Our Vision Statement**

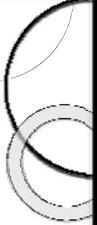
- *“The greater Houston Area will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination.”*

## 2012-2014 Comprehensive Plan

- The development of a nondiscrimination statement is Activity #1 of the Special Population Strategy
- The rationale for the activity was:
  - *“Discrimination based on characteristics such as age, economic or legal circumstance, or gender non-conformity can hinder access to health care by Special Populations. Members of these groups often report postponing health care due to discrimination. While provider-level sensitivity is effective in helping alleviate such barriers, personal efforts may not be enough to overcome the common organizational barriers presented by health care organizations, and structural solutions are also needed.”*

## What the RW System Already Does

- Requires funded providers to:
  - *Adhere to Standards of Care (SOC) regarding client treatment*
  - *Adhere to cultural competence and other training requirements*
  - *Adhere to Cultural and Linguistic Acceptability Standards (CLAS)*
  - *Address most of the groups mentioned in the Strategy per the Request for Proposals (RFP)*
  - *Maintain a Consumer Advisory Board (CAB)*
- Conducts client satisfaction surveys
- Distributes client rights cards
- Operates a consumer hotline
- Trains advocates through Project LEAP
- Receives ongoing consumer input via RWPC



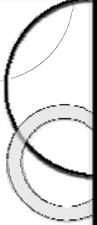
## Activity Status 2012-Present

- Completed background research:
  - Reviewed RFPs, Standards of Care (SOC), Client Rights Card, and CLAS
  - Surveyed other RWPC jurisdictions
- Conducted key informant interviews with individuals involved in the Special Populations Workgroup and with current system processes:
  - Anna Henry (Resource Group), Carin Martin (RWGA), Scot More (Homeless Coalition), David Watson (HDHHS), and Cristan Williams (Transgender Center)
- Drafts of an inclusion statement were developed
- Presentations were given to:
  - Affected Community Committee/RWPC
  - Prioritization Committee/CPG
- The need for additional interviews/presentations was identified:
  - Charles Henley (RWGA), Ann Robison (MCC)
  - HIV Prevention Contractors



## Findings To Date

- Lack of consistency in the Special Populations/protected characteristics mentioned in RFPs, SOC, and client rights
- Per key informants, the groups needing more attention are transgender, YMSM, women, IDU, and the recently released
- Per feedback, there may be lack of awareness among community members about the structural remedies already in place by RWGA and about their rights as consumers



## Findings To Date

- There are multiple ways to address this activity, but no single way appears ideal. For example:
  1. Revise RFPs, SOC, and Client Rights for consistent referencing of groups/protected characteristics? *(Could be outside our scope and in conflict with funder requirements/legal restrictions)*
  2. Focus on consumer education with a brochure/fact sheet about current protections and remedies? *(Could be unnecessary and added work for providers)*
  3. Continue with the development of a statement that would be voluntary for agencies to use and promote? *(Impact could be minimal and added work for providers)*
  4. Do nothing – what’s in place is working! *(Monitor via needs assessments and re-visit in 2014)*
- More information gathering is needed before the Activity can move forward



## Draft Statement #1 (Dec 12)

- *“Our providers will serve any person regardless of race/ethnicity, color, national origin, religious affiliation, political affiliation, native language, birth gender, gender expression, sexual orientation, mental or physical disability, age, past or present addiction status, past or present incarceration status, income, or housing status and allow for participation in their programs, services and activities.”*



## Draft Statement #2 (Feb 13)

- *“For the populations that each provider serves, they will do so in a manner that is free of stigma and discrimination in regards to age, sex, race/ethnicity, sexual orientation, gender identity or expression, socio-economic circumstance, religious or political affiliation, mental or physical disability, or addiction, incarceration, or housing status.”*



## 2013 Client Rights Card

- *“As a client at an agency receiving services funded by the Ryan White Program, you have the following rights:*
  - *To be served without regard to age, gender, race, color, religion, national origin, sexual orientation, political affiliation or disability[.]”*

DRAFT

Schedule of Topics for the  
2013 Affected Community Committee Meetings

(revised 03-27-13)

Shaded areas indicate an off-site meeting location

**AFFECTED COMMUNITY COMMITTEE MEETINGS WITH SPEAKERS:**

Confirmed	Month 2013	Topic	Speaker/Facilitator	Meeting Location
✓	11 am, Tues February 26	<ul style="list-style-type: none"> <li>• Purpose of the Council and Public Hearings</li> <li>• Participation in Health Fairs</li> <li>• Why meetings are held off-site</li> </ul>	Tori Williams	Office of Support
✓	11 am, Tues March 26	How To Best Meet the Need Training – Part 1; Comp Plan Activities	Tori Williams Jen Hadayia	Office of Support
✓	April	<b>Instead of a meeting, members are asked to participate in:</b> How To Best Meet the Need Training – Part 2 1:30 pm, Thurs. 4/11/13		Office of Support
✓	11 am, <b>MONDAY</b> May 20	HIV and Oral Health	Representative, St. Hope Foundation Dental Program	St. Hope Foundation Conroe, Texas
✓	6 pm, Wed. May 29	<b>Host Public Hearing w/ LEAP students in attendance</b>	Tori Williams	City Hall Council Chamber, 900 Bagby St. 77002
	11 am, Tues June 25	Updates on the Affordable Care Act	Januari Leo	Tentative: Legacy Community Health Serv.
Location confirmed	7 pm, <b>FRIDAY</b> , July 19	Navigator Programs	Glenda Kizzee NAACP	Living Without Limits Hostess: Cecilia Ross
	11 am, Tues August 20	The Impact of the Affordable Care Act on ADAP	Sondra Longoria	
	11 am, Tues September 24	Standards of Care, Why Should I Care?	Jennifer Hadayia	
	11 am, Tues October 22	Standards of Care and Outcome Measure Consumer Only Workgrp.	RWGA staff	Office of Support
	11 am, Tues November 26	Tentative: TB & HIV	Lamar Adams	Tentative: City Health Dept.

**Possible Topics:**

Community Involvement in HIV Clinical Research Trials - Morénike Giwa  
Medication Updates

## National Youth HIV & AIDS Awareness Day – April 10

Today's young people are the first generation that has never known a world without HIV and AIDS. In the United States, **almost 40 percent of new HIV infections are young people ages 13 to 29**. Despite this harsh reality, young people and their allies are determined to end this pandemic once and for all.

It's more important than ever to recommit to the fight against HIV and AIDS. We must continue to invest in scientific advancements like a vaccine and a cure - without forgetting the importance of prevention strategies and ensuring equal access to information and healthcare for everyone.

And most importantly, we must invest in young people - bring them to the table not only as partners, but as leaders that can truly turn the tide of the HIV and AIDS epidemic. Only by fully investing in young people - in their health, their education, and their leadership - can we reach an AIDS-free generation.

## Why a National Youth HIV and AIDS Awareness Day?

The creation of NYHAAD is a step toward acknowledging and addressing the needs of young people in the HIV and AIDS response. Each year, young activists in high schools and at colleges and universities across the country will use this day to organize and educate about HIV and AIDS. They will promote HIV testing, fight stigma, and start the necessary conversation we need to deal honestly and effectively with the challenges we face. NYHAAD will also provide a yearly date for all of us to hold our leaders responsible to their commitments and invest in realizing an AIDS-free generation.

## What can I do?

[Click here to add your name in support of National Youth HIV & AIDS Day.](#) Together, we can make sure that the needs – and voices – of young people are central to the U.S. response to HIV & AIDS.

## What can my organization do?

[Click Here to Endorse the National Youth HIV & AIDS Awareness Day](#)

<p><b>Service Category</b></p>	<p><b>Is this a core service?</b> If no, how does the service support access to core services &amp; support clients achieving improved outcomes?</p>	<p><b>How does this service assist individuals <i>not in care</i>* to access primary care?</b>  *<i>EIHA: Early Identification of Individuals with HIV/AIDS</i> seeks to identify the status-unaware and link them into care  *<i>Unmet Need:</i> Individuals diagnosed with HIV but with no evidence of care for 12 months</p>	<p><b>Documentation of Need</b>  (Sources of Data include: 2011 Needs Assessment, 2012-2014 Comp Plan, 2011 Outcome Measures, 2011 Chart Reviews, Special Studies and surveys, etc.)</p>	<p><b>Identify non-Ryan White/non-State Services Funding Sources</b>  (i.e., Alternative Funding Sources)</p>	<p><b>Justify the use of Ryan White Part A, Part B and State Services funds for this service.</b>  <b>Is this a duplicative service or activity?</b></p>	<p><b>Service Efficiency</b> Can we make this service more efficient? For: a) Providers b) Clients  Can we bundle this service?  Has a recent capacity issue been identified?</p>	<p><b>Recommendation(s)</b></p>
<p><b>Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-22-13</b></p>							
<p><b>Ambulatory/Outpatient Primary Medical Care (incl. Vision):</b></p>							
<p><b>Adult – Part A, Including LPAP</b> (Includes OB/GYN) <i>See below for Pediatric – Part A, Vision, and Adult – Part B</i></p>	<p>___Yes ___No</p>						

‡ Service Category for Part B/State Services only.

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 <i>not in care</i> * to access primary care? <i>*EIIHA: Early Identification of Individuals with HIV/AIDS</i> seeks to identify the status-unaware and link them into care <i>*Unmet Need:</i> Individuals diagnosed with HIV but with no evidence of care for 12 months	Documentation of Need (Sources of Data include: 2011 Needs Assessment, 2012-2014 Comp Plan, 2011 Outcome Measures, 2011 Chart Review, Special Studies and surveys, etc.)	Identify non-Ryan White/non-State Services Funding Sources (i.e., 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)
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**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 Primary Medical Care (incl. Vision):**

<p><b>Adult – Part A, Including LPAP</b> (Includes OB/GYN) <i>See below for Pediatric – Part A, Vision, and Adult – Part B</i></p> <p><b>Workgroup 1</b> <b>Motion #1:</b> (Boyle/Pruitt) Votes: Y=10; N=0; Abstentions=Derouen, Malone, Robison</p> <p><b>Motion #2:</b> (Turner/Boyle) Votes: Y=10; N=0; Abstentions= Derouen, Malone, Robison</p> <p><b>Motion 3:</b> (Turner/Boyle) Votes: Y=10; N=0; Abstentions= Derouen, Malone, Robison</p>	<p><input checked="" type="checkbox"/> Yes ___No</p>	<p><u>EIIHA:</u> Identifying and facilitating entry of the newly diagnosed into primary care is the intended outcome of EIIHA. The current estimate of the total number of status-unaware in the EMA is 5,306 (2009). In 2011, 2,401 (21%) clients were "new" to RW. Local Pharmacy Assistance (LPAP) cannot be accessed until client is enrolled in primary care.</p> <p><u>Unmet Need:</u> Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. The current estimate of the total number of individuals with unmet need in the EMA is 7,129 (or 34.2% of living HIV/AIDS cases) (2010). Local Pharmacy Assistance (LPAP) cannot be accessed until client is enrolled in primary care. Evidence of an ART prescription is a criterion used for measuring unmet need.</p>	<p><u>Need (2011):</u> Current # of living HIV/AIDS cases in EMA: 20,875 Rank w/in core services in NA: <i>Primary Care: #1</i> <i>Pharmacy Assistance: #2</i></p> <p><u>Service Utilization (2011):</u> # clients served: <i>Primary Care: 6,842</i> <i>(3% decrease v. 2010)</i> <i>Pharmacy Assistance: 3,064</i> <i>(0.5% decrease v. 2010)</i></p> <p><u>Outcomes (FY2012):</u> 93% of clients increased or maintained CD4; 90% decreased or maintained viral load; 60% had undetectable viral load; &lt;0.01% had an OI</p> <p><u>Comp Plan Alignment (2012):</u> G2, G3 O4, O5, O6, O7 S1 (G1, 5), S2 (G1, 3, 4), S3 (G1, 2), S4 (G2, G3)</p>	<p><u>Primary Care:</u> Medicaid, Medicare</p> <p><u>Local Pharmacy Assistance Program:</u> This service complements the state ADAP program, the State Pharmacy Assistance Program, the public clinic's pharmacy program, Medicare Part D, and RW Health Insurance Assistance. Providers are required to asses for eligibility under private sector patient assistance programs as well.</p>	<p>This service category:</p> <ul style="list-style-type: none"> <li>- Is a HRSA-defined Core Medical Service</li> <li>- Provides for implementation of the Houston Area Continuum of Care Track D</li> <li>- Is ranked as the #1 and #2 service need by PLWHA</li> <li>- Results in desirable health outcomes for clients who access the service</li> <li>- Facilitates implementation of the EIIHA strategy and reduces unmet need</li> <li>- Facilitates National HIV/AIDS Strategy (NHAS) goals related to continuous HIV care</li> <li>- Is aligned with 100% of 2012 Comprehensive Plan strategies</li> </ul>	<p>a- Bundled with: Local Pharmacy Assistance Medical Case Management Non-Medical Case Mgmt Nutritional Counseling Treatment Adherence</p> <p>b- No c- No d- No</p>	<p><b>Motion #1:</b> Accept the service category definition with the following changes: add text in patient education about the importance of keeping appointments, add HPV screenings under women's services, and include/strengthen language about assessing patient health literacy.</p> <p><b>Motion #2:</b> Accept the financial eligibility for each service category as follows: - Primary Care: 300% - LPAP: 300% non-HIV, 500% HIV meds</p> <p><b>Motion #3:</b> Change the financial eligibility for Medical Case Management to 300%.</p>
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‡ Service Category for Part B/State Services only.

Service Category	Justification for Discontinuing the Service
<p><b>Part 2: Services <i>allowed</i> by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-12</b>  <i>(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 <b>5 p.m. on June 8, 2012.</b> This form is available by calling the Office of Support: 713 572-3724)</i></p>	
<b>Buddy Companion/Volunteerism</b>	Low use, need and gap according to the 2002 Needs Assessment (NA).
<b>Childcare Services</b> (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.
<b>Emergency Financial Assistance</b>	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.)
<b>Food Pantry</b> (Urban)	Service available from alternative sources.
<b>HE/RR</b>	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
<b>Home and Community-based Health Services</b> (In-home services)	Category unfunded due to difficulty securing vendor.
<b>Housing Assistance</b> (Emergency rental assistance) <b>Housing Related Services</b> (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.
<b>Minority Capacity Building Program</b>	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
<b>Outreach Services</b>	Significant alternative funding.
<b>Psychosocial Support Services</b> (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.
<b>Rehabilitation</b>	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

**Houston Area HIV Services Ryan White Planning Council**  
**Assessment of the Local Ryan White HIV/AIDS Program Administrative Mechanism**  
**Assessment Checklist**  
(Council approved XX-XX-13)

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### Background

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

### Process

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

### Checklist

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

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

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Council approved XX-XX-13)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
<b>Section I: Procurement/Request for Proposals Process</b>			
<ul style="list-style-type: none"> <li>To assess the timeliness of the AA in authorizing contracted agencies to provide services</li> </ul>	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	Part A/MAI: (1) NGA; and (2) Commissioner’s Court Agendas  Part B/SS: (1) DSHS Contract Face Sheet; and (2) Contract Tracking Sheet
<ul style="list-style-type: none"> <li>To assess the timeliness of the AA in procuring funds to contracted agencies to provide services</li> </ul>	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	b) What percentage of the grant award was procured by the: <input type="checkbox"/> 1 <sup>st</sup> quarter? <input type="checkbox"/> 2 <sup>nd</sup> quarter? <input type="checkbox"/> 3 <sup>rd</sup> quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC
<ul style="list-style-type: none"> <li>To assess if the AA awarded funds to service categories as designed by the PC</li> </ul>	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	c) Did the awarding of funds in specific categories match the allocations established by the PC at the: <input type="checkbox"/> 1 <sup>st</sup> quarter? <input type="checkbox"/> 2 <sup>nd</sup> quarter? <input type="checkbox"/> 3 <sup>rd</sup> quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC  Final PC Allocations Worksheet
<ul style="list-style-type: none"> <li>To assess if the AAs make potential bidders aware of the grant award process</li> </ul>	Confirmation of communication by the AAs to potential bidders specific to the grant award process	d) Does the AA have a grant award process which: <input type="checkbox"/> Provides bidders with information on applying for grants? <input type="checkbox"/> Offers a bidder’s conference?	RFP  Courtesy Notices for Pre-Bid Conferences
<ul style="list-style-type: none"> <li>To assess if the AAs are requesting bids for service category definitions approved by the PC</li> </ul>	Confirmation of communication by the AAs to potential bidders specific to PC products	e) Does the RFP incorporate service category definitions that are consistent with those defined by the PC?	RFP
<ul style="list-style-type: none"> <li>To assess if the AAs are procuring funds in alignment with allocations</li> </ul>	Comparison of final amounts procured and total amounts allocated in each service category	f) At the end of the award process, were there still unobligated funds?	Year-end FY Procurement Reports provided by AA to PC
<ul style="list-style-type: none"> <li>To assess if the AAs are dispersing all available funds for services and, if not, are unspent funds within the limits allowed by the funder</li> </ul>	Review of final spending amounts for each service category	g) At the end of the year, were there unspent funds? If so, in which service categories?	Year-end FY Procurement Reports provided by AA to PC

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
<b>Section I: Procurement/Request for Proposals Process (con't)</b>			
<ul style="list-style-type: none"> <li>To assess if the AAs are making the PC aware of the procurement process</li> </ul>	Confirmation of communication by the AAs to the PC specific to procurement results	h) Does the AA have a method of communicating back to the PC the results of the procurement process?	MOU PC Agendas
<b>Section II: Reimbursement Process</b>			
<ul style="list-style-type: none"> <li>To assess the timeliness of the AA in reimbursing contracted agencies for services provided</li> </ul>	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	a) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA?  b) What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: <input type="checkbox"/> Within 20 days? <input type="checkbox"/> Within 35 days? <input type="checkbox"/> Within 50 days?	Annual Contractor Reimbursement Report
<b>Section III: Contract Monitoring Process</b>			
<ul style="list-style-type: none"> <li>To assess if the AA is monitoring adherence by contracted agencies to PC quality standards</li> </ul>	Confirmation of use of adopted SOC in contract monitoring activities	a) Does the AA use the SOC as part of the contract monitoring process?	RFP  Policy and Procedure for Performing Site Visits  Quality Management Plan

## Ryan White Part A, Houston EMA FY 2011 Primary Care Chart Review

### Chart Review Process

- Charts were reviewed from a random sample of 641 clients out of 5,700 primary care clients (11.2%)
- Over 2,200 medical visit notes were read
- Sample was representative of the RWPA EMA population, with the exception that women were over sampled
- Data abstraction tool used to collect data
- Review period: 3/1/11-2/28/12

### Findings

- Overall increase in performance EMA-wide
- Of those measures comparable to the previous year's chart review:
  - 14/18 measures showed increased performance (78%)
  - 4/18 showed decreased performance (22%)

### Marked Improvements

- Medication adherence assessment
  - 99.5% of clients were assessed, a 19.7% increase (79.8% in 2010). In addition, medication adherence was assessed in 94% of all visits.
- Hepatitis C screening
  - 98.8% of clients were screened, a 27.6% increase (71.2% in 2010)
- Hepatitis B screening
  - 98.6% of clients were screened, a 17.7% increase (80.9% in 2010)

### Measures with Decreased Performance

- CD4 T-cell monitoring, ART, & Hepatitis B vaccination measures had definition changes to explain the variation
- Lipid and syphilis screening showed <2% decrease
- Mental health screening and substance abuse screening showed a 23.6% and 19.7% respective decrease from 2010, but were increased over 2009 rates.

### Ethnic/Racial Disparities

- Some ethnic/racial disparities seen, but the gap appears to be closing
  - Blacks have lower rates of laboratory screening (CD4, VL, lipid)
  - Overall ART prescription and VL suppression W<B<H
  - Cervical cancer screening W<H<B

### Intimate Partner Violence

- Intimate Partner Violence screening was found to be inconsistent EMA-wide
- Consequently, it was added to the 2013-2014 Standards of Care and has been implemented as of March 1, 2013.

### Vision

- Charts were reviewed from a random sample of 110 clients out of 1,585 vision clients (7%)
- Sample was representative of the RWPA EMA population
- Review period: 3/1/11-2/28/12

### Vision

- Overall, performance is high and is consistent with quality vision care
- Findings:
  - 14/18 measures had >95% performance (78%)
  - Slight decreases in CD4 and VL documentation at 93% and 94% respectively (both were 97% in 2010)
  - Dilated Fundal Exam and Cytomegalovirus (CMV) screening were 80%, a 14% and 12% increase respectively (66% and 68% in 2010)

Ryan White Part A Quality Management Program – Houston EMA

# Primary Care Chart Review FY 2011

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

October 2012

**CONTACT:**

Heather Keizman, RN, MSN, WHNP-BC  
Project Coordinator-Clinical Quality Improvement  
Harris County Public Health & Environmental Services  
Ryan White Grant Administration Section  
2223 West Loop South, RM 417  
Houston, TX 77027  
713-439-6037

## **PREFACE**

### **EXPLANATION OF PART A QUALITY MANAGEMENT**

In 2011 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Medical Services to four organizations. More than 6,900 unduplicated-HIV positive individuals are serviced by these organizations.

Harris County Public Health & Environmental Services (HCPHES) must ensure the quantity, quality and cost effectiveness of primary medical care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

## Introduction

On May 3, 2011, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPHES by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV/AIDS. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

- evaluating the extent to which primary care services adhere to the most current HIV United States Health and Human Services Department (HHS) treatment guidelines;
- provide statistically significant primary care utilization data including demographics of individuals receiving care; and,
- make recommendations for improvement.

A comprehensive review of client medical records was conducted for services provided between 3/1/11 and 2/29/12. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents: January 10, 2011*, were used to determine degree of compliance. The current treatment guidelines are available for download at: <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

## Tool Development

The PC/CQI worked with the Clinical Quality Management (CQM) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, 2011* that were developed by the Panel on Clinical Practices for Treatment of HIV Infection convened by the U.S. Department of Health and Human Services (DHHS). In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

## Chart Review Process

All charts were reviewed by a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to treatment guidelines. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

If documentation on a particular element was not found a "no data" response was entered into the database. Some elements require that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was it repeated at the prescribed interval? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to get at quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider? For some data elements, the primary issue was not the final report per se, but more of whether the requisite test/exam was performed or not, i.e., STD screening or whether there was an updated history and physical.

The specific parameters established for the data collection process were developed from national HIV care guidelines.

Tale 1. Data Collection Parameters	
Review Item	Standard
Primary Care Visits	Primary care visits during review period, denoting date and provider type (MD, NP, PA, other). There is no standard of care to be met per se. Data for this item is strictly for analysis purposes only
Annual Exams	Dental and Eye exams are recommended annually
Mental Health	A Mental Health screening is recommended annually screening for depression, anxiety, and associated psychiatric issues
Substance Abuse	Clients should be screened for substance abuse potential at every visit and referred accordingly
Specialty Referrals	This item assesses specialist utilization

Table 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	CD4, Viral Load Assays, and CBCs are recommended every 3-6 months. Clients on ART should have a Liver Function Test and a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Annual screening is recommended, either PPD or chest X-ray
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the study period
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV/AIDS Education	Documentation of topics covered including disease process, staging, exposure, transmission, risk reduction, diet and exercise
Pneumocystis carinii Pneumonia Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis
Mycobacterium Avium Complex Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis
Toxoplasma Gondii	Clients should be tested for prior exposure to <i>T. gondii</i> by measuring anti- <i>Toxoplasma</i> immunoglobulin G upon initiation of care

### The Sample Selection Process

The sample population was selected from a pool of 5,700 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/11 and 2/29/12. The medical charts of 641 clients were used in this review, representing 11.2% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Two caveats were observed during the sampling process. In an effort to focus on women living with HIV/AIDS health issues, women were over-sampled, comprising 43.7% of the sample population. Second,

providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes for each site. The demographic make-up (race/ethnicity, gender, age) of clients who accessed primary care services at a particular site during the study period was determined by CPCDMS. A sample was then generated to closely mirror that same demographic make-up. The clinic-specific lists were forwarded to the clinic 10 business days prior to the review.

### Characteristics of the Sample Population

Due to the desire to over sample for female clients, the review sample population is not generally comparable to the Part A population receiving outpatient primary medical care in terms of race/ethnicity, gender, and age. No medical records of children/adolescents were reviewed, as clinical guidelines for these groups differ from those of adult patients. Table 2 compares the review sample population with the Ryan White Part A primary care population as a whole.

	<b>Sample</b>		<b>Ryan White Part A Houston EMA</b>	
<b>Gender</b>	Number	Percent	Number	Percent
Male	351	54.8%	4,259	74.72%
Female	280	43.7%	1,392	24.42%
Transgender Male to Female	10	1.6%	46	0.81%
Transgender Female to Male	0	0%	3	0.05%
<b>TOTAL</b>	<b>641</b>		<b>5,700</b>	
<b>Race</b>				
Asian	7	1.1%	60	1.05%
African-Amer.	294	45.9%	2,754	48.32%
Pacific Islander	3	.5%	10	0.18%
Multi-Race	2	.3%	22	0.39%
Native Amer.	4	.6%	24	0.42%
White	331	51.6%	2,830	49.65%
<b>TOTAL</b>	<b>641</b>		<b>5,700</b>	
<b>Hispanic</b>				
Non-Hispanic	394	61.5%	3,781	66.33%
Hispanic	247	38.5%	1,919	33.67%
<b>TOTAL</b>	<b>641</b>		<b>5,700</b>	

## Report Structure

In December 2007, the Health Resource and Services Administration's (HRSA), HIV/AIDS Bureau (HAB) released group 1, in a series of *HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents*<sup>1</sup>. All measures included in the 3 group series are intended to serve as indicators for use in monitoring the quality of care provided to patients receiving Ryan White funded clinical care.

HAB performance measures fall within three groups. Each group can be customized as most appropriate to meet the population needs of the various Ryan White HIV/AIDS programs, either at the provider or system level.

- Group 1 measures are intended to serve as a foundation on which to build, and are central to quality HIV/AIDS clinical care. The list of measures included in Group 1 is shorter than in subsequent groups and are intended to be a good starting point for quality improvement activities.
- Group 2 measures are also important indicators of quality HIV/AIDS clinical care. These measures are "next level" measures intended to assist in the development of a well-rounded HIV/AIDS clinical practice and quality management program.
- Group 3 measures are "best practice," measures. However, many of these indicators measure data that is not routinely collected and/or readily available.

This report is arranged so that chart review findings are organized within the HAB HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents 3 group structure. Each section includes the group's measures, and their result. When available, data and results from the 2 preceding years are also provided. Group 1 and Group 2 measures are also depicted with results categorized by race/ethnicity.

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<sup>1</sup> <http://hab.hrsa.gov/deliverhivaids/habperformmeasures.html> Accessed May 1, 2012

## Findings

### *HAB Group 1 Performance Measures*

#### *ART for Pregnant Women*

- Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy (ART)

	2011	2010	2009
Number of HIV-infected pregnant women who were prescribed ART during the 2nd and 3rd trimester	2	17	2
Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	2	18	4
<b>Rate</b>	<b>100%</b>	<b>94.4%</b>	<b>50.0%</b>
<b>Change from Previous Years Results</b>	<b>5.6%</b>	<b>44.4%</b>	<b>-32%</b>

<b>2011 ARV Therapy for Pregnant Women by Race*</b>	
	Hispanic
Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester	2
Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	2
<b>Rate</b>	<b>100%</b>

\*There were no Black or White, non-Hispanic pregnant women in the 2011 sample.

### **CD4 T-Cell Count**

- Percentage of clients with HIV infection who had a CD4 T-cell count performed at least every six months during the measurement year\*

	2011	2010*	2009*
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	549	509	467
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	641	563	525
<b>Rate</b>	<b>85.6%</b>	<b>90.4%</b>	<b>89.0%</b>
<b>Change from Previous Years Results</b>	<b>-4.8%</b>	<b>1.4%</b>	<b>20.9%</b>

\*2010 and 2009 used the following numerator "Number of HIV-infected clients who had 2 or more CD4 T-cell counts during the measurement year"

<b>2011 CD4 by Race</b>			
	Black	Hispanic	White
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	231	218	90
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	281	247	102
<b>Rate</b>	<b>82.2%</b>	<b>88.3%</b>	<b>88.2%</b>

### **Viral Load Monitoring**

- Percentage of clients with HIV infection who had a viral load test performed at least every six months during the measurement year

	2011
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year	549
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	641
<b>Rate</b>	<b>85.6%</b>

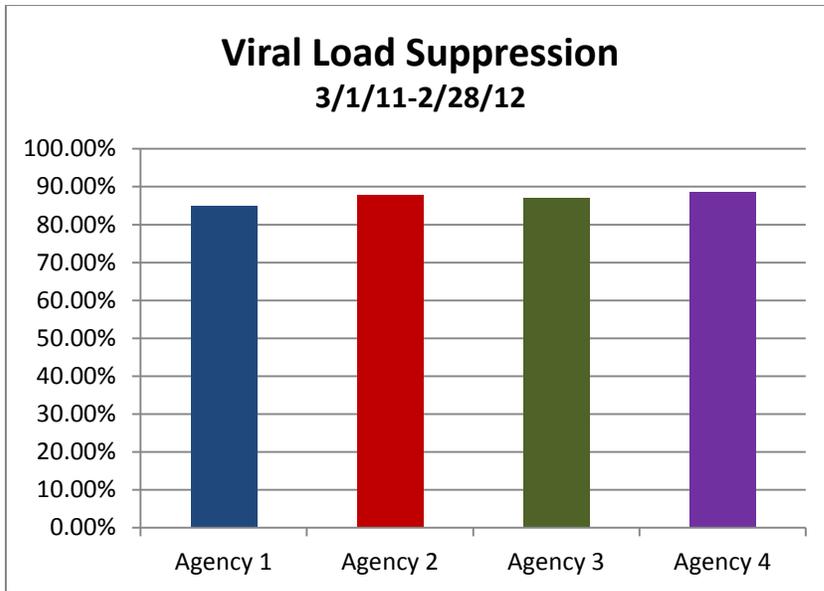
<b>2011 Viral Load by Race</b>			
	Black	Hispanic	White
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year	232	217	90
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges <sup>1</sup> , i.e. MD, PA, NP at least twice in the measurement year	281	247	102
<b>Rate</b>	<b>82.6%</b>	<b>87.9%</b>	<b>88.2%</b>

### ***Viral Load Suppression***

- Percentage of clients with HIV infection with viral load below limits of quantification (defined as <200 copies/ml) at last test during the measurement year

	2011
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	471
Number of HIV-infected clients who: <ul style="list-style-type: none"> <li>• had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and</li> <li>• were prescribed ART for at least 6 months</li> </ul>	538
<b>Rate</b>	<b>87.5%</b>

<b>2011 Viral Load Suppression by Race</b>			
	Black	Hispanic	White
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	196	195	71
Number of HIV-infected clients who: <ul style="list-style-type: none"> <li>• had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and</li> <li>• were prescribed ART for at least 6 months</li> </ul>	228	216	85
<b>Rate</b>	<b>86%</b>	<b>90.3%</b>	<b>83.5%</b>



### ART

- Percentage of clients with current CD4 T-cell counts below 200 cells/mm<sup>3</sup> or AIDS-defining condition who are prescribed antiretroviral therapy (ART)\*

	2011	2010*	2009*
Number of clients with current CD4 T-cell counts below 200 cells/mm <sup>3</sup> or AIDS-defining condition who were prescribed an ART regimen within the measurement year	95	192	427
Number of clients who: • have a CD4 T-cell count below 200 cells/mm <sup>3</sup> or other AIDS-defining condition), and • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	97	193	447
<b>Rate</b>	<b>97.9%</b>	<b>99.4%</b>	<b>95.5%</b>
<b>Change from Previous Years Results</b>	<b>-1.5%</b>	<b>3.9%</b>	<b>-1.8%</b>

- \*2010 and 2009 use the following measure “Percentage of clients with AIDS who are prescribed highly active antiretroviral therapy (HAART)”

<b>2011 ART by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm <sup>3</sup> or AIDS-defining condition who were prescribed an ART regimen within the measurement year	47	40	8
Number of clients who: • have a CD4 T-cell count below 200 cells/mm <sup>3</sup> or other AIDS-defining condition), and • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	48	41	8
<b>Rate</b>	<b>97.9%</b>	<b>97.6%</b>	<b>100%</b>

### **PCP Prophylaxis**

- Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm<sup>3</sup> who were prescribed PCP prophylaxis

	2011	2010	2009
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm <sup>3</sup> who were prescribed PCP prophylaxis	97	71	56
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm <sup>3</sup> , or any other indicating condition	97	75	63
<b>Rate</b>	<b>100%</b>	<b>94.7%</b>	<b>88.9%</b>
<b>Change from Previous Years Results</b>	<b>5.3%</b>	<b>5.8%</b>	<b>30.3%</b>

<b>2011 PCP Prophylaxis by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm <sup>3</sup> who were prescribed PCP prophylaxis	48	41	8
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm <sup>3</sup> , or any other indicating condition	48	41	8
<b>Rate</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Group 1 HAB HIV core clinical performance measures also includes an indicator for Medical Visits, requiring clients visit a medical provider 2 or more times a year. The measure was not included in the chart review analysis because the sample inclusion criteria requires 2 medical visits.

## **HAB Group 2 Performance Measures**

### **Adherence Assessment & Counseling**

- Percentage of clients with HIV infection on ART who were assessed for adherence\*

	<b>Adherence Assessment</b>		
	2011*	2010*	2009*
Number of HIV-infected clients, as part of their primary care, who were assessed for adherence*	585	386	371
Number of HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	588	484	429
<b>Rate</b>	<b>99.5%</b>	<b>79.8%</b>	<b>86.5%</b>
<b>Change from Previous Years Results</b>	<b>19.7%</b>	<b>-6.7%</b>	

\*HAB measure indicates assessment and counseling should be done 2 or more times a year. However, chart review data was not captured in this way. Data is based on annual assessment.

<b>Adherence Assessment Per Visit</b>	
	2011
Number of primary care visits where ART adherence was assessed	1762
Number of primary care visits for HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	1875
<b>Rate</b>	<b>94%</b>

	<b>Adherence Assessment</b>					
	Excellent	Very good	Good	Fair	Poor	Very Poor
Number of primary care visits for each ART adherence rating	1173	186	249	50	64	40
Number of primary care visits where ART adherence was assessed	1762	1762	1762	1762	1762	1762
<b>Rate</b>	<b>66.6%</b>	<b>10.6%</b>	<b>14.1%</b>	<b>2.8%</b>	<b>3.6%</b>	<b>2.3%</b>

- 33.1% of visits reported less than excellent adherence (584/1762)
- Of these, an intervention was documented 59.8% of the time (349/584)
- Reasons for less than excellent adherence were documented for 77 visits

Most Common Reasons Cited for Less Than Excellent Adherence:	Total #
Awaiting ADAP/paperwork issues	16
Did not get refill on time/ran out of meds	16
Acute illness/hospitalization	10
Side effects	7
Financial/can't pay co-pay	5
Depression	5

Other reasons with 3 or fewer responses: drug use, jail, meds stolen, work schedule, difficulty swallowing/giving them to partner, transportation, life stress, wants fewer pills, out of town.

Most Common Interventions Cited:	*Total #
Provider counseling	302
Other**	37
Change Rx	14
Refer to adherence program	7
Side Effect Management	7
Pillbox	1

\* Multiple selections could have been made

\*\*“Other” typically included referral to case management, psychiatry, behavioral health, or pharmacy education

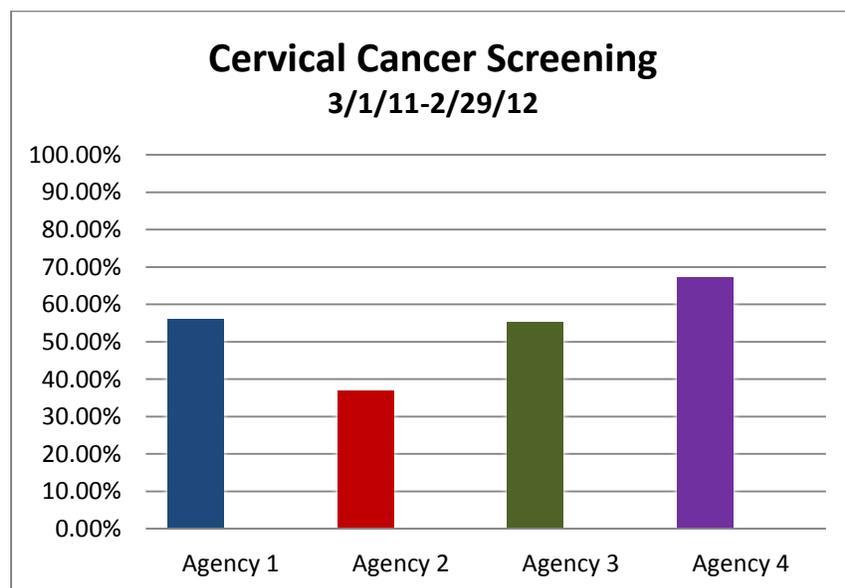
## Cervical Cancer Screening

- Percentage of women with HIV infection who have Pap screening results documented in the measurement year

	2011	2010	2009
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	155	132	122
Number of HIV-infected female clients: <ul style="list-style-type: none"> <li>for whom a pap smear was indicated, and</li> <li>who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*</li> </ul>	265	232	230
<b>Rate</b>	<b>58.5%</b>	<b>56.9%</b>	<b>53.0%</b>
<b>Change from Previous Years Results</b>	<b>1.6%</b>	<b>3.9%</b>	<b>-16.2%</b>

\*2010 and 2009 denominator stated "Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year"

2011 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	90	55	9
Number of HIV-infected female clients: <ul style="list-style-type: none"> <li>for whom a pap smear was indicated, and</li> <li>who had a medical visit with a provider with prescribing privileges at least twice in the measurement year</li> </ul>	144	97	22
<b>Rate</b>	<b>62.5%</b>	<b>56.7%</b>	<b>40.9%</b>



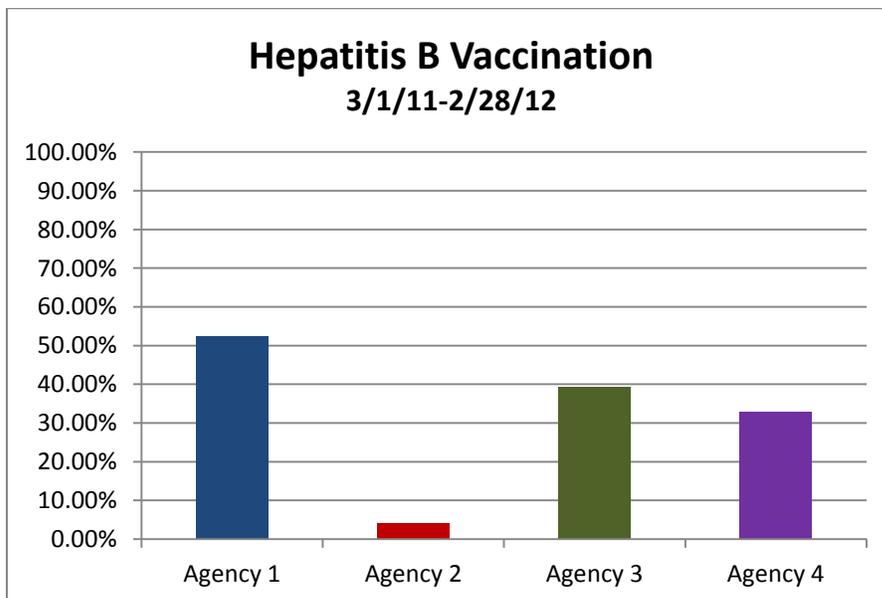
## Hepatitis B Vaccination

- Percentage of clients with HIV infection who completed the vaccination series for Hepatitis B

	2011	2010*	2009*
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	105	309	179
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	323	563	525
<b>Rate</b>	<b>32.5%</b>	<b>54.9%</b>	<b>34.1%</b>
<b>Change from Previous Years Results</b>	<b>-22.4%</b>	<b>20.8%</b>	

\*2010 and 2009 denominator stated "Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year"

2011 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	39	51	14
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	124	155	40
<b>Rate</b>	<b>31.5%</b>	<b>32.9%</b>	<b>35%</b>



### ***Hepatitis C Screening***

- Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since diagnosis of HIV infection

	2011	2010	2009
Number of HIV-infected clients who have documented HCV status in chart	633	401	395
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	641	563	525
<b>Rate</b>	<b>98.8%</b>	<b>71.2%</b>	<b>75.2%</b>
<b>Change from Previous Years Results</b>	<b>27.6%</b>	<b>-4.0%</b>	<b>-1.1%</b>

<b>2011 Hepatitis C Screening by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of HIV-infected clients who have documented HCV status in chart	277	245	100
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	281	247	102
<b>Rate</b>	<b>98.6%</b>	<b>99.2%</b>	<b>98%</b>

### ***HIV Risk Counseling***

- Percentage of clients with HIV infection who received HIV risk counseling within measurement year

	2011	2010	2009
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	526	437	141
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	641	563	525
<b>Rate</b>	<b>82.1%</b>	<b>77.6%</b>	<b>26.9%</b>
<b>Change from Previous Years Results</b>	<b>4.5%</b>	<b>50.7%</b>	<b>-18.5%</b>

<b>2011 HIV Risk Counseling by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	233	211	72
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	281	247	102
<b>Rate</b>	<b>82.9%</b>	<b>85.4%</b>	<b>70.6%</b>

### ***Lipid Screening***

- Percentage of clients with HIV infection on ART who had fasting lipid panel during measurement year

	2011	2010	2009
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	535	449	388
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	588	484	427
<b>Rate</b>	<b>91%</b>	<b>92.8%</b>	<b>90.9%</b>
<b>Change from Previous Years Results</b>	<b>-1.8%</b>	<b>1.9%</b>	<b>0.9%</b>

<b>2011 Lipid Screening by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	224	215	88
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	255	233	91
<b>Rate</b>	<b>87.8%</b>	<b>92.3%</b>	<b>96.7%</b>

### Oral Exam

- Percent of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year

	2011	2010	2009
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	347	296	213
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	641	563	525
<b>Rate</b>	<b>54.1%</b>	<b>52.6%</b>	<b>40.6%</b>
<b>Change from Previous Years Results</b>	<b>1.5%</b>	<b>12.0%</b>	<b>-1.9%</b>

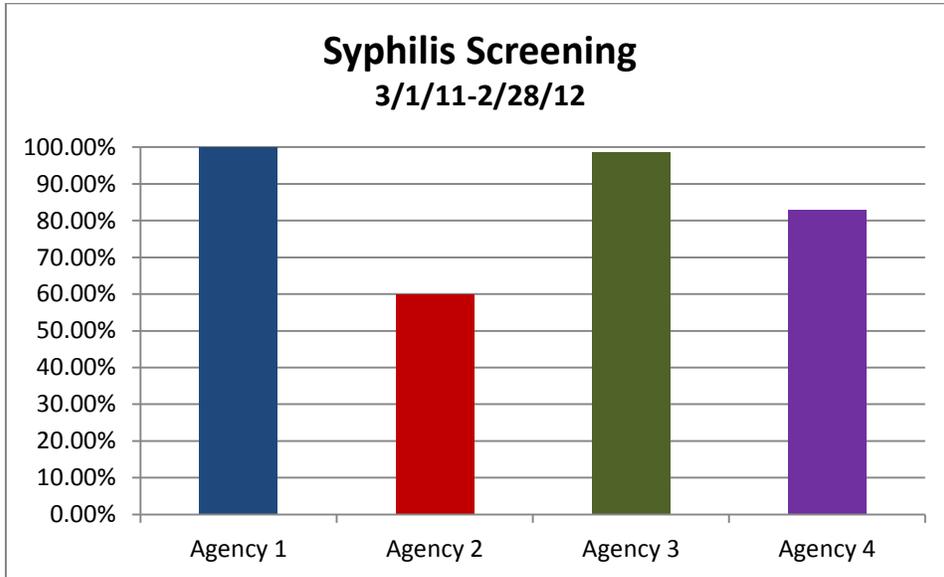
<b>2011 Oral Exam by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	156	135	48
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	282	247	102
<b>Rate</b>	<b>55.3%</b>	<b>65.7%</b>	<b>47.1%</b>

### Syphilis Screening

- Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement year

	2011	2010	2009
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	550	492	462
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	641	563	525
<b>Rate</b>	<b>85.8%</b>	<b>87.4%</b>	<b>88.0%</b>
<b>Change from Previous Years Results</b>	<b>-1.6%</b>	<b>.6%</b>	<b>2.4%</b>

2011 Syphilis Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	242	204	95
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	281	247	102
<b>Rate</b>	<b>86.1%</b>	<b>82.6%</b>	<b>93.1%</b>



### TB Screening

- Percent of clients with HIV infection who received testing with results documented for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis

	2011	2010	2009
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	281	169	99
Number of HIV-infected clients who: <ul style="list-style-type: none"> <li>do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and</li> <li>had a medical visit with a provider with prescribing privileges at least twice in the measurement year.</li> </ul>	579	518	502
<b>Rate</b>	<b>48.5%</b>	<b>32.7%</b>	<b>19.7%</b>
<b>Change from Previous Years Results</b>	<b>15.8%</b>	<b>13.0%</b>	<b>-5.7%</b>

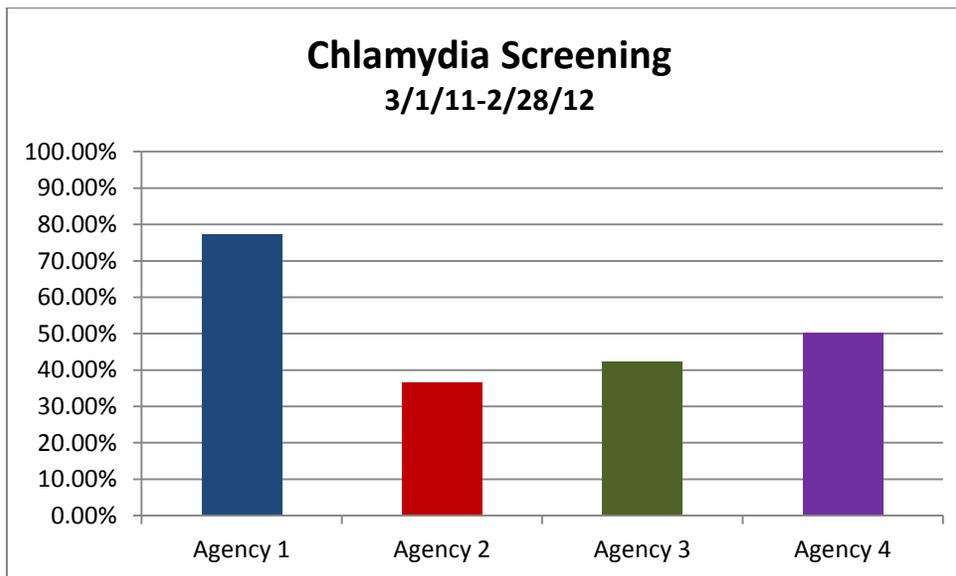
<b>2011 TB Screening by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	125	104	50
Number of HIV-infected clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	255	222	95
<b>Rate</b>	<b>49%</b>	<b>46.8%</b>	<b>52.6%</b>

### ***HAB Group 3 Performance Measures***

#### ***Chlamydia Screening***

- Percent of clients with HIV infection at risk for sexually transmitted infections who had a test for Chlamydia with the measurement year

	2011	2010	2009
Number of HIV-infected clients who had a test for Chlamydia	321	194	143
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	638	563	525
<b>Rate</b>	<b>50.3%</b>	<b>34.5%</b>	<b>27.2%</b>
<b>Change from Previous Years Results</b>	<b>15.8%</b>	<b>7.3%</b>	<b>-13.7%</b>



### ***Gonorrhea Screening***

- Percentage of clients with HIV infection at risk for sexually transmitted infections who had a test for gonorrhea with the measurement year

	2011	2010	2009
Number of HIV-infected clients who had a test for gonorrhea	321	193	151
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	638	563	525
<b>Rate</b>	<b>50.3%</b>	<b>34.3%</b>	<b>28.8%</b>
<b>Change from Previous Years Results</b>	<b>16%</b>	<b>5.5%</b>	<b>-14.5%</b>

### ***Hepatitis B Screening***

- Percentage of clients with HIV infection who have been screened for Hepatitis B virus infection status

	2011	2010	2009
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	632	456	392
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	641	563	525
<b>Rate</b>	<b>98.6%</b>	<b>80.9%</b>	<b>74.7%</b>
<b>Change from Previous Years Results</b>	<b>17.7%</b>	<b>6.2%</b>	<b>-5.5%</b>

### ***Influenza Vaccination***

- Percentage of clients with HIV infection who have received influenza vaccination within the measurement year

	2011	2010	2009
Number of HIV-infected clients who received influenza vaccination within the measurement year	317	208	260
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	641	563	525
<b>Rate</b>	<b>49.5%</b>	<b>37.1%</b>	<b>49.5%</b>
<b>Change from Previous Years Results</b>	<b>12.4%</b>	<b>-12.4%</b>	<b>1.3%</b>

<b>2011 Influenza Screening by Race/Ethnicity</b>			
	Black	Hispanic	White
Number of HIV-infected clients who received influenza vaccination within the measurement year	128	131	51
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	281	247	102
<b>Rate</b>	<b>45.6%</b>	<b>53%</b>	<b>50%</b>

### ***Pneumococcal Vaccination***

- Percentage of clients with HIV infection who ever received pneumococcal vaccination

	2011
Number of HIV-infected clients who received pneumococcal vaccination	465
Number of HIV-infected clients who: <ul style="list-style-type: none"> <li>• had a CD4 count &gt; 200 cells/mm<sup>3</sup>, and</li> <li>• had a medical visit with a provider with prescribing privileges at least twice in the measurement period</li> </ul>	602
<b>Rate</b>	<b>77.2%</b>
<b>Change from Previous Years Results</b>	

### ***MAC Prophylaxis***

- Percentage of clients with HIV infection with CD4 count < 50 cells/mm<sup>3</sup> who were prescribed MAC prophylaxis within the measurement year

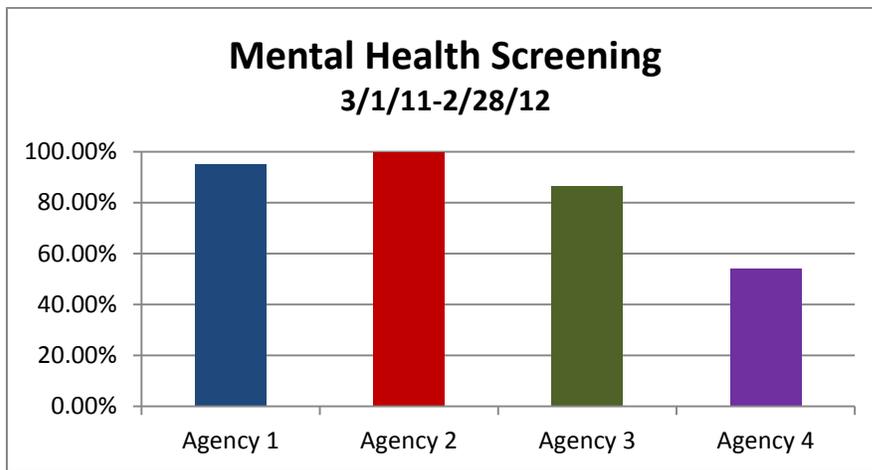
	2011	2010	2009
Number of HIV-infected clients with CD4 count < 50 cells/mm <sup>3</sup> who were prescribed MAC prophylaxis	31	19	14
Number of HIV-infected clients who had a: <ul style="list-style-type: none"> <li>• CD4 count &lt; 50 cells/mm<sup>3</sup> or other defining condition; and</li> <li>• medical visit with a provider with prescribing privileges at least twice in the measurement year</li> </ul>	33	23	15
<b>Rate</b>	<b>93.9%</b>	<b>82.6%</b>	<b>93.3%</b>
<b>Change from Previous Years Results</b>	<b>11.3%</b>	<b>-10.7%</b>	<b>45.5%</b>

### **Mental Health Screening**

- Percentage of clients with HIV infections who have had a mental health screening\*

	2011	2010	2009
Number of HIV-infected clients who received a mental health screening	478	553	361
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	641	563	525
<b>Rate</b>	<b>74.6%</b>	<b>98.2%</b>	<b>68.8%</b>
<b>Change from Previous Years Results</b>	<b>-23.6%</b>	<b>29.4%</b>	<b>5.9%</b>

\*HAB measure indicates only new clients be screened. However, Houston EMA standards of care require medical providers to screen all clients annually.



### **Substance Abuse Screening**

- Percentage of clients with HIV infections who have been screened for substance use (alcohol & drugs) in the measurement year\*

	2011	2010	2009
Number of new HIV-infected clients who were screened for substance use within the measurement year	506	555	402
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	641	563	525
<b>Rate</b>	<b>78.9%</b>	<b>98.6%</b>	<b>76.6%</b>
<b>Change from Previous Years Results</b>	<b>-19.7%</b>	<b>22.0%</b>	<b>-5.5%</b>

\*HAB measure indicates only new clients be screened. However, Houston EMA standards of care require medical providers to screen all clients annually.

- 35.3% of clients (226/641) were already in care, or needed referral for, mental health and/or substance abuse treatment (excludes clients whose MH issues were managed by the PCP)

### ***Toxoplasma Screening***

- Percentage of clients with HIV infection for whom Toxoplasma screening was performed at least once since the diagnosis of HIV infection

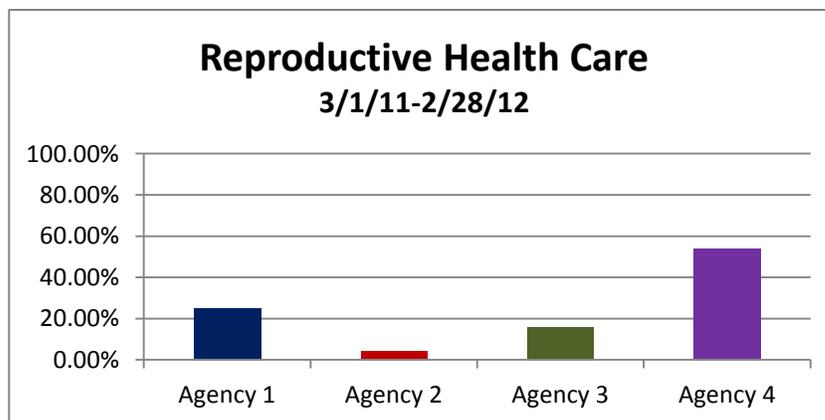
	2011	2010	2009*
Number of HIV-infected clients who have documented Toxoplasma status in health record	545	451	11
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	641	563	525
<b>Rate</b>	<b>85%</b>	<b>80.1%</b>	<b>2.1%</b>
<b>Change from Previous Years Results</b>	<b>4.9%</b>	<b>78.0%</b>	<b>-0.2%</b>

\* Previous years population data was captured for measurement period, as indicated in HAB measure

### ***Other Measures: Reproductive Health Care***

- Percentage of reproductive-age women with HIV infection who received reproductive health assessment and care (i.e, pregnancy plans and desires assessed and either preconception counseling or contraception offered)

	2011
Number of HIV-infected reproductive-age women who received reproductive health assessment and care	35
Number of HIV-infected reproductive-age women who: <ul style="list-style-type: none"> <li>did not have a hysterectomy or bilateral tubal ligation, and</li> <li>had a medical visit with a provider with prescribing privileges at least twice in the measurement period</li> </ul>	124
<b>Rate</b>	<b>28.2%</b>



## Conclusions

Overall, there has been an increase in performance across a variety of different areas compared to the 2010 chart review findings. In particular, dramatic increases have been seen in Hepatitis B and C screenings and medication adherence assessment.

Racial and ethnic disparities continue to be seen for most measures, with African-Americans and Hispanics having lower rates than White clients. However, this gap appears to be closing for some measures such as ART, Viral Load Suppression and Cervical Cancer Screening. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

There was a small 1.6% increase in the rate of cervical cancer screenings to 58.5%. This measure has previously been a Part A performance measure and led to a slight increase from 61% to 69% between 2007 and 2008. To refocus provider attention to this measure, the rate of cervical cancer screenings has been targeted as a performance measure since FY 2009. Continued focus is necessary for this measure to ensure additional improvement.

Reproductive health care is an important component of primary care for women, and was consequently added to this year's chart review. Research has shown that 29% of HIV-positive women desire children in the future (1). Reproductive health assessment and preconception education and counseling can greatly improve perinatal outcomes, as well as prevent undesired or unplanned pregnancies. This chart review demonstrated that 28.2% of reproductive-age women received a comprehensive reproductive health assessment. Additional research is needed to identify barriers to the provision of reproductive health care.

Only two measures observed significant decreases in performance compared to the 2010 chart review data: Mental Health screening and Substance Abuse screening. This year's data is more comparable to the 2009 chart review findings. These screenings are extremely important, as chart review findings also indicate that 35% of patients have a mental health and/or substance abuse co-morbidity. Additional research is needed to determine the cause of the low rate given the protocols that are already in place.

1. Chen JL et al., Fertility desires and intentions of HIV-positive men and women, *Family Planning Perspectives*, 2001, 33(4):144-152.

# Vision Care Chart Review FY 2011

Prepared by Harris County Public Health Services –  
Ryan White Grant Administration

December 2012

**CONTACT:**

Heather Keizman, RN, MSN, WHNP-BC  
Project Coordinator–Clinical Quality Improvement  
Harris County Public Health & Environmental Services  
Ryan White Grant Administration  
2223 West Loop South, RM 417  
Houston, TX 77027  
713-439-6037  
[hkeizman@hcpbes.org](mailto:hkeizman@hcpbes.org)

## **Introduction**

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health & Environmental Services. During FY 11, a comprehensive review of client vision records was conducted for services provided between 3/1/11 to 2/29/12.

The primary purpose of this annual review process is to assess Part A vision care provided to persons living with HIV and AIDS in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S. Public Health Service for general vision care targeting individuals with HIV/AIDS. Therefore, Ryan White Grant Administration has adopted general guidelines published by the American Optometric Association, as well as internal standards determined by the clinic, to measure the quality of Part A funded vision care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

## **Scope of This Report**

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 11 vision care chart review. In addition to this report, the vision care provider reviewed will also receive an electronic copy of the raw database in order to facilitate further analysis. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

## **The Data Collection Tool**

The data collection tool employed in the review was developed through a period of in-depth research conducted by the Ryan White Grant Administration. By researching the most recent vision practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for vision care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: completeness of the Client Intake Form (CIF), CD4 and VL measures, eye exams, and prescriptions for lenses. See Appendix A for a copy of the tool.

## **The Chart Review Process**

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from vision care guidelines and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

**Table 1. Data Collection Parameters**

Review Area	Documentation Criteria
Laboratory Tests	Current CD4 and Viral Load Measures
Client Intake Form (CIF)	Completeness of the CIF: includes but not limited to documentation of primary care provider, medication allergies, Hx of medical problems, Ocular Hx, and current medications
Complete Eye Exam (CEE)	Documentation of annual eye exam; completeness of eye exam form; comprehensiveness of eye exam (visual acuity, refraction test, binocular vision assessment, fundus/retina exam, and glaucoma test)
Ophthalmology Consult (DFE)	Performed/Not performed
Lens Prescriptions	Documentation of the Plan of Care (POC) and completeness of the dispensing form

## The Sample Selection Process

The sample population was selected from a pool of 1,585 unduplicated clients who accessed Part A vision care between 3/1/11 and 2/28/12. The medical charts of 110 of these clients were used in the review, representing 7% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/11 and 2/29/12 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

The lists of client codes were forwarded to the corresponding agency 5-10 business days before reviews were scheduled to commence.

## Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving vision care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who receive vision care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of persons with HIV or AIDS. Table 2 compares the review sample population with the Ryan White Part A vision care population as a whole.

**Table 2. Demographic Characteristics of FY 11 Houston EMA Ryan White Part A Vision Care Clients**

Race/Ethnicity	Sample		Ryan White Part A EMA	
	Number	Percent	Number	Percent
African American	45	41%	630	40%
White	62	56%	921	58%
Asian	1	<1%	15	1%
Native Hawaiian/Pacific Islander	1	<1%	4	<1%
American Indian/Alaska Native	1	<1%	10	<1%
Multi-Race	0		5	<1%
<b>TOTAL</b>	<b>110</b>	<b>100%</b>	<b>1,585</b>	<b>100%</b>
<b>Hispanic Status</b>				
Hispanic	40	36%	536	34%
Non-Hispanic	70	64%	1,049	66%
<b>TOTAL</b>			<b>1,585</b>	<b>100%</b>

**Table 2. Demographic Characteristics of FY 11 Houston EMA Ryan White Part A Vision Care Clients (cont'd)**

Race/Ethnicity	Sample		Ryan White Part A EMA	
	Number	Percent	Number	Percent
African American	45	41%	630	40%
White	62	56%	921	58%
Asian	1	<1%	15	1%
Native Hawaiian/Pacific Islander	1	<1%	4	<1%
American Indian/Alaska Native	1	<1%	10	<1%
Multi-Race	0		5	<1%
<b>TOTAL</b>	<b>110</b>	<b>100%</b>	<b>1,585</b>	<b>100%</b>
<b>Hispanic Status</b>				
Hispanic	40	36%	536	34%
Non-Hispanic	70	64%	1,049	66%
<b>TOTAL</b>			<b>1,585</b>	<b>100%</b>
<b>Gender</b>				
	<b>110</b>	<b>100%</b>		
Male	86	78%	1,234	78%
Female	24	22%	342	22%
Transgender Male to Female	0		8	<1%
Transgender Female to Male	0		1	<1%
<b>TOTAL</b>	<b>110</b>	<b>100%</b>	<b>1,585</b>	<b>100%</b>
<b>Age</b>				
<= 24	3	3%	41	3%
25 – 34	16	15%	234	15%
35 – 44	26	24%	434	27%
45 – 54	43	39%	603	38%
55 – 64	18	16%	227	14%
65+	4	4%	46	3%
<b>TOTAL</b>	<b>110</b>	<b>100%</b>	<b>1,585</b>	<b>100%</b>

## Findings

### *Laboratory Tests*

Having up-to-date lab measurements for CD4 and viral load (VL) levels enhances the ability of vision providers to ensure that the care provided is appropriate for each patient. CD4 and VL measures indicate stage of disease, so in cases where individuals are in the late stage of HIV disease, special considerations may be required.

Patient chart records should provide documentation of the most recent CD4 and VL information. Ideally this information should be updated in coordination with an annual complete eye exam. As noted in the table below, slight decreases were noted in lab documentation compared to FY10.

	2011	2010	2009
<b>CD4</b>	93%	97%	47%
<b>VL</b>	94%	97%	47%

### *Client Intake Form (CIF)*

A complete and thorough assessment of a patient’s health history is essential when caring for individuals infected with HIV or anyone who is medically compromised. The agency assesses this information by having patients complete the CIF. Information provided on the CIF, such as ocular history or medical history, guides clinic providers in determining the appropriateness of diagnostic procedures, prescriptions, and treatments. The CIF that

is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will highlight findings for only some of the data collected on the form.

Below are highlights of the findings measuring completeness of the CIF.

	2011	2010	2009
<b>Primary Care Provider</b>	100%	100%	100%
<b>Medication Allergies</b>	100%	100%	100%
<b>Medical History</b>	100%	100%	99%
<b>Current Medications</b>	100%	100%	99%
<b>Reason for Visit</b>	100%	100%	100%
<b>Ocular History</b>	96%	100%	99%

### *Eye Examinations (Including CEE/DFE) and Exam Findings*

Complete and thorough examination of the eye performed on a routine basis is essential for the prevention, detection, and treatment of eye and vision disorders. When providing care to individuals with HIV/AIDS, routine eye exams become even more important because there are a number of ocular manifestations of HIV disease, such as CMV retinitis.

	2011	2010	2009
<b>Complete Eye Exam</b>	96%	97%	98%
<b>Dilated Fundus Exam</b>	80%	66%	78%
<b>Internal Eye Exams</b>	100%	98%	97%
<b>Documentation of Diagnosis</b>	100%	100%	99%
<b>Documentation of Treatment Plan</b>	100%	100%	100%
<b>Visual Acuity</b>	99%	100%	98%
<b>Refraction Test</b>	96%	97%	97%
<b>Observation of External Structures</b>	96%	99%	98%
<b>Internal Eye Exam</b>	100%	66%	97%
<b>Glaucoma Test</b>	95%	98%	97%
<b>Cytomegalovirus (CMV) screening</b>	80%	68%	83%

## ***Prescriptions***

Of records reviewed, 95% (96%-FY10, 92%-FY 09 reviews) documented new prescriptions for lenses at the agency within the year.

## **Conclusions**

Findings from the FY 11 Vision Care Chart Review indicate that the vision care provider provides comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

There has been a significant increase in DFE & CMV screening compared to the previous chart review (80%- FY11 for both, 66% DFE- FY10, 68% CMV- FY10), however these rates are still lower than the other performance measures. The probable cause is that these assessments sometimes require the client to return to the clinic for a separate appointment. While the majority of the exam is provided by an optometrist, the client needs to see another provider, an ophthalmologist, to obtain the DFE & CMV screening. These can sometimes be provided on the same day, but at other times require that the client return for another appointment. It should be noted, however, that no clients with CD4<50 went without DFE & CMV screening, which is the current standard of care (2).

Overall, FY 2011 chart review findings indicate a continued focus on quality vision care services.

# Appendix A—FY 11-Vision Chart Review Data Collection Tool

Mar 1, 11 to Feb 29, 12

Pt. ID # \_\_\_\_\_ Site Code: \_\_\_\_\_

1. AGE: \_\_\_\_\_
2. SEX: 1 – Male 2 - Female 3 - Transgender
3. Reason for Visit within year is doc: Y - Yes N - No
4. Result of Visit within year is doc: Y - Yes N - No

## **CLIENT INTAKE FORM (CIF)**

5. CIF includes PRIMARY CARE PROVIDER documentation: Y - Yes N - No
6. On CIF, MEDICATION ALLERGIES are documented: Y - Yes N - No
7. CIF includes MEDICAL HISTORY: Y - Yes N - No
8. On CIF, CURRENT MEDS are listed: Y - Yes N - No
9. On CIF, the REASON for TODAY's VISIT is documented: Y - Yes N - No
10. On CIF, the OCULAR HISTORY is documented: Y - Yes N - No

## **CD4 & VL**

11. Most recently documented CD4 count is within past 12 months: Y - Yes N - No
12. Most recently documented VL count is within past 12 months: Y - Yes N - No

## **EYE CARE:**

13. COMPLETE EYE EXAM (CEE) was performed annually within yr: Y - Yes N - No
14. Eye Exam included ASSESSMENT OF VISUAL ACUITY: Y - Yes N - No
15. Eye Exam included REFRACTION TEST: Y - Yes N - No
16. Eye Exam included OBSERVATION OF EXTERNAL STRUCTURES: Y - Yes N - No
17. Eye Exam included PHARMACEUTICALS viewing fundus/retina & associated structures (slit-lamp exam):  
Y - Yes N - No
18. Eye Exam included GLAUCOMA TEST (IOP): Y - Yes N - No
19. Internal Eye Exam findings are documented per visit within yr: Y - Yes N - No
20. Eye Exam written diagnoses are documented per visit within year: Y - Yes N - No
21. Eye Exam included CYTOMEGALOVIRUS (CMV) SCREENING: Y - Yes N - No
22. Eye Exam written treatment plan is documented per visit within year: Y - Yes N - No
23. Dilated Fundus Exam (DFE) done within year included: Y - Yes N - No
24. New prescription lenses were prescribed within year: Y - Yes N - No
25. Total # of visits to eye clinic within year: \_\_\_\_\_

## Appendix B – Resources

1. Casser, L., Carmiencke, K., Goss, D.A., Knieb, B.A., Morrow, D., & Musick, J.E. (2005). \_Optometric Clinical Practice Guideline—Comprehensive Adult Eye and Vision Examination. *American Optometric Association*. Retrieved from <http://www.aoa.org/Documents/CPG-1.pdf> on April 15, 2012.
2. Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. MMWR 2009;58 (No. RR-4) April 10, 2009.
3. Heiden D., Ford N., Wilson D., Rodriguez W.R., Margolis T., et al. (2007). Cytomegalovirus Retinitis: The Neglected Disease of the AIDS Pandemic. *PLoS Med* 4(12): e334. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2100142/> on April 15, 2012.
4. International Council of Ophthalmology. (2011). *ICO International Clinical Guideline, Ocular HIV/AIDS Related Diseases*. Retrieved from <http://www.icoph.org/resources/88/ICO-International-Clinical-Guideline-Ocular-HIVAIDS-Related-Diseases-.html> on December 15, 2012.

**Ryan White Part A, Part B and State Services  
 "How to Best Meet the Need" (HTBMN) Workgroup Schedule**  
 (as of 03-22-13)

**TRAINING ON THE HTBMN PROCESS:  
 11:00 a.m. ~ Tuesday, March 26, 2013  
 For meeting location, please call: 713 572-3724**

**TRAINING ON THE DOCUMENTS USED IN THE PROCESS:  
 1:30 p.m. ~ Thursday, April 11, 2013 ~ Room 416  
 2223 West Loop South, Houston, Texas 77027**

**Information & workgroup packets will be available on April 11, 2013 and  
 online at [www.rwpcHouston.org](http://www.rwpcHouston.org) on the calendar for each date below**  
 (packets are in pdf format and are posted as they become available).

Packets can also be obtained from the Office of Support and at each workgroup:  
 2223 W. Loop South, Suite 240, Houston, TX 77027; or call 713 572-3724.

**Workgroup #1 and #3:**

✂ The Council is particularly interested in discussing how Ryan White could be used to initiate and support a **Navigator Program** in the Houston area that would provide community-based, in-person assistance to People Living with HIV/AIDS as they seek to enroll in Medicaid, CHIP, and private health insurance through the Health Insurance Marketplace (formerly known as the "Exchange").

**Workgroup 1:**

**Monday, April 15, 2013 @ 1:30 p.m.  
 2223 West Loop South, Room 416**

**Workgroup 3:**

**Thursday, April 18, 2013 @ 1:30 p.m.  
 2223 West Loop South, Room 416**

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

- ✂ Ambulatory/Outpatient Medical Care (including Local Pharmacy Assistance, Medical Case Management & Service Linkage - Adult)
- ✂ Ambulatory/Outpatient Medical Care (including Local Pharmacy Assistance, Medical Case Management & Service Linkage - Pediatric)
- ✂ Clinical Case Management
- ✂ Non-Medical Case Management (Service Linkage)
- ✂ Health Insurance Premium & Co-pay Assistance<sup>‡</sup>
- ✂ Medical Nutritional Therapy (including Nutritional Supplements)

**Thursday, April 18, 2013 @ 9:00 a.m.  
 2223 West Loop South, Room 416**

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

- ✂ Early Intervention Services<sup>‡</sup>
- ✂ Food Pantry (Rural)<sup>‡</sup>
- ✂ Legal Assistance
- ✂ Professional Counseling (Mental Health)<sup>‡</sup>
- ✂ Substance Abuse Treatment/Counseling
- ✂ Linguistic Services<sup>‡</sup>
- ✂ Home & Community-based Health Services (Adult Day Treatment)<sup>‡</sup>
- ✂ Hospice
- ✂ Oral Health – Untargeted<sup>‡</sup> & Rural
- ✂ Vision Care
- ✂ Transportation (van-based-Untargeted & Rural)

**Monday, April 29, 2013 @ 1:30 p.m.  
 2223 West Loop South, Room 416**

**Workgroup #5 includes the service categories:**

- ✂ The Blue Book

**Tuesday, May 14, 2013 - 10:00 a.m.  
 2223 West Loop South, Room 240**

Part A service categories in BOLD type are due to be RFP'd. FYI: There are no Part A or MAI services categories to be RFP'd for FY 2014.  
<sup>‡</sup> Service Category for Part B/State Services only; Part B and State Services service categories are RFP'd in the Houston HSDA every other year, including an RFP for FY 2014. To confirm information about Part B and State Services funded services, please call 713 526-1016.

## Timeline of Critical 2013 Ryan White Planning Council Activities

General Information: The following is a list of significant activities regarding the 2013 Houston Ryan White Planning Council. Consumers, providers & members of the general public are encouraged to attend & provide public comment at any of the meetings described below. For more information or to receive calendars &/or meeting packets, please call the Office of Support: 713 572-3724.

Tues. March 26	11 a.m. <b>Consumer Training</b> on the How to Best Meet the Need (HTBMN) process.
Tues. April 2	<b>Project LEAP</b> student applications due. Call 713 572-3724 for application forms. Classes begin May 1.
Thurs. April 11	12 noon. The Council meets to approve the survey for the <b>2014 Houston Area HIV Needs Assessment and more.</b>
1:30 – 4 p.m.	<b>Council &amp; Community Training for the HTBMN process.</b> Community members & the Quality Assurance (QA), Priority & Allocations (P&A) & Affected Community Committees are encouraged to attend.
April thru Dec.	Data collection for the 2014 Houston Area HIV/AIDS Needs Assessment.
Apr – May	<b>HTBMN Workgroups meet.</b> Call 713 572-3724 for details.
Thurs. April 25	12:30 pm. P&A meets to allocate <b>Part A unspent funds.</b>
Tues. May 14	10 a.m. HTBMN workgroup for the <b>Blue Book.</b> The Operations Committee reviews the FY14 Council Support Budget.
Thurs. May 16	10 a.m. QA meets to approve the <b>FY14 HTBMN results &amp; review subcategory allocation requests.</b> Draft copies are forwarded to P&A.
Thurs., May 23	12:30 pm. P&A meets to recommend the <b>FY14 service priorities</b> for Ryan White Parts A & B & State Services funds.
Wed. May 29	7 p.m., Public Hearing on the <b>FY14 How To Best Meet the Need results.</b>
Thurs. May 30	10 a.m. Special QA meeting to review public comments regarding the FY14 HTBMN results.
Thurs. June 6	12 noon. Steering Committee meets to approve the <b>FY14 HTBMN results.</b>
June 12 – 20	Special P&A meetings to draft the <b>FY14 allocations for RW Part A &amp; B &amp; State Services funding.</b>
Fri. June 7	5 p.m. Deadline for submitting <b>New Idea Forms</b> to the Office of Support. Please contact the Office of Support at 713 572-3724 to request a copy of the required forms.
Thurs. June 13	12 noon. Council approves the <b>FY14 HTBMN results.</b>
<b>Thurs. June 20</b>	10 am. QA meets to review the results of the assessment of the administrative mechanism.
<b>Thurs. June 20</b>	12:30 noon. P&A meets to approve the <b>FY14 allocations for RW Part A &amp; B &amp; State Services funding.</b>
Mon. June 24	7 p.m. Public Hearing on the <b>FY14 service priorities &amp; allocations.</b>
Tues. June 25	12:30 p.m. Special P&A meeting to review public comments re the FY14 service priorities & allocations.
July, date: TBD	Conduct the Year Two <b>Comprehensive Plan</b> midyear evaluation.
July/Aug.	Form workgroup to develop the <b>FY14 EIIHA Strategy.</b>
<b>Wed. July 3</b>	12 noon Steering Committee approves the <b>FY14 service priorities &amp; allocations.</b>
Thurs. July 11	12 noon. Council approves the <b>FY14 service priorities &amp; allocations.</b>
Thurs. July 25	12:30 p.m. If necessary, P&A meets to address problems Council sends back regarding the FY14 priority & allocations. They also allocate unspent funds.
Thurs. Aug. 1	<b>THE STEERING COMMITTEE MEETING WHERE ALL ITEMS MUST BE REVIEWED BEFORE BEING SENT TO COUNCIL–THIS IS THE LAST CHANCE TO APPROVE ANYTHING NEEDED FOR THE FY14 GRANT.</b>
Thurs. Aug. 8	12 noon. <b>Project LEAP</b> presents the results of their needs assessment to the Council & CPG.
Fri. Sept. 6 5 p.m.	Deadline for submitting <b>New Idea Forms</b> to the Office of Support. Please contact the Office of Support at 713 572-3724 to request a copy of the required forms.
October 15	Review & possibly update the Memorandum of Understanding between all Part A stakeholders.
Oct./Nov.	Workgroups meet to review <b>FY14 Standards of Care (SOC) &amp; Outcome Measures (OM)</b> for all services.
Tues. Oct. 16	1 p.m. <b>Consumer Workgroup</b> meeting to review FY 2013 SOC & OM.
Oct./Nov.	Review the evaluation of 2013 <b>Project LEAP.</b> Operations Committee will host a HHTBMN workgroup to make recommendations on 2014 Project LEAP.
Nov.	The Resource Group contacts all stakeholders for changes to the RW Part B/SS Letter of Agreement.
Tues. Nov. 12	9:30 a.m. Commissioners Court to receive the <b>World AIDS Day</b> Resolution.
Thurs. Nov. 14	12 noon. Council recognizes all external committee members.
Dec. Date: TBD	Conduct the Year Two Outcome Evaluation of the <b>Comprehensive Plan.</b>
Sun. Dec. 1	<b>World AIDS Day.</b>
Thurs. Dec. 12	12 noon Council meeting to elect the <b>2014 Council officers.</b>

## 2013 Proposed New Idea

(Applicant must complete this two-page form as it is. Agency identifying information must be removed or the application will not be reviewed. Please read the attached documents before completing this form: 1.) HRSA HIV-Related Glossary of Service Categories to understand federal restrictions regarding each service category, 2.) Criteria for Reviewing New Ideas, and 3.) Criteria & Principles to Guide Decision Making.)

**THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY**

<u># 1</u>	Control Number	Date Received <u>03/6/13</u>	
Proposal will be reviewed by the:		HTBMN Wnkgoup: <u>4/15/13 + 4/18/13</u>	
		Quality Assurance Committee on: <u>03/21/13</u>	(date)
		Priority & Allocation Committee on: <u>06/12/13</u>	(date)

**THIS PAGE IS FOR THE QUALITY ASSURANCE COMMITTEE**

(See Glossary of HIV-Related Service Categories & Criteria for Reviewing New Ideas)

1. SERVICE CATEGORY: \_\_\_\_\_ OR (circle) Navigator Program DATE: 03/06/13  
 (The service category must be one of the Ryan White Part A or B service categories as described in the HRSA Glossary of HIV-Related Service Categories unless the idea relates to a Navigator Program.)

Based on how many clients 3 Service Linkage Workers see annually in 15 minutes unit of service increments.

This will provide 750 clients with 15,000 units of service.

2. ADDRESS THE FOLLOWING:  
 A. DESCRIPTION OF SERVICE:

With the implementation of the Patient Protection and Affordable Care Act (ACA) on January 1, 2014, many people who were uninsured will become eligible for affordable health care coverage. Using data from the U.S. Census Bureau and estimates of the number of people that will potentially be impacted by the Texas Health and Human Service Commission, the following table includes the estimated number of people who could be impacted by the ACA within the Houston EMA:

County	Currently Uninsured	Marketplace with Tax Credits*	Marketplace without Tax Credits**	Medicaid Expansion ***	Eligible but Not Enrolled Children (CHIP/Medicaid)	Remain Uninsured
Chambers	5,772	2,382	550	1,283	550	1,008
Fort Bend	103,556	42,737	9,862	23,012	9,862	18,081
Harris	1,108,842	457,617	105,604	246,409	105,604	193,607
Liberty	17,474	7,211	1,664	3,883	1,664	3,051
Montgomery	88,754	36,629	8,453	19,723	8,453	15,497
Waller	12,109	4,997	1,153	2,691	1,153	2,114
Houston EMA Totals	1,336,507	551,573	127,286	297,001	127,286	233,358

For people living with HIV and AIDS, based on the income and insurance status of the population, the Texas Department of Health Services estimates that of the approximately 35,000 people who sought Ryan White funded services in 2010, 50% will be eligible for Medicaid in 2014. In addition, there is reason to believe that a significant proportion of the approximately 21,000 people living with HIV and AIDS not currently in care may become eligible for Medicaid

The Marketplace, also known as health insurance exchanges, will begin to function in October 2013. The Marketplace is the program where individuals can apply for healthcare coverage, such as Medicaid and insurance subsidies. Most of the people in the table above will not know about their options through the Marketplace, the new benefits or how to enroll. The proposed new services, **Patient Navigation**, will involve outreach into our community and identify persons living with HIV/AIDS (PLWHA) who are not in care, never established care, dropped out of care, and assisting them with the enrollment into the Marketplace. Patient Navigators will conduct public education activities to raise awareness about the Marketplace, help people apply for and enroll in plans offered through the Marketplace, ensure enrollment is accurate and complete, as well as provide referrals.

Through HIV Counseling, Testing and Referrals (CTR) programs, HIV+ individuals of target populations will be identified and made aware of their serostatus. Patient Navigators will work in tandem with the CTR Health Educators to ensure a relationship embedded with the premise of early identification and linkages to affordable healthcare coverage that will address all core and ancillary medical needs improve access to quality health care and services, build a healthy community and improve Houston's health equity. When a newly diagnosed HIV+ individual is identified, if possible a patient navigator will be introduced at the time of post-test counseling to a Patient Navigator. If a Patient Navigator is not readily accessible, the CTR Health Educator will receive consent from the client to have the Patient Navigator contact them within 24 hours of their post-test counseling. At the initial meeting, the Patient Navigator will initiate a dialog with the client to address their initial concerns regarding their serostatus, assess their emotional wellbeing, and develop a co-dependent relationship and discuss the client's immediate needs. This initial dialog is intended to develop trust, and initiate a rapport between the client and the Patient Navigator. The Patient Navigator will conduct a brief session regarding HIV pathogenesis and disease management, as well as the need for establishing primary care. Furthermore, one of the most essential and vital responsibilities for the Patient Navigator will be to provide the client with information on navigating the Marketplace, including facilitating enrollment, identifying health care providers and support services, as well as assist with making medical appointments.

**B. TARGET POPULATION (Race or ethnic group and/or geographic area):**

All HIV+ individuals living in the Houston EMA

**C. SERVICES TO BE PROVIDED (including goals and objectives):**

1. Patient Navigators will link 85% of the newly diagnosed HIV+ individuals that qualify to affordable health coverage through the Marketplace.
2. Patient Navigators will educate 85% of current Ryan White consumers about their options with the Marketplace.
3. Patient Navigators will be an assigned member of each CTR team.
4. Patient Navigators will conduct 50 outreach and public education workshops on the health coverage options and financial assistance that are provided through the Marketplace.
5. Patient Navigators will distribute fair, accurate, and impartial information about the full range of health coverage options that are available through the Marketplace, including public programs.
6. Patient Navigators will facilitate enrollment of 750 clients in qualified health plans (QHPs) through the Marketplace.
7. Patient Navigators will make referrals to health insurance consumer assistance or state agencies for help with grievances, complaints, appeals, and questions about using coverage.
8. Patient Navigators will provide information and services in a manner that is culturally and linguistically appropriate and accessible to people with disabilities.



PLEASE STATE HOW THIS NEW IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS:

This new idea meets the Priority and Allocations Principles A, B, F and G

In addition it meets:

Criteria Step 1 B, D and F

And

Criteria Step 2 A, B, C, E and F

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

Recommended for Increased Funding in the Amount of: \$ \_\_\_\_\_

Not Recommended for Increased Funding

Other:

REASON FOR RECOMMENDATION:

DRAFT  
Quality Assurance Committee

2012 Criteria for Reviewing New Ideas

Approved by the Steering Committee on April 7, 2011

In order for the Quality Assurance Committee to review a request for a new idea, the idea must:

- 1.) Fit within the HRSA Glossary of HIV-Related Service Categories unless it is an idea for a Navigator Program.
- 2.) Not duplicate a service currently being provided by Ryan White Part A or B or State Services funding.
- 3.) Document the need using one or more Planning Council publications.
- 4.) *For an emerging need only*, attach documentation from an outside source. Acceptable sources may include:
  - Letter on agency letterhead from three other agencies describing their experience related to this need.
  - Or, documentation from HIV websites or newspaper articles including a copy of the original document or study cited in the article or website.

# Priority and Allocations

## FY 2013 Guiding Principles and Decision Making Criteria

(approved by the Priority and Allocations Committee on 02-23-12)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort**. Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV/AIDS. Decisions will address at least one or more of the following principles **and** criteria.

*Principles are the standards guiding the discussion of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

### Principles

- A. Ensuring ongoing client access to a comprehensive system of core services as defined by HRSA
- B. Eliminating barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
- C. Meeting the needs of diverse populations as addressed by the epidemiology of HIV
- D. Identify individuals unaware of their status and link them to care and address the needs of those that are aware of their status and not in care.
- E. Expressing the needs of the communities with HIV for whom the services are intended

### Allocations only

- F. Documented or demonstrated cost-effectiveness of services and minimization of duplication
- G. Availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, local foundations and non-governmental social service agencies

*Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.*

### DECISION MAKING CRITERIA STEP 1:

- A. Documented service need with consumer perspectives as a primary consideration
- B. Documented effectiveness of services with a high level of benefit to people and families living with HIV infection, including quality, cost, and outcome measures when applicable
- C. Documented response to the epidemiology of HIV/AIDS in the EMA and HSDA

- D. Documented response to emerging needs reflecting the changing local epidemiology of HIV/AIDS while maintaining services to those who have relied upon Ryan White funded services.
- E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
- F. Documented consistency with the Continuum of Care and its underlying principles to the extent allowable under the Ryan White Program: to build public support for HIV services; to inform people of their serostatus and, if they test positive, get them into care; to help people maintain their negative status; to help people with HIV improve their health status and quality of life and prevent the progression to AIDS; and to help people with AIDS improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

## **DECISION MAKING CRITERIA STEP 2:**

- A. Services are effective with a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
- B. Services are accessible to all populations infected, affected, or at risk, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
- C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and STDs
- D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
- E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
- F. Services are available to meet the needs of all people and families living with or at risk for HIV infection as applicable under Part A and B guidelines
- G. Services meet or exceed standards of care
- H. Services reflect latest medical advances, when appropriate
- I. Services meet a documented need that is not fully supported through other funding streams

**PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS. All decisions are expected to address needs of the overall community affected by the epidemic.**



Dear Ryan White HIV/AIDS Program Colleagues:

The Affordable Care Act (ACA) will benefit People Living with HIV/AIDS (PLWH) in many ways. These benefits include: (1) prohibiting insurers from denying coverage to individuals with pre-existing conditions; (2) stopping insurance companies from dropping coverage just because someone who got sick made a mistake on their application; (3) ending lifetime dollar limits on coverage and phasing out annual limits on essential health benefits by 2014; (4) requiring coverage for inpatient services and other essential health benefit categories; and (5) considering payments from the AIDS Drug Assistance Program (ADAP) as true out-of-pocket expense under Medicare Part D Program. When key parts of the health care law take effect in 2014, there will be a new way for individuals, families, and small business owners to get health coverage through the Health Insurance Marketplace, also known as the Affordable Insurance Exchange.

The HIV/AIDS Bureau recognizes that outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into health insurance coverage is critical to ensure that clients fully benefit from the new coverage opportunities created by the health care law. RWHAP grantees and planning bodies are encouraged to review their Fiscal Year 2013 HIV service priorities, allocations, contracts and budgets and consider utilization of RWHAP resources to support Affordable Care Act related outreach and enrollment activities. The attached table highlights RWHAP service categories by Part that can be used to support outreach, benefits counseling and enrollment activities of RWHAP clients into private health insurance plans through the Health Insurance Marketplace and into Medicaid in their jurisdiction.

As more PLWH gain access to health care coverage, it is important to remember that the RWHAP will continue to be the payer of last resort. Grantees and subgrantees must ensure proper use of RWHAP funds and comply with the statutory requirement that RWHAP funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made by another payment source."

Thank you for your continued commitment to RWHAP clients and your efforts to ensure eligible individuals learn about and enroll in new coverage opportunities. If you have additional questions, please contact your project officer.

Sincerely,

Laura W. Cheever, M.D., Sc.M.  
Acting Associate Administrator

Attachment: Ryan White and Affordable Care Act Outreach, Enrollment and Benefits Counseling

03/12/2013



## Ryan White and Affordable Care Act Outreach, Enrollment and Benefits Counseling

This table highlights Ryan White HIV/AIDS Program service categories by Part that can be used to support outreach, benefits counseling and enrollment activities.

Note: Not all Ryan White providers offer all of the service categories listed below. Decisions regarding use of Ryan White Part A and Part B funding for specific services are made by the jurisdiction based on needs assessment data.

	Service Category	Appropriate For	Rationale
Part A/B #1	<p><b>Early Intervention Services (EIS)</b> that include identification of individuals at points of entry and access to services and provision of:</p> <ul style="list-style-type: none"> <li>• Referral services</li> <li>• Linkage to care</li> <li>• Health education &amp; literacy training that enable clients to navigate the HIV system of care</li> <li>• HIV testing (with prior Project Officer approval)</li> </ul> <p><b>(Core Medical Service)</b></p>	<p>Benefits Counseling</p> <p>Enrollment</p> <p>Outreach Education</p>	<p>Referrals and linkages to care may include enrollment in Medicaid, Medicare, private insurance plans through the health insurance Marketplaces/ Exchanges and benefits counseling. Services are generally provided to clients who are new to care.</p>
Part A/B #2	<p><b>Medical Case Management Services</b> (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication.</p> <p>Activities that include at least the following:</p> <ul style="list-style-type: none"> <li>• Initial assessment of service needs</li> <li>• Development of a comprehensive, individualized care plan</li> <li>• Coordination of services required to implement the plan</li> <li>• Continuous client monitoring to assess the efficacy of the plan</li> <li>• Periodic re-evaluation and adaptation of the plan at least every 6 months, or more frequently, as necessary.</li> </ul> <p><b>(Core Medical Service)</b></p>	<p>Benefits Counseling</p> <p>Enrollment</p>	<p>Medical Case Management includes a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits/entitlement counseling and referral activities to assist clients with access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other State or local health care and supportive services). It will depend on the local structure of the medical case management model. Services are provided to prevent clients from falling out of care.</p>
Part A/B #3	<p><b>Case Management (Non-medical)</b> services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services.</p> <ul style="list-style-type: none"> <li>• Benefits/entitlement counseling and referral ac-</li> </ul>	<p>Benefits Counseling</p> <p>Enrollment</p>	<p>The service definition includes benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care.</p>

	Service Category	Appropriate For	Rationale
	<p>tivities to assist eligible clients to obtain access to public and private programs for which they may eligible</p> <ul style="list-style-type: none"> <li>• All types of case management encounters and communications (face-to-face, phone, other)</li> <li>• Transitional case management for incarcerated persons as they prepare to exit the correctional system</li> </ul> <p><b>(Support Service)</b></p>		
<b>Part A/B #4</b>	<p><b>Health Education/Risk Reduction</b> services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission</p> <ul style="list-style-type: none"> <li>• Provision of information about available medical and psychosocial support services</li> <li>• Counseling on how to improve their health status and reduce the risk of HIV transmission to others</li> </ul> <p><b>(Support Service)</b></p>	Outreach Education	PLWHA who are aware of their status and not in care often cite lack of awareness of health resources. Entry into care is a prevention and risk reduction tool, thus education of clients with regard to the Affordable Care Act and other resources available to them as a key component of health education and risk reduction should occur. Services can be provided to clients who are not in care or who have fallen out of care.
<b>Part A/B #5</b>	<p><b>Outreach Services</b> designed to identify individuals who do not know their HIV status and/or individuals who know their status and are not in care and help them to learn their status and enter care</p> <p><b>(Support Service)</b></p>	Outreach Education	Outreach services can provide additional information on the Affordable Care Act benefits and help clients learn of their status and enter care. Services are generally provided to clients who are not aware of their status and/or not in care.
<b>Part A/B #6</b>	<p><b>Referral for Health Care/Supportive Services</b> that direct a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of Ambulatory/ Outpatient Medical Care or Case Management Services May include: benefits/entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services.</p> <p>Referrals may be made:</p> <ul style="list-style-type: none"> <li>• Within the Non-medical Case Management system by professional case managers</li> <li>• Informally through community health workers or support staff</li> <li>• As part of an outreach program</li> </ul> <p><b>(Support Service)</b></p>	Benefits Counseling Enrollment Outreach Education	This service specifically mentions benefits/entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs. It supports retention, adherence to services and assists in clients navigating through available resources. Services are generally provided to clients who have a change in insurance status, new eligibility, or require a change in treatment regimen.
<b>MAI/ Part B</b>	<p>The overall goal of the Ryan White Part B MAI program is to improve minority access to HIV/AIDS medications to treat HIV/AIDS and prevent opportunistic</p>	Benefits Counseling	This service is specifically designed to increase access to medication programs which include Medicaid, Medicare, pri-

	Service Category	Appropriate For	Rationale
	infection through the Part B ADAP and as appropriate to other programs providing prescription drug coverage.	Enrollment Outreach Education	vate insurance through the health insurance Marketplaces/ Exchanges and benefits counseling. Services are generally provided to minority clients.
<b>Part C #1</b>	<b>Medical Case Management</b> including a range of patient-centered services that result in a coordinated care plan, which links patients to medical care, psychosocial, and other services including treatment adherence services. <b>(Core Medical Service)</b>	Benefits Counseling Enrollment	Medical Case Management includes a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits/entitlement counseling and referral activities assisting clients to access other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other State or local health care and supportive services). It will depend on the local structure of the medical case management model. In some cases this may be done by eligibility specialist or benefits advocates. Services are provided to prevent clients from falling out of care.
<b>Part C #2</b>	<b>Case Management (Non-medical)</b> services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services May include: Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may eligible <b>(Support Service)</b>	Benefits Counseling Enrollment	This service definition includes benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care.
<b>Part C #3</b>	<b>Outreach</b> to identify people with HIV, or at-risk of contracting HIV, to educate them about the benefits of early intervention and link them into primary care <b>(Support Service)</b>	Outreach Enrollment	Outreach services can provide additional information on the Affordable Care Act benefits and help clients learn of their status and enter care. Services are generally provided to clients who are not aware of their status and/or not in care.
<b>Part D</b>	<b>Medical Case Management Services</b> (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. Activities that include at least the following: <ul style="list-style-type: none"> <li>• Initial assessment of service needs <ul style="list-style-type: none"> <li>• Development of a comprehensive, individualized care plan</li> <li>• Coordination of services required to implement</li> </ul> </li> </ul>	Benefits Counseling Enrollment	Medical Case Management includes a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits/entitlement counseling and referral activities to assist clients with to access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other State or local health care and supportive services). It will depend on the local structure of the medical case management model. In some cases this may be left to eligibility specialist or

	Service Category	Appropriate For	Rationale
	<p>the plan</p> <ul style="list-style-type: none"> <li>• Continuous client monitoring to assess the efficacy of the plan</li> <li>• Periodic re-evaluation and adaptation of the plan at least every 6 months, or more frequently, as necessary</li> </ul> <p><b>(Core Medical Service)</b></p>		<p>benefits advocates. Services are provided to prevent clients from falling out of care.</p>
	<p><b>Case Management (Non-Medical)</b> services are defined as those services which are needed for individuals with HIV/AIDS to achieve their HIV medical outcomes. Case management which, includes medical, non-medical, and family-centered services.</p> <p>May include:</p> <ul style="list-style-type: none"> <li>• Financial assessment/eligibility counselors (staff whose role is to determine client eligibility for Medicaid and other insurance programs and assist them to apply).</li> <li>• Staff assists clients with linkage, engagement, and retention in HIV care.</li> </ul> <p><b>(Support Service)</b></p>	<p>Outreach Education Enrollment</p>	<p>This service includes patient and family centered benefits/entitlement counseling and referral activities are allowable as part of this service under Ryan White Part D. Services are provided to prevent clients from falling out of care</p>



## **Key Provisions of the Affordable Care Act for the Ryan White HIV/AIDS Program**

The Affordable Care Act increases access to health insurance coverage and health services for all Americans, including people living with HIV/AIDS (PLWH), through a number of private market reforms, an expansion of Medicaid eligibility, and the establishment of Health Insurance Marketplaces (also referred to as Exchanges). The federal government, states, insurers, and consumers have a number of roles and responsibilities to help with implementation of the Affordable Care Act. This brief provides an overview of the major provisions within the Affordable Care Act that benefit PLWH.

### ***Private Insurance Market Reforms***

The Affordable Care Act includes a number of private health insurance market reforms that will benefit PLWH. PLWH cannot be prevented from purchasing most private health insurance plans-- from which they historically have been excluded -- based on having HIV/AIDS as a pre-existing condition. Most reforms will be effective on January 1, 2014, although some provisions have been effective since 2010. These reforms include:

- Guaranteed availability of coverage, which prevents insurers from denying coverage to individuals based on pre-existing conditions
- Fair health insurance premiums, which prohibits discriminatory premium rates by preventing insurers from charging more for individuals based on pre-existing conditions
- Prohibition of pre-existing condition exclusions or other discrimination based on health status
- Prohibitions against imposing annual dollar limits on essential health benefits
- Dependent coverage extension (up to age 26)
- Coverage of specified preventive health services without cost-sharing

Visit <http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html> to learn more about Affordable Care Act private market reforms.

### **Key Players & Some Core Responsibilities**

*Federal action:* Monitor compliance with and enforce federal laws (except where states are primary regulators of the insurance industry and are substantially enforcing requirements)

*State action:* Monitor compliance with and enforce state insurance laws

*Insurer action:* Comply with federal and state laws

*Consumer action:* Understand the law and sign-up for updates by visiting HealthCare.gov

## ***Medicaid Coverage***

The Affordable Care Act establishes a new Medicaid eligibility category for low-income adults between 19-64 years of age with income at or below 133 percent of the Federal Poverty Level (FPL). If a state expands its Medicaid program, low-income people living with HIV who meet the new eligibility criteria will no longer have to wait for an AIDS diagnosis to qualify for Medicaid.

In states that implement this Medicaid expansion, eligibility will be determined using Modified Adjusted Gross Income (MAGI) based methods. If necessary for establishing income eligibility, an income disregard equal to 5 percentage points of the FPL will be applied. Under the law, the “newly eligible” individuals will be enrolled into a Medicaid Alternative Benefit Plan, which must include coverage of the ten statutory essential health benefit categories and comply with state and federal regulations.

### **Key Players & Some Core Responsibilities**

*Federal Action:* CMS will provide guidance to states on Medicaid expansion, approve state plan amendments for expansion, and regulate inclusion of essential health benefits in Alternative Benefit Plans. CMS will also provide the additional Federal Matching Assistance Percentage (FMAP) for states that choose to expand their Medicaid Program.

*State Action:* If a state implements Medicaid expansion, it is responsible for establishing Medicaid Alternative Benefit plans for “new eligible” individuals, which must include coverage of essential health benefits. Regardless of its expansion decision, a state must determine income using a Modified Adjusted Gross Income (MAGI) based methodology for non-elderly, non-disabled eligibility groups (except for groups whose eligibility is based on medical need or on receipt of Medicare) covered in each state. States are also responsible for developing a transition strategy and coordinating with the Health Insurance Marketplace in their state.

*Health Provider Action:* In states that choose to expand and use a managed care model, providers should consider negotiating and contracting with Medicaid managed care plans to ensure alignment with payer of last resort policy.

*Consumer Action:* Consumers should learn if their state is expanding its Medicaid program and whether they are eligible. If enrolled in a Medicaid managed care plan, the consumer should make sure he/she selects a primary care provider.

## ***Health Insurance Marketplaces***

Starting January 2014, PLWH with incomes between 100-400% FPL who are not eligible for other affordable insurance through an employer or other government program may be eligible for federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through a Health Insurance Marketplace (or Exchange).

Individuals between 100%-400% FPL may be eligible for premium tax credits distributed on a sliding-income scale and based on the premium of the second lowest cost silver plan offered in a state's Health Insurance Marketplace. Individuals between 100%-250% FPL may also be eligible for cost-sharing reductions if they enroll in a silver level plan. Indians are eligible for additional cost-sharing reductions if their household income is below 300% FPL or for services and items provided by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. Other eligibility requirements for this assistance and subsidies apply. To learn more about premium tax credits, visit <http://www.healthcare.gov/marketplace/costs/tax-credits/index.html>.

Health Insurance Marketplaces are designed to make buying health insurance coverage in the individual and small group market easier and more affordable. These Marketplaces will provide a "one-stop shop" for individuals to compare qualified health plan options, get answers to health coverage questions, find out if they are eligible for affordability programs like Medicaid and CHIP or premium tax credits to purchase private insurance, and enroll in a qualified health plan that meets their individual needs. Visit <http://www.healthcare.gov/marketplace/index.html> to learn more about Health Insurance Marketplaces.

States can choose to operate their own Health Insurance Marketplace (State-based Marketplace), participate in one in partnership with HHS (State Partnership Marketplace), or allow HHS to manage and operate a Federally-facilitated Marketplace. Visit <http://cciio.cms.gov/resources/factsheets/state-marketplaces.html> to learn more about what type of Health Insurance Marketplace may be operating in your state.

### **Key Players & Some Core Responsibilities**

*Federal Action:* HHS approves operating plans for states that choose to establish their own State-based Marketplace. A State Partnership Marketplace enables states to assume primary responsibility for carrying out certain activities related to plan management, consumer assistance and outreach, or both. HHS will carry out all minimum Marketplace functions not performed by states in the State Partnership Marketplace and will oversee operation of the entire Marketplace. In states that do not have a State-based Marketplace or a State Partnership Marketplace, HHS will be responsible for certifying qualified health plans and establishing and monitoring compliance with network adequacy standards and essential community provider requirements. HHS will also administer, oversee, and support in-person application assistance to consumers, including a Navigator Program in Federally-facilitated or State Partnership Marketplaces to assist consumers in understanding their health insurance options and enrolling in a health plan.

*State Action:* States must decide whether to establish a State-based Marketplace, State Partnership Marketplace, or rely on a Federally-facilitated Marketplace. The deadline for notifying HHS of establishing a State-based Marketplace passed on December 14, 2012. States had until February 15, 2013 to notify HHS and submit an application to participate in a State Partnership Exchange, or cooperate in other ways with HHS with respect to a Marketplace in their State. States operating State-based Marketplaces are responsible for the following: approving and contracting with accredited qualified health plans for State-based Marketplaces

and ensuring they comply with non-discrimination standards and EHB requirements; establishing and monitoring compliance with network adequacy standards and essential community provider requirements for State-based Marketplaces; developing a streamlined eligibility and enrollment process to assess and enroll individuals into Medicaid or the Marketplace and develop a transition strategy for moving individuals from the Pre-Existing Condition Insurance Plan to a qualified health plan in the Marketplace; and administering, overseeing, and supporting in-person application assistance, including a Navigator Program. In states that choose to carry out consumer assistance activities as a partner in a State Partnership Marketplace, the states will support the Navigator program as well as administer and support other in-person assistance programs.

*Insurer Action:* Insurers may choose to offer coverage--their qualified health plans--through the Marketplaces. They must ensure all health plans offered through the Marketplaces meet qualified health plan standards, including network adequacy standards and inclusion of a sufficient number of essential community providers, as well as other qualified health plan standards. Insurers may choose to market their qualified health plans.

*Health Provider Action:* Health providers should consider contracting with health plans to ensure they will be included in networks by January 1, 2014 to ensure alignment with payer of last resort policy.

*Consumer Action:* Initial open enrollment for the Marketplaces begins on October 1, 2013 and ends on March 31, 2014. Consumers should apply before December 15, 2013 to ensure that their new qualified health coverage begins on January 1, 2014. Utilizing consumer assistance programs, such as Navigators, can help consumers understand their Marketplace health plan options. Consumers should also visit <http://www.healthcare.gov/marketplace/get-ready/index.html> to learn about more ways to prepare for enrollment in the Health Insurance Marketplace.

### ***Essential Health Benefits***

PLWH who obtain insurance through non-grandfathered health plans (inside or outside Health Insurance Marketplaces) or through Medicaid in a Medicaid Alternative Benefit Plan will be ensured coverage of “essential health benefits” (EHB). With respect to plan years (small group market) and policy years (individual market) beginning on or after January 1, 2014, non-grandfathered health plans offered in the individual and small group markets (inside and outside the Health Insurance Marketplaces) and Medicaid Alternative Benefit Plans must offer a core package of items and services known as the “essential health benefits” (EHB). EHB must include items and services within at least the following ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

On November 20, 2012, the Center for Medicaid and CHIP services (CMCS) released a letter to State Medicaid Directors to provide guidance to states on the use of Alternative Benefit Plans for

the new eligibility group of low-income adults and the relationship between Alternative Benefit Plans and EHB.<sup>1</sup> CMCS also issued a proposed rule on January 14, 2013 outlining EHB coverage requirements in Medicaid.<sup>2</sup>

A final rule issued in February 2013 outlines health insurance issuer standards for EHB that non-grandfathered individual and small group health insurance issuers must cover both inside and outside the Health Insurance Marketplace.<sup>3</sup> The Affordable Care Act requires that the scope of the EHB be equal to the scope of benefits offered in a “typical employer plan.” To give states the flexibility to define EHB in a way that would best meet the needs of their residents, this rule finalizes a benchmark-based approach. This approach allows states to select a benchmark plan from options offered in the market. If a base-benchmark plan does not cover any benefits in any of the ten required categories of EHB, the base-benchmark plan must be supplemented by adding the entire category of benefits from another of the benchmark plan options to establish the EHB-benchmark plan for that state. Twenty-six states selected a benchmark plan for their state. In the other states and Puerto Rico, the largest small group market plan by enrollment in each state will be the base-benchmark and in the other U.S. territories, the largest Federal Employee Health Benefit Plan by enrollment will be the base-benchmark.<sup>4</sup> To learn more about a state’s EHB-benchmark plan selection, please visit <http://cciio.cms.gov/resources/data/ehb.html>.

Beginning in 2014, plans that are required to cover EHB also must cover a certain percentage of the total allowed costs of providing benefits, known as actuarial value or “metal levels.” These levels are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Metal levels will allow consumers to compare insurance plans with similar levels of coverage and cost-sharing based on premiums, provider networks, and other factors.

Further, a health plan is not deemed to provide EHB unless it covers at least one drug in every United States Pharmacopeia (USP) category and class, or the same number of prescription drugs in every category and class as the EHB benchmark plan, whichever is greater. Health plans must also have procedures in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health plan.

Visit <http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html> to learn more about the EHB final regulation for non-grandfathered individual and small group market plans.

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<sup>1</sup> See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>

<sup>2</sup> See <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

<sup>3</sup> See [http://www.ofr.gov/OFRUpload/OFRData/2013-04084\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf)

<sup>4</sup> Appendix A of the final EHB regulation includes the final list of EHB-benchmark plan for coverage years in 2014 and 2015. See [http://www.ofr.gov/OFRUpload/OFRData/2013-04084\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf).

### **Key Players & Some Core Responsibilities**

*Federal action:* HHS defined essential health benefits based on a benchmark plan selected by each State. HHS reviews proposed benchmark plan selections submitted by states to ensure compliance with federal law and non-discrimination standards.

*State action:* States select a benchmark plan for the individual and small group market (both inside and outside the Health Insurance Marketplace) that defines EHB and ensure benchmark plans contain all required benefits and otherwise comply with federal law. States must also ensure that Medicaid Alternative Benefit Plans include coverage of EHB as outlined in the federal regulation.

*Insurer action:* Under the final rule, non-grandfathered insurers in the individual and small group market must include coverage of EHB using the EHB-benchmark plan as a reference plan. Insurers may set different limitations on coverage so long as they remain substantially equal to the state's benchmark plan and would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. Health plans must also comply with prescription drug formulary minimum requirements as outlined in the final rule.

*Consumer action:* Although non-grandfathered health plans in the individual and small group market are required to cover EHB, insurers' benefit design may vary. Consumers should review plans' benefits when selecting a health plan.

RW Part A Service Utilization Report																	
		Goal	Clients Served	Male	Female	AA (non-)	(non-)	(non-)		0-12	13-19	20-24	25-34	35-44	45-54	55-64	65+
1		2,800	2,322	73%	27%	49%	16%	2%	32%	0%	1%	7%	24%	30%	27%	10%	1%
1.a	Primary Care - Public Clinic (a)	2,800	2,322	100%	0%	51%	14%	2%	34%	0%	0%	4%	18%	26%	34%	15%	2%
1.b	Primary Care - CBO Targeted to AA (a)	1,130	1,007	64%	36%	99%	0%	1%	0%	0%	1%	13%	35%	29%	17%	5%	0%
1.c	Primary Care - CBO Targeted to Hispanic (a)	1,035	1,043	83%	17%	0%	0%	0%	100%	0%	0%	7%	29%	39%	21%	4%	0%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	675	727	89%	11%	0%	93%	7%	0%	0%	0%	5%	21%	31%	29%	13%	1%
1.e	Primary Care - CBO Targeted to Rural (a)(f)	190	359	70%	30%	45%	28%	2%	25%	0%	0%	13%	30%	29%	21%	7%	0%
1.f	Primary Care - Women at Public Clinic (a)	1,200	1,008	0%	100%	66%	8%	0%	25%	0%	1%	3%	20%	29%	31%	13%	2%
1.g	Primary Care - Pediatric (a)	10	10	50%	50%	70%	10%	10%	10%	20%	50%	30%	0%	0%	0%	0%	0%
1.h	Vision	1,600	1,603	79%	21%	42%	24%	2%	32%	0%	0%	3%	16%	25%	38%	15%	3%
2				76%	24%	45%	23%	2%	31%	0%	1%	7%	27%	32%	24%	8%	1%
3																	
3.a	Clinical Case Management	600	1,203	73%	27%	51%	27%	2%	20%	0%	0%	7%	23%	25%	31%	12%	1%
3.b	Med CM - Targeted to Public Clinic (a)	585	286	97%	3%	56%	15%	3%	26%	0%	0%	0%	19%	26%	36%	17%	2%
3.c	Med CM - Targeted to AA (a)	805	1,417	66%	34%	99%	0%	1%	0%	0%	1%	11%	30%	30%	22%	6%	1%
3.d	Med CM - Targeted to H/L(a)	695	802	81%	19%	0%	0%	0%	100%	0%	1%	7%	28%	37%	21%	4%	1%
3.e	Med CM - Targeted to White and/or MSM (a)	370	628	86%	14%	0%	93%	7%	0%	0%	1%	4%	20%	26%	30%	15%	3%
3.f	Med CM - Targeted to Rural (a)	150	462	71%	29%	43%	23%	2%	32%	0%	0%	10%	26%	31%	25%	7%	1%
3.g	Med CM - Targeted to Women at Public Clinic (a)	375	240	0%	100%	64%	12%	0%	24%	0%	5%	17%	30%	24%	16%	6%	2%
3.h	Med CM - Targeted to Pedi (a)	125	109	47%	53%	77%	3%	1%	19%	59%	31%	10%	0%	0%	0%	0%	0%
3.i	Med CM - Targeted to Veterans	200	210	94%	6%	67%	23%	0%	10%	0%	0%	0%	2%	7%	37%	43%	11%
3.j	Med CM - Targeted to Youth	120	86	98%	2%	66%	10%	1%	22%	0%	12%	88%	0%	0%	0%	0%	0%
4		200	187	66%	34%	32%	43%	2%	23%	0%	0%	5%	18%	29%	32%	13%	2%
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	187	66%	34%	32%	43%	2%	23%	0%	0%	5%	18%	29%	32%	13%	2%
5		650	448	82%	18%	38%	28%	2%	32%	0%	0%	2%	19%	26%	32%	17%	4%
6		NA	NA														
7		NA	NA														
8		40	14	86%	14%	29%	43%	0%	29%	0%	0%	0%	29%	50%	21%	0%	0%
9		55	23	74%	26%	52%	43%	0%	4%	0%	0%	0%	22%	17%	30%	22%	9%
10		NA	NA														
11		NA	NA														
12																	
12.a	Service Linkage Targeted to Youth	320	275	72%	28%	67%	5%	1%	26%	0%	11%	89%	0%	0%	0%	0%	0%
12.b	Service Linkage at Testing Sites	260	73	62%	38%	66%	8%	3%	23%	0%	0%	0%	42%	26%	22%	10%	0%
12.c	Service Linkage at Public Clinic Primary Care Program (a)	3,500	3,771	62%	38%	62%	12%	1%	25%	0%	0%	0%	19%	27%	35%	16%	3%
12.d	Service Linkage at CBO Primary Care Programs (a)	2,100	2,811	73%	27%	52%	19%	2%	27%	2%	2%	8%	25%	29%	24%	8%	1%
13		NA	NA														
14																	
14.a	Transportation Services - Urban	200	169	51%	49%	63%	16%	1%	20%	0%	1%	6%	18%	20%	31%	20%	3%
14.b	Transportation Services - Rural	100	123	63%	37%	37%	40%	2%	21%	0%	1%	6%	17%	28%	33%	12%	3%
14.c.1	Transportation vouchers (bus passes)	2,500	2,530														
14.c.2	Transportation vouchers (gas vouchers)	50	69														
15		360	310	68%	32%	57%	21%	2%	21%	0%	0%	1%	10%	26%	36%	24%	2%
16		NA	NA														
<b>Net unduplicated clients served - all categories*</b>																	
		NA		72%	28%	53%	18%	2%	27%	1%	1%	6%	21%	27%	30%	13%	2%
				74%	26%	49%	27%	2%	23%	0%	5%		18%	29%	31%	16%	
*10,200 clients to be served is based on the number of unduplicated clients served in FY 2011 (10,180)																	

RW MAI Service Utilization Report																	
	MAI unduplicated served includes clients also served under Part A	Goal	Clients Served YTD	Male	Female	AA (non-Hispanic)	(non-Hispanic)	(non-Hispanic)		0-12	13-19	20-24	25-34	35-44	45-54	55-64	65+
1.b	Primary Care - MAI CBO Targeted to AA	1,315	1,396	67%	33%	99%	0%	1%	0%	0%	1%	13%	33%	29%	19%	5%	0%
1.c	Primary Care - MAI CBO Targeted to Hispanic	950	933	84%	16%	0%	0%	0%	100%	0%	0%	8%	30%	39%	20%	3%	0%
RW Part A New Client Service Utilization Report																	
Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/10 - 2/28/11)																	
			New Clients			AA (non-	(non-	(non-									
1				74%	26%	55%	17%	2%	27%	1%	2%	11%	29%	25%	23%	8%	0%
2				78%	22%	50%	22%	2%	26%	0%	1%	14%	33%	26%	20%	6%	1%
3.a	Clinical Case Management	400	1,203	73%	27%	51%	27%	2%	20%	0%	0%	7%	23%	25%	31%	12%	1%
3.b-3.h	Medical Case Management	1,600	2,061	73%	27%	52%	21%	2%	25%	1%	2%	11%	28%	27%	23%	7%	1%
3.i	Medical Case Management - Targeted to Veterans	60	53	89%	11%	64%	30%	2%	4%	0%	0%	0%	6%	9%	49%	28%	8%
4		40	88	75%	25%	27%	45%	2%	25%	0%	0%	9%	19%	28%	27%	14%	2%
	Non-Medical Case Management (Service Linkage)	3,700	2,856	70%	30%	58%	15%	2%	25%	1%	2%	8%	24%	27%	27%	10%	2%
		260	73	62%	38%	66%	8%	3%	23%	0%	0%	0%	42%	26%	22%	10%	0%
	Service Linkage at Testing Sites (Youth, 13-24 yrs. of age)		33	73%	27%	70%	0%	3%	27%	0%	18%	82%	0%	0%	0%	0%	0%
<b>Footnotes:</b>																	
(a)	Bundled Category																
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.																
(d)	Funded by Part B and/or State Services																
(e)	Not funded in FY 2012																
(f)	Does not include services funded by Part B and/or State Services																

**The Houston Regional HIV/AIDS Resource Group, Inc.**  
**FY 1213 Ryan White Part B**  
**Procurement Report**  
**September 1, 2012 - January 31, 2013**



**Spending Target: 71%** (Based on DSHS mandated 7-month spend-out requirement)

Priority	Service Category	Original Contracted Amount	% of Grant Award	Amendment	Amended Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
1	Outpatient Ambulatory Medical Care - Rural	\$182,290	10%		\$182,290	10%	9/1/2012	\$118,992	65%
	AIDS Pharmaceutical Assistance	\$13,125	1%		\$13,125	1%	9/1/2012	\$7,893	60%
3	Medical Case Management - Rural	\$90,418	5%		\$90,418	5%	9/1/2012	\$40,875	45%
4	Oral Health Care - General	\$933,345	53%		\$933,345	53%	9/1/2012	\$607,600	65%
	Oral Health Care - Prosthodontics	\$245,190	14%		\$245,190	14%	9/1/2012	\$172,291	70%
7	Health Insurance Premiums and Cost Sharing	\$172,083	10%		\$172,083	10%	9/1/2012	\$168,496	98%
10	Home and Community Based Health	\$141,167	8%		\$141,167	8%	9/1/2012	\$90,480	64%
<b>Total Houston HSDA</b>		<b>1,777,618</b>	<b>100%</b>	<b>\$0</b>	<b>1,777,618</b>	<b>100%</b>		<b>1,206,627</b>	<b>68%</b>

MCM: Some positions were vacant but have since been filled.

Health Insurance: Agency is spending in RW B before State Services.

**The Houston Regional HIV/AIDS Resource Group, Inc.**  
**FY 1213 DSHS State Services**  
**Procurement Report**  
**September 1, 2012 - January 31, 2013**



**Spending Target: 42%**

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Mental Health Services	\$252,200	13%	\$1,360	\$253,560	13%	9/1/2012	\$123,120	49%
7	Health Insurance Premiums and Cost Sharing	\$1,082,276	56%	\$5,837	\$1,088,113	54%	9/1/2012	\$216,828	20%
9	Hospice - full year	\$284,214	15%	\$1,533	\$285,747	14%	9/1/2012	\$111,540	39%
9	Hospice - March to August, 2013	\$0	0%	\$66,055	\$66,055	3%	9/1/2012	\$0	0%
11	EIS - Incarcerated	\$166,211	9%	\$896	\$167,107	8%	9/1/2012	\$71,209	43%
13	Food Bank	\$80,000	4%	\$432	\$80,432	4%	9/1/2012	\$25,300	31%
15	Legal Assistance - Rural	\$52,480	3%	\$0	\$52,480	3%	9/1/2012	\$12,752	24%
16	Linguistic Services	\$28,000	1%	\$151	\$28,151	1%	9/1/2012	\$13,000	46%
<b>Total Houston HSDA</b>		<b>1,945,381</b>	<b>100%</b>	<b>\$76,264</b>	<b>2,021,645</b>	<b>100%</b>		<b>573,749</b>	<b>28%</b>

HIP: Agency is spending RW B funds before State Services.

Legal Assistance: Agency is a month behind on billing.

Amendments reflect (1) \$66,055 to cover Part A gap in Hospice until it becomes fully funded in September, 2013, and (2) following the scenario for increases.

**DRAFT**  
**Priority and Allocations**  
**FY 2014 Guiding Principles and Decision Making Criteria**  
(Approved by Priority and Allocations Committee 03-28-13)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort**. Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV/AIDS. Decisions will address at least one or more of the following principles **and** criteria.

*Principles are the standards **guiding the discussion** of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

**Principles**

- A. Ensuring ongoing client access to a comprehensive system of core services as defined by HRSA
- B. Eliminating barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
- C. Meeting the needs of diverse populations as addressed by the epidemiology of HIV
- D. Identify individuals unaware of their status and link them to care and address the needs of those that are aware of their status and not in care.
- E. Expressing the needs of the communities with HIV for whom the services are intended

**Allocations only**

- F. Documented or demonstrated cost-effectiveness of services and minimization of duplication
- G. Availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies

*Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.*

**DECISION MAKING CRITERIA STEP 1:**

- A. Documented service need with consumer perspectives as a primary consideration
- B. Documented effectiveness of services with a high level of benefit to people and families living with HIV infection, including quality, cost, and outcome measures when applicable

- C. Documented response to the epidemiology of HIV/AIDS in the EMA and HSDA
- D. Documented response to emerging needs reflecting the changing local epidemiology of HIV/AIDS while maintaining services to those who have relied upon Ryan White funded services.
- E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
- F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan and the Continuum of Care and their underlying principles to the extent allowable under the Ryan White Program: to build public support for HIV services; to inform people of their serostatus and, if they test positive, get them into care; to help people maintain their negative status; to help people with HIV improve their health status and quality of life and prevent the progression to AIDS; and to help people with AIDS improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

## **DECISION MAKING CRITERIA STEP 2:**

- A. Services are effective with a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
- B. Services are accessible to all populations infected, affected, or at risk, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
- C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and STDs
- D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
- E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
- F. Services are available to meet the needs of all people and families living with or at risk for HIV infection as applicable under Part A and B guidelines
- G. Services meet or exceed standards of care
- H. Services reflect latest medical advances, when appropriate
- I. Services meet a documented need that is not fully supported through other funding streams

**PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS. All decisions are expected to address needs of the overall community affected by the epidemic.**

# DRAFT

## FY 2014 Priority Setting Process

(Approved by the Priority and Allocations Committee on 03-28-13)

1. Agree on the principles to be used in the decision making process.
2. Agree on the criteria to be used in the decision making process.
3. Agree on the priority-setting process.
4. Agree on the process to be used to determine service categories that will be considered for allocations. (This is done at a joint meeting of members of the Quality Assurance, Priority and Allocations and Affected Community Committees and others, or in other manner agreed upon by the Planning Council).
5. Staff distributes to committee members an information binder containing documents to be used in the Priority and Allocations Committee decision-making processes.
6. Committee members attend a training session to review the documents contained in the information binders and to hear presentations from representatives of other funding sources such as HOPWA, Prevention, Medicaid and others.
7. Staff prepares a table that lists services that received an allocation from Part A or B or State Service funding in the current fiscal year. The table lists each service category by HRSA-defined core/non-core category, need, use, lack of availability and difficulty in accessing and includes a score for each of these five items. The utilization data is obtained from calendar year CPCDMS data. The medians of the scores are used as guides to create midpoints for the need of HRSA-defined core and non-core services. Then, each service is compared against the midpoint and ranked as equal or higher (H) or lower (L) than the midpoint.
8. The committee meets to do the following. This step occurs at a single meeting:
  - Review documentation not included in the binders described above.
  - Review and adjust the midpoint scores.
  - After the midpoint scores have been agreed upon by the committee, **public comment** is received.
  - During this same meeting, the midpoint scores are again reviewed and agreed upon, taking public comment into consideration.
  - Ties are broken by using the first non-tied ranking. If all rankings are tied, use independent data that confirms usage from CPDMS or ARIES.
  - By matching the rankings to the template, a numerical listing of services is established.
  - Justification for ranking categories is denoted by listing principles and criteria.
  - Categories that are not justified are removed from ranking.
  - If a committee member suggests moving a priority more than five places from the previous year's ranking, this automatically prompts discussion and is challenged; any other category that has changed by three places may be challenged; any category that moves less than three places cannot be challenged unless documentation can be shown (not cited) why it should change.
  - The Committee votes upon all challenged categorical rankings.
  - At the end of challenges the entire ranking is approved or rejected by the committee.

(continued on next page)

9. At a subsequent meeting, the Priority and Allocations Committee goes through the allocations process.
10. Staff removes services from the priority list that are not included on the list of services recommended to receive an allocation from Part A or B or State Service funding. The priority numbers are adjusted upward to fill in the gaps left by services removed from the list.
11. The single list of recommended priorities is presented at a Public Hearing.
12. The committee meets to review public comment and possibly revise the recommended priorities.
13. Once the committee has made its final decision, the recommended single list of priorities is forwarded as the priority list of services for the following year.

**DRAFT**  
**2013 Policy for Addressing Unobligated and Carryover Funds**

(approved by the Priority and Allocations Committee – 03-28-13)

**Background**

The Ryan White Planning Council must address two different types of money: Unobligated and Carryover.

**Unobligated** funds are funds allocated by the Council but, for a variety of reasons, are not put into contracts. Or, the funds are put into a contract but the money is not spent. For example, the Council allocates \$700,000 for a particular service category. Three agencies bid for a total of \$400,000. The remaining \$300,000 becomes unobligated. Or, an agency is awarded a contract for a certain amount of money. Halfway through the grant year, the building where the agency is housed must undergo extensive remodeling prohibiting the agency from providing services for several months. As the agency is unable to deliver services for a portion of the year, it is unable to fully expend all of the funds in the contract. Therefore, these unspent funds become unobligated. The Council is informed of unobligated funds via Procurement Reports provided to the Quality Assurance (QA) and Priority and Allocations (P&A) Committees by the respective Administrative Agencies (AA), HCPHS/ Ryan White Grant Administration and The Resource Group.

**Carryover** funds are the RW Part A Formula and MAI funds that were unspent in the previous year. Annually, in October, the Part A Administrative Agency will provide the Committee with the estimated total allowable Part A and MAI carryover funds that could be carried over under the Unobligated Balances (UOB) provisions of the Ryan White Treatment Extension Act. The Committee will allocate the estimated amount of possible unspent prior year Part A and MAI funds so the Part A AA can submit a carryover waiver request to HRSA in December.

The Texas Department of State Health Services (DSHS) does not allow carryover requests for unspent Ryan White Part B and State Services funds.

It is also important to understand the following applicable rules when discussing funds:

- 1.) The Administrative Agencies are allowed to move 10% of unobligated funds from one service category to another. But, the 10% rule applies to the amount being moved from one category and the amount being moved into the other category. For example, 10% of an \$800,000 service category is \$80,000. But, if a \$500,000 category needs the money, the Administrative Agent is only allowed to move 10%, or \$50,000 into the needy category, leaving \$30,000 unobligated.
- 2.) Due to procurement rules, it is difficult to RFP funds after the mid-point of any given fiscal year.

In the final quarter of the applicable grant year, after implementing the Council-approved October reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, the AA may reallocate any remaining unspent funds as necessary to ensure the Houston EMA/HSDA has less than 5% unspent Formula funds and no unspent Supplemental funds. The AA for Part B and *State Services* funding may do the same to ensure no funds are returned to the Texas Department of State Health Services (TDSHS). The applicable AA must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting.

## Recommendations for Addressing Unobligated and Carryover Funds:

- 1.) Requests from Currently Funded Agencies Requesting an Increase in Funds in Service Categories where The Agency Currently Has a Contract: These requests come at designated times during the year. Usually, requests of this nature are addressed using unobligated funds.

A.) In response, the AA will provide funded agencies a standard form to document the request (see attached). The AA will state the amount currently allocated to the service category, state the amount being requested, and state if there are eligible entities in the service category. This form is known as a *Request for Service Category Increase*. The AA will also provide a Summary Sheet listing all requests that are eligible for an increase (e.g. agency is in good standing).

The AA must submit this information to the Office of Support in an appropriate time for document distribution for the April, July and October\* P&A Committee meetings. The form must be submitted for all requests regardless of the completeness of the request. The AA for Part B and State Services Funding will do the same, but the calendar for the Part B AA to submit the Requests for Service Category Increases to the Office of Support is based upon the current Letter of Agreement. The P&A Committee has the authority to recommend increasing the service category funding allocation, or not. If not, the request "dies" in committee.

- 2.) Requests for New Ideas: These requests can come from any individual or agency at any time of the year. Usually, they are also addressed using unobligated funds. The individual or agency submits the idea and supporting documentation to the Office of Support. The Office of Support will submit the form(s) as an agenda item at the next QA Committee meeting for informational purposes only, the Office of Support will inform the Committee of the number of incomplete or late requests submitted and the service categories referenced in these requests. The Office of Support will also notify the person submitting the New Idea form of the date and time of the first committee meeting where the request will be reviewed. All committees will follow the RWPC bylaws, policies, and procedures in responding to an "emergency" request.

Response to Requests: Although requests will be accepted at any time of the year, the Priority and Allocations Committee will Review requests at least three times a year (in April, July, and October). The AA will notify all Part A or B agencies when the P&A Committee is preparing to allocate funds.

- 3.) Committee Process: The Committee will prioritize recommended requests so that the AA can distribute funds according to this prioritized list up until May 31, August 31 and the end of the grant year. After these dates, all requests (recommended or not) become null and void and must be resubmitted to the AA or the Office of Support to be considered in the next funding cycle.

After reviewing requests and studying new trends and needs the committee will review the allocations for the next fiscal year and, after filling identified gaps in the current year, and if appropriate and possible, attempt to make any increase in funding less dramatic by using an incremental allocation in the current fiscal year.

- 4.) Projected Unspent Formula Funds: Annually in October, the Committee will allocate the projected, current year, unspent, Formula funds so that the Administrative Agent for Part A can report this to HRSA in December.

**K]`]Ua g, J]Wcf]U (County Judge's Office)**

**From:** Henley, Charles (PHES)  
**Sent:** Thursday, March 21, 2013 3:36 PM  
**To:** Williams, Victoria (County Judge's Office)  
**Cc:** Ricciardello, Thomas (PHES); Cerna, Vicki (PHES); Martin, Carin (PHES)  
**Subject:** FYI - FY 13 Budget passes Congress

FYI, for better or worse, the FY 13 federal budget has been passed by both the House and Senate. This will enable HRSA to finalize our FY 13 awards. There does not appear to any "fix" for the Sequester for HHS programs such as Ryan White, CDC, FQHCs, etc. so there will likely be a reduction in our FY 13 award compared to FY 12.

[http://www.cnn.com/2013/03/21/politics/congress-budget/index.html?hpt=po\\_c2](http://www.cnn.com/2013/03/21/politics/congress-budget/index.html?hpt=po_c2)

Just for benchmarking purposes, the table below shows examples of the potential impact in dollars of Sequester-related reductions in Houston's RW award ranging from 5% to 10%.

Potential Impact of Sequestration-related Budget Decreases on the FY 13 Ryan White Grant Award							
Base Award	FY 12	FY 2013					
		-5%	-6%	-7%	-8%	-9%	-10%
Part A	\$ 18,215,829	\$ 17,305,038	\$ 17,122,879	\$ 16,940,721	\$ 16,758,563	\$ 16,576,404	\$ 16,394,246
MAI	\$ 1,773,377	\$ 1,684,708	\$ 1,666,974	\$ 1,649,241	\$ 1,631,507	\$ 1,613,773	\$ 1,596,039
Total	\$ 19,989,206	\$ 18,989,746	\$ 18,789,854	\$ 18,589,962	\$ 18,390,070	\$ 18,190,177	\$ 17,990,285
Net Change		\$ (999,460)	\$ (1,199,352)	\$ (1,399,244)	\$ (1,599,136)	\$ (1,799,029)	\$ (1,998,921)

*Per earlier communication from HHS, all formula based grant programs should anticipate at least a 5% reduction based on Sequestration.*

Charles Henley  
 Manager, Ryan White Grant Administration  
 Harris County Public Health & Environmental Services (HCPHES)  
 2223 West Loop South, #417  
 Houston, TX 77027  
 (713) 439-6034 (voice); (713) 439-6338 (fax)  
[chenley@hcpbes.org](mailto:chenley@hcpbes.org)  
[www.hcpbes.org/rwga](http://www.hcpbes.org/rwga)

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**Houston Area HIV Services Ryan White Planning Council**

2223 West Loop South, Suite 240, Houston, Texas 77027

713 572-3724 telephone; 713 572-3740 fax

[www.rwpchouston.org](http://www.rwpchouston.org)

**Houston Ryan White Planning Council  
and External Committee Member  
Statement of Confidentiality**

I, the undersigned, am a member of the Houston Ryan White Planning Council.

I understand that in the course of my term on the Planning Council, I may learn certain facts about individuals in the application/nomination and membership selection process, during the public comment portion of a meeting or while in attendance at a Ryan White Planning Council committee or workgroup meeting, that are of a highly personal and confidential nature (i.e. information such as, but not limited to: HIV status, medical conditions, sexual orientation, or other personal matters).

I agree not to disclose any information of a personal and confidential nature to any person not affiliated with the Houston Ryan White Planning Council or any other persons not authorized to access such information, without specific written consent of the individual to whom such information pertains.

I further agree not to disclose any information of a personal and confidential nature after the termination of my relationship with the Houston Ryan White Planning Council.

I understand that discussion or decisions that occur during meetings associated with the activities of the Ryan White Planning Council may be documented in meeting minutes and if I disclose personal, confidential or private information about myself, (i.e. information such as, but not limited to: HIV status, medical conditions, sexual orientation, or other personal matters), that this information may become a part of public record in the form of meeting minutes.

I also understand that a violation of this confidentiality agreement will result in my immediate removal from the Ryan White Planning Council and may also result in civil monetary penalties, criminal penalties, or liability for monetary damages.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**OFFICE OF SUPPORT**  
**Staff Policies and Procedures**

Updated: February 2013



## **∞ HARRIS COUNTY ETHICS AND CONFIDENTIALITY ∞**

Per *Harris County Personnel Regulations*, effective October 1, 2010:

All Harris County employees shall maintain the highest standards of ethical behavior. Employees will exercise honesty and integrity, respect, confidentiality, and fairness in the execution of their official responsibilities. All public servants shall carry out the public's business in a manner that benefits the public interest and trust.

Employees shall protect the County's assets and its reputation through professional and personal conduct and avoid circumstances that create an appearance of impropriety.

Harris County is the custodian of many types of information, including information that is confidential and private. Individuals who have access to such information are expected to be familiar with and to comply with all applicable laws pertaining to access, use, protection and disclosure of all such information.

For additional information see the Harris County Code of Ethics (Attachment 8, page 132).

## **∞ COUNTY JUDGE'S OFFICE ETHICS CODE ∞**

Per a memo from County Judge Robert Eckels, dated May 22, 1995:

A member of the County Judge's staff (staff member) shall not accept any benefit of more than de minimis value from any person (including a corporation) who conducts business with the County or seeks to do business with the County. Benefit includes food, goods, services, money, lodging, transportation or any other thing of more than de minimus value. A staff member may, however, accept meals or entertainment or attend events for which a charge is made if approved in advance by the chief of staff (manager of the Office of Support) and if done in the company of the person providing the meals or entertainment or paying the charge for events.

The word "de minimus" as used in this paragraph means "little". Some items that may be of de minimus value would be baseball caps, coffee mugs, and inexpensive pens and pencils. Each person will be called upon to make his or her own determination of whether an item meets this standard. However, it is my expectation that when in doubt, you will err on the cautious side and will refuse any offers of items about which you are unsure.

For additional information see the Memo from County Judge Robert Eckels, dated May 22, 1995 (Attachment 11, page 202).

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*Assets/Inventory/Property Handling*

**1** A.1-1 Property Handling Guidelines, Harris County Accounting Procedures Manual ... 23

*Budgeting and Contracting*

**2** B.0 Budget Policy and Guidelines, Harris County Accounting Procedures Manual..... 29

**3** Letter - County Judge’s Office, dated September 15, 2000..... 34

**4** RWPC Policy 400.03 - Process for Approving the Council Support Budget..... 39

*Emergency Preparation*

**5** Email - M. Brudner, dated August 29, 2008 ..... 41

*Meeting Preparation and Record Keeping*

**6** Harris County Records Control Schedule..... 42

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**8** Harris County Code of Ethics ..... 132

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**10** O.1 Preparation of Time Record, Harris County Accounting Procedures Manual ..... 191

**11** Memo - County Judge Robert Eckels, dated May 22, 1995 ..... 202

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**12** RWPC Policy 900.01 - Petty Cash ..... 203

**13** Sample - Reimbursement Form ..... 205

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**15** T.1 Travel Policies, Guidelines and Procedures,  
         Harris County Accounting Procedures Manual ..... 207

## **INTRODUCTION**

The Ryan White Planning Council's Office of Support was created by the Planning Council during the 1997 funding year as a result of a major Council reorganization that was done with technical assistance from John Snow, Inc./HRSA. The first staff person was hired into the position of Manager in August of 1998. The primary responsibility of the Office of Support is to provide direct support to the Ryan White Planning Council toward the complete and legal fulfillment of all Part A Council responsibilities within the Ryan White CARE Act.

The Office of Support is a Harris County division under the jurisdiction of the County Judge's Office. Office of Support staff are Harris County Employees and are legally obligated to abide by the policies and procedures of Harris County and the County Judge's Office. Additionally, as an entity funded by the Ryan White HIV/AIDS Treatment Extension Act of 2009, the Office of Support is legally obligated to abide by the requirements of the Act and related interpretations of HRSA. Where there is ambiguity or question, the policies of the County shall prevail.

## **ACCOUNTING**

The designated Office of Support staff person will assist the Manager in completing and submitting County forms, inputting data and running reports in order to process and monitor all budget related items in accordance with Harris County Accounting Procedures.

### **Payroll & Time Records**

See Payroll & Time Records under PERSONNEL, page 18.

## **ASSETS/INVENTORY/PROPERTY HANDLING**

### **General**

The purpose of this policy is to describe general policies and guidelines regarding the handling of property assigned to the Office of Support for the Ryan White Planning Council. Inventory must be entered into the Harris County IFAS system and updated annually. The purpose of this policy is to establish when and what criteria is to be used to determine the items that are to be inventoried.

### **Areas of Responsibility**

The designated Office of Support staff person, under the supervision of the Manager, will manage Office of Support assets, such as furniture and equipment, in accordance with Harris County policy.

With permission from the Manager of the Office of Support, staff are to use the appropriate check-out form before removing property from the Office of Support. Annually, in January, the Office of Support will conduct an inventory to ensure that all items included on the Office's inventory listing are still in the Office's control. The designated employee, under the supervision of the Manager, will be responsible for conducting the annual inventory.

### **Process for Checking Out Property**

All staff are to do one of the following in order to check out property from the Office of Support:

- A. Email the Manager of the Office of Support to request permission to take equipment such as the laptop computer, chairs, tables or other items from the Office. The request must include a complete list of items to be checked out as well as the date the items will be taken from and the date they will be returned to the Office. Equipment cannot be taken without written permission.
- B. Document on the sign-out sheet in the equipment cabinet in the meeting room of Suite 240 that equipment is being taken and when it will be returned. Each item being removed from the Office of Support must be listed on the sign-out sheet.

### **Process for Conducting Inventory**

The designated employee will:

- A. Take the IFAS fixed-assets class and/or classes designed to update IFAS users to changes related to fixed-assets.
- B. Annually in January, conduct an inventory of property and equipment on hand and reconcile this to the County's inventory records.
- C. Notify the Manager of the Office of Support immediately if reconciliation is not possible so that discrepancies can be investigated and reconciled.
- D. Address all questions or request guidance related to fixed-assets to the Manager of the Office of Support who will contact the appropriate representative in the County Judge's office.

### **Attachments**

For additional information see:

- Harris County Accounting Procedures Manual Policy A1-1 dated 05/13/08, *Property Handling Guidelines* (Attachment 1, page 23)

## **BUDGETING AND CONTRACTING**

The Manager will manage the Council Support Budget in accordance with HRSA and Harris County regulations.

Part A Planning Councils may use Ryan White Program funds to support certain activities related to carrying out required functions. Reasonable and necessary activities include both tasks directly related to legislative functions and the following costs that support multiple functions:

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

Per instructions from the County Judge's Office (Attachment 3, page 34), the Manager will submit an annual proposed budget to the Ryan White Planning Council for their consideration and approval. Once an annual budget is approved, according to Ryan White Planning Council policy 400.03, *Process for Approving the Council Support Budget* (Attachment 4, page 39) and the County process, the Manager may work from that budget without further direction from the

Council. The Manager will update the budget on an ongoing basis and provide reports on expenditures and projections to the Council as requested.

The Manager may make expenditures and changes within the budget of up to \$5,000 if he/she determines that the expenditure is needed to continue/conduct Council responsibilities as long as he/she does not exceed the overall allocation. The Administrative Agent and the Council must be notified of changes within the Office of Support budget. Any needed/suggested expenditures in excess of \$5,000 that have not already been approved in the Council budget should be taken through the Council process for approval. Any necessity for expenditure in excess of \$5,000 without prior Council approval requires notification, justification and approval by the County Judge's Office and the Administrative Agent, in consultation with the Planning Council Chair before the expenditure can be made. In accordance with PHS grant policy, all requests for the purchase of equipment not pre-approved in the Council's annual budget developed prior to the grant year (e.g., computer hardware) should be submitted to the Administrative Agency for prior approval. This is consistent with the process followed by all Houston EMA Title I subcontractors and assures compliance with PHS grants policy concerning equipment purchases.

### **Attachments**

For additional information see:

- *Harris County Accounting Procedures Manual, Budget Policy and Guidelines.* (Attachment 2, page 29)

## **CONTRACTING**

### **Contracting for Services within the Office of Support Budget**

The Manager will contract necessary services in accordance with Harris County policy.

As appropriate, the Manager will seek and coordinate community and Council input for "How to Best Meet the Need" of any projects to be contracted and/or directed by Office of Support. However, neither Council members nor community members may be utilized in the creation of a scope of services for a project that will later be contracted.

For RFP'd projects requiring an external review committee, the Manager will oversee the selection of the committee to ensure that Council requirements for "How to Best Meet the Need" are appropriately evaluated. Neither Council Members nor Planning Council External Members may be used as External Reviewers.

The Manager, in accordance with the appropriate County departments, will be responsible for contract negotiations for and monitoring of any projects under the Office of Support. Council members may not be utilized for either of these activities.

## **COMPUTER**

### **General**

The purpose of this policy is to describe procedures for storing documents in the Office of Support computer network and for distributing information via email verses the postal service.

### **Storing Documents in the Office of Support Computer Network**

All documents must be stored on the shared J drive, even those documents that are “in progress”. The purpose of the J drive is to make certain that other staff members can access Council work products even if the author is unavailable. Exceptions to this are documents that contain: personnel information, the health status of an employee or volunteer and other sensitive information that require limited access to all employees. Other exceptions are reports stored within software that is job specific, such as planning documents prepared with SPSS software accessible only to the Health Planner.

### **Naming Files**

Most work produced by the Office of Support is generated from the standing committees of the Ryan White Planning Council. Therefore, whenever possible, store a document within the committee file.

New folders may not be added to the J drive without approval from the Manager.

Documents must contain the file name in the footer. An exception to this is occasional correspondence.

All documents are to be dated either the day the document was created or the day the activity is going to happen (an agenda for a meeting should be dated the day of the meeting). The date in the file name must be updated if the document is updated.

Tip: If a committee makes changes to a document and those changes are made, date the document the day after the committee meeting so you will know that changes approved by the committee have been incorporated into the document.

Documents must be labeled as follows:

Drive	Committee	Type of Document	Unique Qualifier	Date Created OR Date of Activity
J:\	Quality Assurance	Agenda		08-13-03
		Chart		09-07-03
		Fax	Williams	
		Flyer	HTBMN	
		Letter	Williams	
		List	Avail Vol	
		Map	HSDA	
		Memo	Williams	
		Minutes		
		Proposal	Navigator Prog	
		Timeline	HTBMN Tasks	

**Email Verses Mailout System for Council, Council Committees and Work Groups**

Email the Assistant Coordinator any changes to a mailing/distribution list (copy the Council Coordinator if it is an email change) – do not make the change yourself. Give the Assistant Coordinator complete new information such as the recipient’s name, address, phone number, zip code and email address.

When setting up a new committee or workgroup:

The Assistant Coordinator will create a database and print mailing labels for all members. The mailing label list will be stored in the back of the committee/workgroup folder. The Council Coordinator will star the names of members who prefer to receive information via email.

The Assistant Coordinator will use the label list for all mailouts. She will not send a meeting packet to anyone with a star by their name on the mailing list.

**CONFIDENTIALITY**

All Office of Support staff members will sign the Office of Support Statement of Confidentiality statement provided to them during their new employee orientation. Questions regarding the Statement or confidentiality issues are to be referred to the Manager.

## **DOCUMENT STORAGE**

### **General**

The purpose of this policy is to describe procedures for storing the following types of records:

- Financial
- Human Resources and Payroll
- Project LEAP
- Volunteer

### **Financial Documents**

The designated Office of Support staff person, under the supervision of the Manager, will manage financial documents maintained by the Office of Support, such as petty cash reimbursement requests, receipts and more, in accordance with Harris County policy. See Office of Support Petty Cash Policy for additional information.

### **Human Resources and Payroll Documents**

The designated Office of Support staff person, under the supervision of the Manager, will store records which are maintained by the Office of Support such as personnel files, volunteer files, records related to issuance of keys, identification cards and more, in accordance with Harris County policy. Specifically:

- All personnel records, including those related to drug testing, employee security records, payroll documents and more will be stored in a secure location. Access to the secure location is to be limited to the Manager and the Payroll Clerk. Reports related to drug testing will be stored in a sealed envelope that is attached to the individual's employee file.

### **Project LEAP**

All Project LEAP student application forms and membership records are to be stored in a secure location. Access to the secure location is to be limited to the Manager and one additional, designated employee. Once applicants have been notified of their admission into the Project LEAP Program, all interview notes and working papers are to be shredded. Project LEAP application forms and membership records are not subject to the *Harris County Records Control Schedule* (Attachment 6, page 42) and are to remain in a secure location where they can be maintained by the Office of Support.

### **Volunteer**

All volunteer application forms and membership records are to be stored in a secure location. Access to the secure location is to be limited to the Manager and one additional, designated employee. A document that is identified as confidential and not part of the public record because it contains requested personal health information, is to be stored separately within the volunteer file and marked as "Confidential". Once application forms and Committee recommendations have been prepared for transfer to the County Judge's Office, all interview notes and working papers are to be shredded. Volunteer applications and membership records are not subject to the

*Harris County Records Control Schedule* (Attachment 6, page 42) and are to remain in a secure location where they can be maintained by the Office of Support.

## **EMERGENCY PREPARATION**

When a Hurricane watch or other emergency situation is announced for Harris County, Office of Support Staff should prepare for the impending occurrence. A Hurricane Watch for the area is usually issued when a Condition 3 has developed. A Condition 3 means a situation is developing that could be a threat to Harris County in approximately 32-48 hours.

The Manager is to review the emergency plan with employees on an annual basis.

Per the email from M. Brudner dated August 29, 2008 (Attachment 5, page 41), secure all cash, checkbook(s) and active reimbursement request forms and receipt books in the Office of Support safe that is normally used to secure petty cash.

The Assistant Coordinator is to distribute up to date staff contact information to the Liaison for the County Judge, Manager and all Office of Support staff members.

Important papers, records and similar work related materials are to be stored in a secure place away from windows. The Office of Support has large, gray plastic bins for each employee for this purpose.

All important, active documents are to be copied onto a CD or flash drive, labeled and given to the Manager or Assistant Coordinator for storage in the safe normally used to secure petty cash.

Disconnect all computers and portable electric equipment and move such equipment to a secure place away from windows or flood prone areas. Cover with plastic sheeting if necessary.

Clear off desk and tabletops and cover with plastic sheeting any equipment that cannot be moved from rooms with windows. Close all room doors when office is closed before the storm.

Monitor radio for weather information and county bulletins.

### **Attachments**

For additional information see:

- [www.hcoem.org](http://www.hcoem.org)

## **MEAL POLICY**

### **General**

Consistent with a primary focus of the Ryan White Program, the RWPC Office of Support may provide meals in specific instances with Manager approval to support consumer participation, including but not limited to:

- Ryan White Planning Council/Committee/Workgroup meetings and Planning Council-sponsored meetings (e.g. Needs Assessment focus groups, Town Hall style community input events) wherein Planning Council members are representing the Council;
- Project LEAP training classes, the purpose of which is to develop skills consumers who may participate in Planning Council meetings will utilize to contribute to Ryan White program goals and objectives;
- Healthy snacks and beverages will be available at all authorized meetings to support consumers who are prescribed medications that are recommended to be taken with food.

### **Restrictions**

Under no circumstances may Ryan White funds be used to provide meals to RWPC Office of Support employees (however, grantee employees may purchase meals with their own funds so long as such transactions are separate from the purchase of meals to support consumer participation as described in this policy).

In order to promote participation and ensure consumer confidentiality, participants in events where meals are provided under the guidelines described in this policy shall not be forced to document their status. RWPC Office of Support staff shall provide reasonable guidance to participants to clarify the provision of meals purchased with Ryan White funds are intended to support consumer participation.

### **Definitions**

Consumer: Individuals who are infected with, or affected by HIV/AIDS, including Persons Living with HIV/AIDS, family members, caregivers, patient advocates and others)

Staff: Employees of the RWPC Office of Support

### **Attachments**

For additional information see:

- <http://dhhs.gov/asfr/ogapa/grantinformation/hhsgps107.pdf>

## MEETING PREPARATION AND RECORD KEEPING

### General

All Ryan White Planning Council, Committee and Workgroup meetings are open to the public, with the exception of hearings conducted by the Grievance sub-committee of the Operations Committee, “personnel issues”, and any other exception allowable under the Open Meetings Act (see Ryan White Council Policy 200.03, Meetings, Attachment 7, page 130). All rules and regulations outlined in the Texas Open Meetings Act are to be adhered to.

Council work products are to be labeled “DRAFT” and dated until they have been approved by the Planning Council. Approved documents are to be dated.

Meeting packets are to be distributed a minimum of 6 days in advance of the date of the meeting.

Council and Standing Committee meeting agendas are to:

- Include the time, date and location of the meeting
- Be signed by the Manager of the Office of Support
- Be filed with the Office of the Harris County Clerk at least 72 hours in advance of the meeting

Emails documenting receipt of the agendas by the County Clerk are to be printed, stapled to the agenda and kept on file in the Office of Support.

Council meeting agendas that have been signed by the Manager of the Office of Support are to be displayed in the Office of Support.

All meetings are to be audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and minutes are public record and are to be stored in the shared J drive of the Office of Support computer network. The length of time they are to be stored is determined by the *Harris County Records Control Schedule* (Attachment 6, page 42).

The staff person assigned to take minutes at the meeting is responsible for filing the following items in the official Council and Committee record books:

- Meeting packet
- Signed minutes
- Meeting handouts

The length of time these documents are to be stored is determined by the *Harris County Records Control Schedule*(Attachment 6, page 42).

## **Attachments**

For additional information see:

- Texas Open Meetings Act: [www.oag.state.tx.us/open/og\\_training.shtml](http://www.oag.state.tx.us/open/og_training.shtml)

## **PHOTOGRAPHS AND VIDEO TAPES OF VOLUNTEERS**

Photographs and/or video tapes of Ryan White Planning Council volunteers (including external committee and workgroup members) can be displayed in the Council office and included in Council related displays and presentations only if there is a signed consent form on file from the volunteer allowing the use of their photograph or video tape for Ryan White Planning Council's literature, displays and/or publications.

## **PERSONNEL**

Members of the Office of Support staff are to follow *Harris County Personnel Regulations* (Attachment 9, page 136).

County employees have no employment tenure. Employment is at-will for an indefinite period and the County or District and the employee are free to terminate employment with or without notice at any time for any reason.

It is important to note that Office of Support employee positions are funded using grant funds from the Ryan White Program. The Ryan White Program is funded by the federal government on an annual basis and governed by legislation that is currently scheduled to end on February 28, 2014.

## **Harris County Ethics and Confidentiality**

Per *Harris County Personnel Regulations*, effective October 1, 2010 (Attachment 9, page 136):

- All Harris County employees shall maintain the highest standards of ethical behavior. Employees will exercise honesty and integrity, respect, confidentiality, and fairness in the execution of their official responsibilities. All public servants shall carry out the public's business in a manner that benefits the public interest and trust.
- Employees shall protect the County's assets and its reputation through professional and personal conduct and avoid circumstances that create an appearance of impropriety.
- Harris County is the custodian of many types of information, including information that is confidential and private. Individuals who have access to such information are expected to be familiar with and to comply with all applicable laws pertaining to access, use,

protection and disclosure of all such information.

### **County Judge's Office Ethics Code**

Per a memo from County Judge Robert Eckels, dated May 22, 1995 (Attachment 11, page 202):

- A member of the County Judge's staff (staff member) shall not accept any benefit of more than de minimis value from any person (including a corporation) who conducts business with the County or seeks to do business with the County. Benefit includes food, goods, services, money, lodging, transportation or any other thing of more than de minimus value. A staff member may, however, accept meals or entertainment or attend events for which a charge is made if approved in advance by the chief of staff (manager of the Office of Support) and if done in the company of the person providing the meals or entertainment or paying the charge for events.
- The word "de minimus" as used in this paragraph means "little". Some items that may be of de minimus value would be baseball caps, coffee mugs, and inexpensive pens and pencils. Each person will be called upon to make his or her own determination of whether an item meets this standard. However, it is my expectation that when in doubt, you will err on the cautious side and will refuse any offers of items about which you are unsure.

Employees should contact their supervisor with questions pertaining to ethics and/or confidentiality.

### **Hiring**

Hiring of County Employees within the Office of Support will be conducted in accordance with Harris County policy.

The County entity responsible for the hiring of staff within the Office of Support is the County Judge's Office. Hiring of the Manager's position will be done utilizing input from the Planning Council's personnel committee.

The Manager is responsible for hiring the other positions within the Office of Support in consultation with the personnel committee. However, the final decision to offer a position to a potential applicant is the sole responsibility of the Manager of the Office of Support.

### **Termination**

Termination of County Employees within the Office of Support will be conducted in accordance with Harris County policy.

The County entity responsible for overseeing the termination of staff within the Office of Support is the County Judge's Office. Termination of the Manager's position will be done by

the County Judge's Office, with notification to the Planning Council's personnel committee.

The Manager is responsible for the termination of the other positions within the Office of Support and for notifying the Planning Council's personnel committee in the event this occurs.

### **Employee Schedules**

The Manager is responsible for scheduling employee time and prioritizing work products to ensure that official Council meetings and projects are adequately staffed and/or completed. However, the Manager is also responsible for ensuring that staffing requirements do not conflict with Employment Law or County Policy. In the event that the Office of Support is not able to meet a staffing request made by the Council, the Manager will notify the Council with the reason that the request will not be or was not fulfilled. In this event, it is suggested that the Manager provide the Council and/or committee with recommendations for overcoming any ongoing staffing problem.

The Council may and will assign work products to the Office of Support. The Manager will determine how and what staff and/or consultants will be utilized to accomplish Council assigned tasks.

### **Requests for Staff Time**

Any request for use of staff time by Council members or other County employees that is not already identified as falling within that staff member's responsibility should be forwarded to the Manager for determination of appropriateness and/or priority.

- An employee asks the Manager for permission to take time off or change their normal work schedule.
- The Manager reviews the request and decides if time off can be granted.
- The employee contacts other staff members to see if they can provide coverage for the dates/time off that has been approved.
- The employee sends the Manager and other staff members the list of dates/times that have been approved and the staff person who will be covering for the employee.

### **Employee Evaluations**

The personnel committee will conduct an annual evaluation of the Manager in December based on the outlined "Responsibilities of the RWPC's Manager". This evaluation will be submitted to the County Judge's Office and may be used in any performance evaluations, pay evaluation, advancement, and/or termination proceedings. However, the Council's Personnel Committee may at any time initiate an evaluation process or request that performance counseling be done.

The Manager will conduct, at least, an annual written performance evaluation during the month

of December on every employee who is working for the Office of Support as of the evaluation date. The Manager may conduct additional performance evaluation and counseling as he/she deems necessary. The employee evaluations may be used in any pay evaluation, advancement and/or termination proceedings.

All official employee evaluations are public information and may be requested for viewing by anyone according to the County's public information policy.

### **Employee Pay Scale, including Raises**

The initial pay scale for each employee position within in the Office of Support will be (recommended) by the Ryan White Planning Council. Subsequent pay raises, including Cost of Living Adjustments (COLA) and merit raises will be increased according to County policy.

COLA raises may result in a pay scale that is above the original, Council approved amount. The Manager may not give merit raises in excess of the Council approved pay scale. The Manager may seek to change the pay scale of any/all staff positions through the normal Council process.

The Manager will notify the Planning Council of any changes to staff salaries.

### **Payroll & Time Records**

The employees of the Office of Support will sign in and out of the office using the in-house sign in sheets. At the appropriate time of the month, employees with submit time records in accordance with Harris County regulations – see *Harris County Accounting Procedures Manual, Preparation of Time Record* (Attachment 10, page 191). In-house sign in sheets and time records are to be kept on file in the Office of Support for a period of time that is dictated by the *Harris County Records Control Schedule* (Attachment 6, page 42).

### **Attachments**

For additional information see:

- Harris County Code of Ethics (Attachment 8, page 132)

## **PETTY CASH**

### **General**

Harris County has authorized the Office of Support for the Ryan White Planning Council to have a Petty Cash fund in the amount of \$3,000 for the purpose of reimbursing Council and external committee members for expenses related to participating in Ryan White Planning Council meetings, including committee and workgroup meetings; reimbursing staff for small (under \$100), pre-approved, out-of-pocket, job related expenses; and purchasing items that are miscellaneous in nature and under \$100. Examples of such items are the cost of postage for

certified mail and office supplies that are not available through the County vendor. This policy establishes the guidelines by which these funds are to be distributed. See Ryan White Planning Council Policy No. 900.01, *Petty Cash* (Attachment 12, page 203) for allowable reimbursements to Planning Council and external committee members.

### **Non-Allowable Expenses**

The following items will not be reimbursed from Petty Cash:

- Any items over \$100.
- Parking, toll, or other auto or travel related expenses. Please use the appropriate Harris County travel form for this.

### **Areas of Responsibility**

The Manager of the Office of Support is responsible for:

- 1.) Cashing the Harris County check for replenishing the Petty Cash fund;
- 2.) Reconciling individual reimbursement requests with cash on hand; and
- 3.) Approving petty cash reimbursement and reconciliation requests to the County Auditor's Office.

The Custodian of the Petty Cash fund is responsible for:

- 1.) Maintaining the cash in a locked and secure place;
- 2.) Reviewing reimbursement requests;
- 3.) Distributing funds and logging in receipts; and
- 4.) Obtaining the proper receipts for documenting the expense.

### **Process for Reimbursement**

Receipts can be submitted at anytime within 45 days of the date of the event. Any request over this time frame must be submitted as a special request for approval from the Manager of the Office of Support. Receipts submitted 30 days after the end of the Part A grant fiscal year will not be reimbursed. Requests for petty cash reimbursements will not be considered unless submitted on a completed "Petty Cash Request" form and accompanied by receipts.

The Custodian of the Petty Cash funds will:

- 1.) Review the reimbursement request forms and required receipt(s) (see Attachments 13 and 14, page 205-206). The form will be returned to the person making the request if it is not complete or out of compliance with Council and/or Office of Support policies.
- 2.) Distribute the appropriate amount of petty cash funds only if the request form and required receipt(s) are complete and in order.

- 3.) Have the recipient sign the Office receipt book for the amount received.
- 4.) Write the receipt number on the upper right hand corner of the reimbursement form.
- 5.) File the receipt forms.
- 6.) At least once a month, submit the receipt forms to the Manager of the Office of Support for reconciliation and submission to the County Auditor's Office for reimbursement.

### **Cash Advances**

Harris County Policy does not allow cash advances.

Failure to adhere to these policies may result in the employee becoming personally responsible for the expense.

## **REQUESTS FOR INFORMATION**

All requests for information under the Open Records Act will be submitted to the County Attorney for opinion prior to the release of information requested. The Office of Support will attempt to make all public information available upon request according to Harris County policy. Information that is required to be confidential will not be released from the Office.

Staff members must seek direction from the Manager before releasing any information that has not already been approved for public release and distribution.

### **Line of Communication**

The Manager is not the official spokesperson of the Ryan White Planning Council. However, the Manager may represent the Council on its behalf as requested and/or directed.

When a request is made of the Manager that may require interaction with the County, the Manager, as the designated County interface with the Planning Council, will determine the appropriate line of communication within the County structure.

Only the Manager may speak officially on behalf of the Office of Support, unless he/she has directed another staff person to do so.

### **Data Collection and Evaluation**

The Office of Support will assure that all client specific data is maintained in accordance with applicable State and Federal laws, rules and regulations concerning confidentiality and access to records. Procedures for protecting the confidentiality of individuals who participate in evaluation and assessment activities conducted by or directed under the auspices of the Office of

Support, will be outlined and approved by the Manager prior to the project being implemented.

## **STUDENT INTERNS**

During orientation on their first day with the Office of Support, all student interns will sign the following Office of Support forms:

- Student Intern Contact Form
- Confidentiality Statement
- Release and Indemnification Agreement

A separate file for each student intern will be created and filed along with other secured personnel records.

## **TRAVEL**

### **General**

Travel will be conducted in accordance with Harris County policy.

### **Attachments**

For more information see:

- Harris County Accounting Procedures Manual, *Travel Policies, Guidelines and Procedures* (Attachment 15, page 207)

**Houston EMA  
Manager's Report  
04-04-13**

**Updates from the Manager of the Office of Support**

- Staff spent most of March preparing for the FY 2014 How To Best Meet the Need process. On March 26<sup>th</sup>, the Manager provided training to the members of the Affected Community Committee on the How to Best Meet the Need Process. See the attached agenda for the April 11<sup>th</sup> training on the documents to be used in the Process. If you have not signed up to participate in the April 11<sup>th</sup> training or one of the workgroups, please see Tori or Georgette.
- Staff continue to interview Project LEAP applicants. Currently, 30 individuals have applied to participate in the program which starts on May 1, 2013. As you know, Project LEAP is a comprehensive advocacy training program for HIV-positive individuals in the Greater Houston Area. The goal is to train people living with HIV/AIDS so that they become active participants in local HIV/AIDS planning activities by serving on a planning body, such as the Ryan White Planning Council or the Community Planning Group (CPG).
- Staff continue to participate in webinars that outline details related to Navigation Programs as defined by the Affordable Care Act.

**Council Updates**

- In response to a request from the Austin Planning Council, Greg Monk, Chair of the Houston Planning Council, has agreed to mentor the Chair of the Austin Planning Council.
- Participants at a joint meeting of the Quality Assurance, Priority and Allocations and Affected Community Committees approved the attached criteria which will be used to select the FY 2014 services supported with Ryan White Part A, Part B and *State Services* dollars.
- The Council is currently allocating funds to 16 of the 28 allowable HRSA service categories. A New Idea Form is used to ask the Council to reconsider including a service that is no longer being funded with Ryan White funds. The Quality Assurance Committee received a New Idea Form describing how Ryan White can be used to initiate and support a Navigator Program in the Houston Area. As defined by the Affordable Care Act, Navigator Programs provide community-based, in-person assistance to people who wish to enroll in Medicaid, CHIP, and private health insurance through the Health Insurance Marketplace. After comparing the idea that was presented against their criteria for accepting new ideas, the Committee has forwarded the idea to a How To Best Meet the Need workgroup for more in depth discussion and consideration.
- The Priority and Allocations Committee approved the following documents:
  - FY 2014 Principles & Criteria
  - FY 2014 Priority Setting Process
  - 2013 Policy on Allocating Unspent Funds
- The Needs Assessment Group (NAG) is made up of representatives from partner organizations, consumers and others who are working collaboratively with the Council to create the 2014 Houston Area HIV/AIDS Needs Assessment. On April 2, 2013, the NAG approved the survey sampling frame and the client survey form for the assessment. On April 10, 2013, the Comprehensive HIV Planning Committee will review these work products and forward them to the Steering Committee and Council for their approval in May.

**Budgets & Contracts**

- At this time, the Office of Support is unable to report year-to-date expenditures because the budget is still being loaded into the County's computerized accounting system.

# **Houston Area HIV Services Ryan White Planning Council**

Training for the Quality Assurance, Priority and Allocations, and  
Affected Community Committees and the  
"How to Best Meet the Need" Workgroups

**1:30 – 4:00 p.m., Thursday, April 11, 2013**  
**2223 W. Loop South, Room 416, Houston, Texas 77027**

## **AGENDA**

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- I. Welcoming Remarks and Purpose of the Meeting (2 min.)      Greg Monk, Chair  
Ryan White Planning Council
  
- II. "How To Best Meet the Need" Meeting Packets (1 min.)  
and Meeting Information      Tori Williams, Office of Support, RWPC
  
- III. Process for Selecting FY 2014 Service Categories (2 min.)      Cecilia Ross and Michael Bass, Co-Chairs  
Quality Assurance Committee
  
- IV. Tools Used in the FY 2014 Decision-Making Process (35 min.)      Jen Hadayia, Office of Support, RWPC
  - A. 2013 Joint Epidemiological Profile
  - B. 2011 Needs Assessment
  - C. 2012 Comprehensive HIV Prevention and Care Services Plan
  - D. Unmet Need
  - E. Early Identification of Individuals with HIV/AIDS (EIIHA)
  - F. Special Studies
  - G. National and Statewide HIV Plans
  - H. Exercise--Case Study
  - I. FY2014 Service Category Information Summaries
  
- V. Part A Data (20 minutes)      Charles Henley and Staff  
Ryan White Grant Administration, HCPHS\*
  - A. Allocations: General & MAI \*Funds
  - B. Expenditures: General & MAI Funds
  - C. Service Utilization
  - D. Outcome Measures
  
- VI. Part B and State Services Funds & Data (10 min.)      Yolanda Jones, The Resource Group

## **B R E A K**

- VII. Alternative Resources (30 min.)
  - A. SPNS: Medical Home for HIV+ Homeless People      Nancy Miertschin, Harris Health Systems
  - B. Ryan White Part C at Harris Health Systems
  - C. Ryan White Part D at Harris Health Systems
  - D. Ryan White Part D through The Resource Group      Yolanda Jones, The Resource Group
  - E. Prevention: Core Prevention, ECHPP & Merck Grant      Rep., Houston Dept. Health & Human Services
  - F. DSHS: non-RW funding in the Houston Area      Paul E. Grunenwald, Tx. Dept. of State Health Serv
  - G. HOPWA      Melody Barr, Houston Dept. of Housing &  
Community Develop.

VIII. Navigator Programs

- A. Ryan White Guidance (10 min.)
- B. Overview (10 min.)
  - a) Navigators in the Affordable Care Act
  - b) Local response to federal RFP
- C. Existing Local Programs (25 min.)
  - a) Gateway to Care's Navigator Program
  - b) Community Health Workers Program
  - c) 1115 waiver-funded Navigator initiatives
  - d) SOAR Program
  - e) RW Part D funded Navigator Program

Charles Henley  
Ron Cookston, Gateway to Care

Joe Fuentes or Caroline Pickens, HACS  
Yolanda Jones

IX. Appreciations and Closure (5 min.)

Greg Monk

**ADJOURN**

**How To Best Meet the Need Workgroup Chair Meeting**

Tori Williams

\* Abbreviations used in this document:

- MAI – Minority AIDS Initiative
- HCPHS – Harris County Public Health Services
- SS- State Services funding
- HOPWA – Housing Opportunities for People with AIDS

Harris County

# HCPHES

Public Health & Environmental Services

Herminia Palacio, M.D., M.P.H.  
Executive Director  
2223 West Loop South  
Houston, Texas 77027  
Tele: (713) 439-6000  
Fax: (713) 439-6080

Les Becker M.B.A.  
Chief Operating and  
Financial Officer  
Operations and Finance  
2223 West Loop South  
Houston, Texas 77027  
Tele: (713) 439-6000  
Fax: (713) 439-6080

## Houston EMA Ryan White Part A and MAI Administrative Agency Report

April 4, 2013

- **RWGA has reallocated funds per the Council's approved policy authorizing the Grantee to shift funds during the final quarter of the grant year in order to ensure the Houston EMA does not exceed 5% of its Formula award in total unspent funds.** The table below compares FY 12 final quarter reallocations made to date to those made in FY 10 and FY 11. The FY 12 totals may continue to change before being finalized in late April. The next FY 12 RW/A and MAI procurement report is slated for publication on April 10<sup>th</sup>.

Grant Year → ↓ Service Category	FY 2010 <i>final quarter reallocations</i>	FY 2011 <i>final quarter reallocations</i>	FY 2012 <i>final quarter reallocations</i>
Primary Medical Care	834,334	177,496	313,555
LPAP	-644,938	-84,304	-329,609
Medical Case Management	-91,384	-166,926	-29,531
Medical Nutritional Therapy	13,684	0	0
Non-Medical Case Management	-98,012	73,734	45,585
Grant Administration/ RWGA	-11,991	0	0

- **FY 2013 Award Update and Contract Status. No change since previous update.** As previously discussed, the Houston EMA received a partial grant award for FY 13. RWGA issued FY 13 contracts accordingly, with some contracts being written for less than 12 months of funding (assuming a level funding scenario). For example, adult primary medical care contracts began the year with three (3) months of funding under Part A and four (4) months of funding under MAI (if applicable). The contracts for *Service Linkage at Testing Sites* and *Medical Nutritional Therapy* were issued with six (6) months funding. The remaining contracts, issued for the level funding scenario amount, are subject to amendment if the final FY 13 grant award is significantly less than the level funding scenario. The impact on Part A awards because of Sequestration is not yet known, however grantees may receive between 5% – 10% less than would have otherwise been the case.

[www.hcphes.org](http://www.hcphes.org)

Charles Henley, Manager

HCPHES/Ryan White Grant Administration Section  
2223 West Loop South, #417, Houston, TX 77027  
(713) 439-6034 (voice) [chenley@hcphes.org](mailto:chenley@hcphes.org) (email)

THE HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
PART B/SS ADMINISTRATIVE AGENCY  
PART C AND D GRANTEE  
RYAN WHITE PLANNING COUNCIL MONTHLY REPORT  
APRIL 2013



DSHS FUNDING (RYAN WHITE PART B AND DSHS STATE SERVICES)

- Sha'Terra Johnson-Fairley started on April 1<sup>st</sup> as the new TRG Planner.

HRSA FUNDING

RURAL PRIMARY CARE NETWORK OF EAST TEXAS (RURAL PART C)

- The Rural Primary Care Network of East Texas is awaiting the final determination of the impact of sequestration on its funding.
- The RPCN is transitioning to a new project officer in the coming months. The transition did not occur in March as anticipated.

1 CARES 4 ANOTHER/POSITIVE VIBE PROJECT (PART D PROJECT)

- The 1 CARES 4 Another and Positive VIBE Project is awaiting the final determination of the impact of sequestration on its funding.
- The 1C4A and PV Project is transitioning to a new project officer in the coming months. The transition did not occur in March as anticipated.
- The Part D Non-Competing Continuation is due on April 8<sup>th</sup>.
- Jen Hadayia presented the transgender survey results at the Part D Psycho(social) meeting on March 5<sup>th</sup>.
- Jen Hadayia presented the Needs Assessment survey at the Part D Partners meeting on March 19<sup>th</sup>.

SIRR Partnership of Greater Houston

- The March meeting included a presentation by Charles Henley on the impact of ACA on the RW Program and a presentation by Jen Hadayia of the preliminary results of the consumer portion of the SIRR survey. Recommendations were made by SIRR to address several issues that were identified. A draft memo will be issued in the coming weeks.
- The April meeting will be focused on establishing the 2013 goals of SIRR.

CONTACT INFORMATION

PATRICK L. MARTIN  
[plmartin@hivresourcegroup.org](mailto:plmartin@hivresourcegroup.org)

YVETTE GARVIN  
[ygarvin@hivresourcegroup.org](mailto:ygarvin@hivresourcegroup.org)

SHA'TERRA JOHNSON-FAIRLEY  
[sfairley@hivresourcegroup.org](mailto:sfairley@hivresourcegroup.org)

March 7, 2013

TO: HIV/AIDS Community Partners

FR: Co-Chairs of the Federal AIDS Policy Partnership, Ryan White Work Group  
Ann Lefert, National Alliance of State and Territorial AIDS Directors  
Bill McColl, AIDS United

RE: Update on Future of the Ryan White Program

As Co-Chairs of the Ryan White Work Group we wanted to provide you with a critical update on the current thinking of national policy advocates and community representatives who have participated in several face to face meetings regarding reauthorization of the Ryan White Program. As you know, the current authorization ends on September 30, 2013. However, since there is no sunset provision in the legislation, even if Congress does not take action, the Ryan White Program will continue and funding can continue to be appropriated through the annual congressional appropriations process.

We are aware that reauthorization of the Ryan White Program has been seen as a consistent hallmark of our national HIV advocacy process and a way for Congress to convey its sustained support for federal support for HIV/AIDS care and services. With that in mind, it is important to note that similar federal programs, including the Housing Opportunities for People With AIDS (HOPWA) at the Department of Housing and Urban Development (HUD), was established in 1992 and is considered by the Office of Management and Budget to be one of the most cost effective programs in the budget, but it has never been reauthorized. HOPWA funding has always received strong bi-partisan congressional support. We have every reason to believe that the Ryan White Program will also continue to receive strong bipartisan support.

The protracted budget and appropriations cycle of the 113th Congress would make legislative action on the Ryan White Program in 2013 logistically challenging. However, there are also strong policy reasons to delay reauthorization. The top reasons are:

- \* Members of the authorizing committees want to better understand how the Ryan White Program will complement the Affordable Care Act after it is implemented in both states that expand Medicaid and states that do not expand.
- \* There is a need to educate new members of Congress to make sure that reauthorization continues forward as a bipartisan program as it has in the past (There are at least 108 new House Members since the last reauthorization).
- \* There are Congressional and Administration concerns that there is not enough time on the legislative calendar to accomplish a reauthorization in 2013.

We also believe that the Obama Administration is likely to hold off on seeking legislative action on the Ryan White Program until there is a strong understanding and agreement among the Administration, Congress and the community on how to move forward. To be clear, both the Obama Administration and most Members of Congress continue to strongly support the Ryan White Program and we have every indication that they will try to fund the Program at its current

levels (or as close to those levels as possible under the current sequestration and appropriation challenges). However, your strong advocacy is needed to make sure funding is not reduced. The Ryan White Work Group is working closely with the Administration, Congress and community advocates to ensure that the Ryan White Program continues and that the comprehensive services provided to clients today continue to be available as some Ryan White Program clients transition to other sources of coverage offered through the Affordable Care Act. Additionally, the Ryan White Program must be used to dramatically improve both treatment and potential prevention outcomes in communities where people living with HIV/AIDS are not receiving the health benefits of being in care, on treatment and virally suppressed. A valued quality of the Ryan White Program is its responsiveness to the unique needs of individual jurisdictions. This flexibility is essential as communities use the Ryan White Program in conjunction with other resources to increase access to the expanding number of people diagnosed with HIV in need of treatment, care and supportive services.

The Ryan White Work Group has met several times in person to share intelligence, discuss the future of the Program, and plan for how our work group will educate Members of Congress and others about the unique and essential role of the Ryan White Program and provide the HIV/AIDS advocacy community's perspective on how it will integrate with the Affordable Care Act. To that end we have created three subcommittees that are doing this hard work. They are:

- \* Vision and framing
- \* Operationalizing the vision: breaks down into short, medium and long
- \* Strategy, questions (for HRSA) and technical fixes

These committees will be meeting and reporting back to the larger group. They will also develop factsheets and a set of Frequently Asked Questions (FAQs) to help educate Member of Congress about the ongoing need for the Ryan White Program's essential services after the Affordable Care Act is implemented. In order to accomplish this work, we are in close cooperation with the Federal AIDS Policy Partnership AIDS Budget and Appropriations Coalition (ABAC) as they do their work.

If you are interested in joining the Ryan White Work Group or any of the subcommittees please contact Ann Lefert ([alefert@nastad.org](mailto:alefert@nastad.org)) or Bill McColl ([wmccoll@aidsunited.org](mailto:wmccoll@aidsunited.org)).

**Ann Lefert**

**Director, Policy and Health Care Access**

National Alliance of State & Territorial AIDS Directors (NASTAD)

444 North Capitol Street NW, Suite 339

Washington, DC 20001

Phone: (202) 434.7138 Fax: (202) 434.8092

[alefert@NASTAD.org](mailto:alefert@NASTAD.org) [www.NASTAD.org](http://www.NASTAD.org)



## The Denver Principles - 1983 and today

*In 1983, an AIDS diagnosis was a death sentence. The delegates to the 1983 Second National AIDS Forum in Denver who wrote the Denver Principles had all had their diagnoses, and they wrote from the point of view of men and women determined to die well and until then to do everything they could to bring change.*

*Today, HIV/AIDS is a manageable chronic disease – for most, not all. We get to focus more on the living well. We are no longer (most of us) People with AIDS, we are People with HIV.*

*But the main points of the Denver Principles are still valid. We will not be labeled as "victims;" we are capable, self-empowered people living with a virus. We demand a place at the table when HIV issues are being discussed. Care providers should treat us – and all their clients – as people with medical issues, not as passive objects of care. Stigma, legal discrimination, poverty, and unequal access to health care are not just health issues, they are social justice issues. We have the same right to fulfilling lives as everyone else.*

*Those were the Denver Principles in 1983, they are the Denver Principles today, and they are the charter NAPWA is founded on.*

### The Denver Principles

#### Statement from the Advisory Committee of People with AIDS (1983)

We condemn attempts to label us as 'victims,' a term which implies defeat, and we are only occasionally 'patients,' a term which implies passivity, helplessness, and dependence upon the care of others. We are 'People With AIDS.'

#### RECOMMENDATIONS FOR HEALTH CARE PROFESSIONALS

1. Come out, especially to their patients who have AIDS.
2. Always clearly identify and discuss the theory they favor as to the cause of AIDS, since this bias affects the treatments and advice they give.
3. Get in touch with their feelings (e.g., fears, anxieties, hopes, etc.) About AIDS and not simply deal with AIDS intellectually.
4. Take a thorough personal inventory and identify and examine their own agendas around AIDS.
5. Treat people with AIDS as a whole people, and address psychological issues as well as biophysical ones.
6. Address the question of sexuality in people with AIDS specifically, sensitively and with information about gay male sexuality in general, and the sexuality of people with AIDS in particular.

#### RECOMMENDATIONS FOR ALL PEOPLE

1. Support & Membership in our struggle against those who would fire us from our jobs, evict us from our homes, refuse to touch us or separate us from our loved ones, our community or our peers, since available evidence does not support the view that AIDS can be spread by casual, social contact.
2. Not scapegoat people with AIDS, blame us for the epidemic or generalize about our lifestyles.

### **RECOMMENDATIONS FOR PEOPLE WITH AIDS**

1. Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda and to plan their own strategies.
2. Be involved at every level of decision-making and specifically serve on the board of directors of provider organizations.
3. Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.
4. Substitute low-risk sexual behaviors for those which could endanger themselves or their partners; we feel that people with AIDS have an ethical responsibility to inform their potential partners of their health status.

### **RIGHTS OF PEOPLE WITH AIDS**

1. To live as full and satisfying sexual and emotional lives as anyone else.
2. To receive quality medical treatment and quality social service provision without discrimination of any form, including sexual orientation, gender, diagnosis, economic status or race.
3. To obtain full explanations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardizing their treatment and to make informed decisions about their lives.
4. To ensure privacy and confidentiality of medical records, to receive human respect and the right to choose who their significant others are.
5. To die – and to LIVE – in dignity.

[Email this page](#)



Find us

National Association of People with AIDS 8401 Colesville Road, Suite 505, Silver Spring, MD 20910

Telephone: 240-247-0880 | Toll Free: 866-846-9366 | Facsimile: 240-247-0574

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February 18, 2013

## Two Opportunities: Free Legal Assistance for People with Disabilities

### Houston Volunteer Lawyers Program and LyondellBasell *Beginning Wednesday, February 20, 2013*

The Mayor's Office for People with Disabilities (MOPD), in partnership with Houston Volunteer Lawyers Program and LyondellBasell, is offering a **free** legal advice clinic on Wednesday, February 20, 2013, 5:30 p.m. - 8:30 p.m. at the Metropolitan Multi-Service Center, 1475 West Gray Street, Houston 77019. During the evening, volunteer attorneys will provide brief legal advice to qualifying participants in the following areas: bankruptcy, consumer, family (divorce, custody and child support), guardianship, immigration law, Internal Revenue Service controversies, landlord/tenant, wills and probate.

This is a quarterly clinic. The other 2013 dates are Wednesday, May 15, Wednesday, July 17 and Wednesday, October 16. Qualifying clinic participants will also receive referrals to legal service providers for ongoing legal assistance.

### South Texas College of Law Free Legal Clinic *Beginning Thursday, February 21, 2013*

The Mayor's Office for People with Disabilities (MOPD), in partnership with the South Texas College of Law (STCL), is offering **free** monthly legal clinics for persons with disabilities. Clinics offered by STCL take place on every third Thursday of each month, 1 p.m. - 3 p.m. at the Metropolitan Multi-Service Center, 1475 West Gray Street, Houston 77019. STCL provides legal services in areas of community education, estate planning, family law and probate.

Persons interested in obtaining legal services at either program and/or to request any accommodations, contact June Eaton 832.394.0814 or [june.eaton@houstontx.gov](mailto:june.eaton@houstontx.gov) in advance.

For more information about MOPD, a division of the Department of Neighborhoods, visit [www.houstontx.gov/disabilities](http://www.houstontx.gov/disabilities).



[Register for CitizensNet](#)

Add [cityofhouston@houstontx.gov](mailto:cityofhouston@houstontx.gov) to your address book to ensure proper delivery of CitizensNet emails and to prevent spam filters from blocking the emails. Follow these [instructions](#).