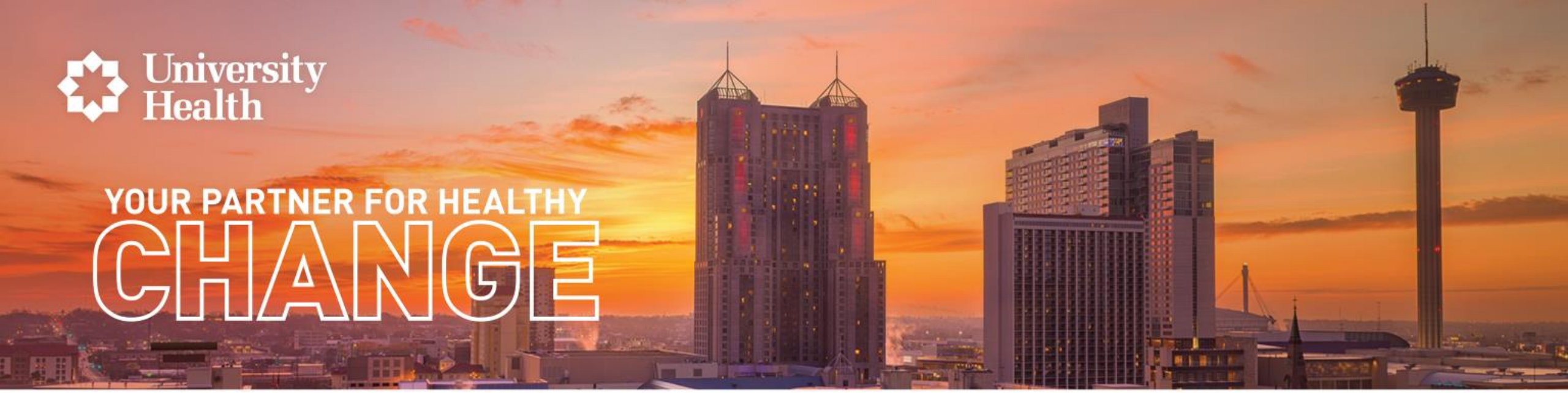

Ryan White and Operation BRAVE Programs Administration Overview (101)

Updated: February 9, 2023

Overview

- Ryan White and Operation BRAVE Programs(s) Basics
- San Antonio Area Administrative Agency
- San Antonio Area HIV Health Services Planning Council
- San Antonio Area Ryan White and Operation BRAVE Program(s) Eligibility
- San Antonio Area Ryan White and Operation BRAVE Program(s) Funded Services
- San Antonio Area Ryan White and Operation BRAVE Program(s) Services Basics
- HIV Care Continuum
- San Antonio Area Demographics
- Nationwide Demographics
- Texas Demographics

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Ryan White and Operation BRAVE Program(s) Basics

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What is the Ryan White Program?

- The Ryan White HIV/AIDS Program provides HIV-related services in the United States for those who do not have sufficient health care coverage or financial resources for coping with HIV disease.
- The program fills gaps in care not met by other payers. Ryan White is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).
- The Ryan White Program is the third largest source of federal funding for HIV care in the U.S., after Medicare and Medicaid.

- Ryan White is legislation or law.
  - It is part of the Public Health Services Act Title XXVI.

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History of the Ryan White Program

- Started in 1990 as the “Ryan White C.A.R.E. Act”
  - Focus was on end of life issues that persons living with HIV/AIDS (PLWHA) and their families faced
- In 1996, Highly Active Antiretroviral Therapy (HAART) becomes widely available
  - Ryan White Reauthorized with special funding for the AIDS Drug Assistance Program (ADAP)
- In 2000, C.A.R.E. Act reauthorized to address the unmet medical needs of persons living with HIV/AIDS (PLWHA)

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History of the Ryan White Program Continued

- In 2006, the Act was reauthorized and amended as the Ryan White HIV/AIDS Treatment Modernization Act of 2006
- In 2009, the Ryan White HIV/AIDS Treatment Modernization Act was reauthorized and amended again as the Ryan White HIV/AIDS Treatment Extension Act of 2009
- As of FY2021, the grant is funded at $2.42 Billion
  - Overall, it provides services to more than 500,000 individuals each year who do not have sufficient health care coverage or financial resources for coping with the HIV/AIDS disease

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History of the Operation BRAVE Program

- In the 2019 State of the Union (SOTU) Address, an initiative to End the HIV Epidemic was announced to begin in 2020.
  - The Ending the HIV Epidemic (EHE) will be a ten (10) year initiative focusing on reducing new HIV infections by 90% before 2030.
- Ending the HIV Epidemic in the United States (U.S.) is a bold plan announced in 2019 that aims to end the HIV epidemic in the U.S.by 2030. Agencies across the U.S. and HHS developed an operational plan to pursue that goal accompanied by a request for additional resources that were provided by Congress.
- The plan leverages critical scientific advances in HIV prevention, diagnosis, treatment, and outbreak response by coordinating the highly successful programs, resources, and infrastructure of many HHS agencies and offices.
- In its first phase, the initiative is focusing on areas where HIV transmission occurs most frequently, providing 57 geographic focus areas with an infusion of additional resources, expertise, and technology to develop and implement locally tailored EHE plans.

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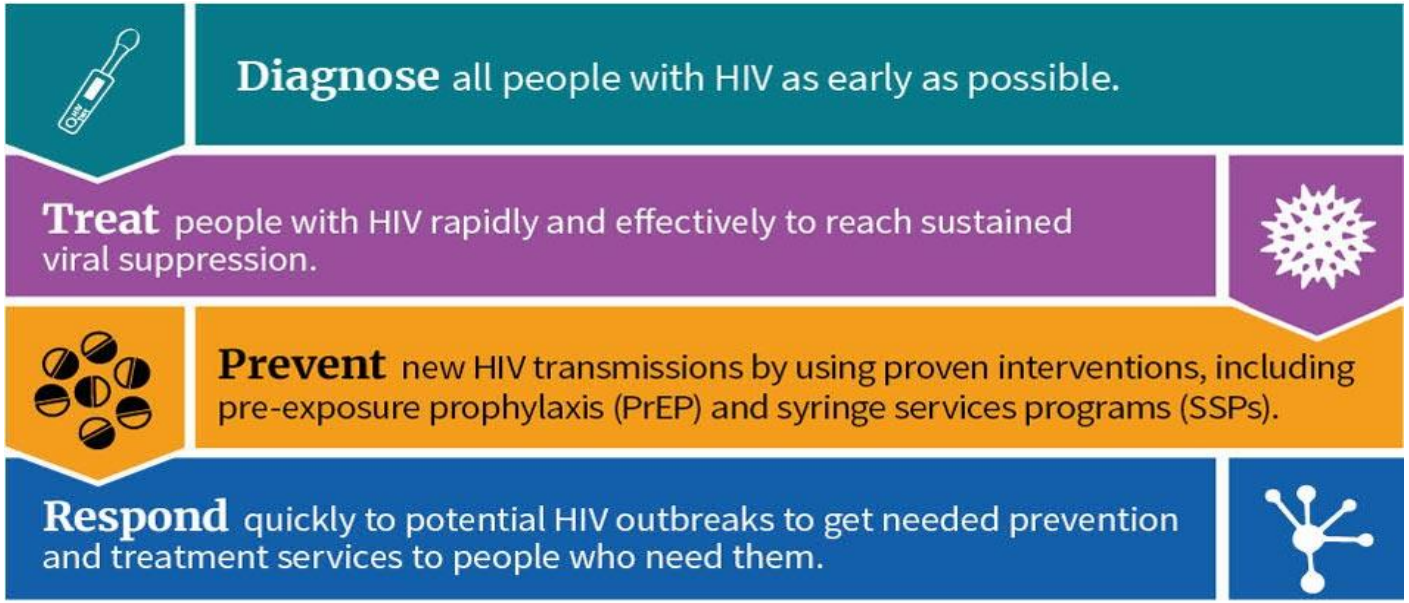
History of the Operation BRAVE Program Continued

- The EHE initiative focuses on four key strategies that, implemented together, can end the HIV epidemic in the U.S.



- The EHE program at University Health (UH) is Operation BRAVE and is funded for the Treat and Respond key strategies (also known as pillars).

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Ryan White Legislation

The Ryan White Legislation created a number of programs, called Parts (known as “Titles” before 2006), to meet needs for different communities and populations affected by HIV/AIDS.

- Part A
  - Funds go to local areas that have been hit hardest by the HIV epidemic; The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV to improve their health outcomes
- Part B
  - Provides funds to improve the quality, availability, and organization of HIV health care and support services in states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and the U.S. Pacific Territories and Associated Jurisdictions
- Part C
  - Funds local, community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people living with HIV
- Part D
  - Funds are used to provide family-centered primary medical care and support services to women, infants, children, and youth living with HIV; Part D funds are competitive grants that go directly to local public or private healthcare organizations including hospitals, and to public agencies
- Part F
  - Provides funds for a variety of programs:
    - Provides grant funding that supports several research, technical assistance, and access-to-care programs
    - Special Projects of National Significance Program (SPNS), AIDS Education and Training Centers (AETCs), HIV/AIDS Dental Reimbursement Program, Community Based Dental Partnership Program, and Minority AIDS Initiative (MAI)

Public Health Service Act Title XXVI (Ryan White HIV/AIDS Program Legislation)

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Legislative Regulations

- HHS 45 CFR 75
  - https://www.hhs.gov/grants/grants/grants-policies-regulations/index.html
- OMB Uniform Guidance 2 CFR Part 200
  - https://www.hhs.gov/grants/grants/grants-policies-regulations/index.html

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HRSA Resources & Requirements

- Policy Clarification Notices (PCNs)
- Program Letters
- HIV Care and Treatment Clinical Care Guidelines and Protocols
- Quality Management
- Performance Measure Portfolio
- Part A Monitoring Standards Guidance
- Part B Monitoring Standards Guidance
- Part A and B Program Manuals

https://ryanwhite.hrsa.gov/grants/manage/recipient-resources

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DSHS Resources & Requirements

- Laws, Rules, and Authorization

https://www.dshs.texas.gov/hiv-std-program/texas-dshs-hiv-std-program-hiv-std-policies-procedures/laws-rules-authorization

- HIV/STD Policies and Procedures

https://www.dshs.texas.gov/hiv-std-program/texas-dshs-hiv-std-program-hiv-std-policies-procedures

- HIV Medical and Support Service Categories

https://www.dshs.texas.gov/hiv-std-program/texas-dshs-hiv-std-program-hiv-medical-support-service-categories

- Housing Opportunities for Persons With AIDS (HOPWA)

https://www.dshs.texas.gov/hiv-std-program/dshs-tb-hiv-std-section-thisis/funding-information-faqs/texas-dshs-hiv-std

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Legislative Requirement: Payor of Last Resort

- By statute, Ryan White Program funds may not be used, “for any item or service to the extent that payment has been made, or can reasonably be expected to be made…” by another payment source.

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Additional Legislative and Policy Requirements

- The AA is required to ensure that 75% of Ryan White funds are spent on core medical services and 25% of funds are spent on support services.
  - Currently, the AA has allocated 85% of funds to core medical services under Part A and 15% to support services
- The AA must expend at least 95% of Ryan White Part A funds or will be deemed ineligible for future Ryan White Part A Supplemental funds.
- The AA can receive up to 10% of Part A Formula, Part A Supplemental, and Part A MAI funds to cover administrative costs; The Planning Council budget is included in the 10% of Part A funds.
- The AA can also receive up to 5% of Part A Formula, Part A Supplemental, and Part A MAI funds for quality management activities.

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The Ryan White and Operation BRAVE Programs at the Federal Level

- Administered by HHS, HRSA, HAB
- Through appropriations, HRSA distributes funding through PARTS to cities, states, and local community-based organizations (all Administrative Agencies) to provide HIV-related services
- HRSA provides funding to UH
  - Part A Formula, Part A Supplemental, Minority AIDS Initiative (MAI), and Part D
  - Ending the Epidemic (EHE) Operation BRAVE
- HRSA provides funding to Texas Department of State Health Services (DSHS), who then provides funding to UH
  - Part B
- HRSA provides funding to other local Community-Based Organizations
  - Part C

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The Ryan White Program at the State Level

- UH receives Ryan White Part B Service Delivery (SD), HIV Health and Social Services (State Funds), and HIV Health and Social Services (State Services) funds from DSHS
- HRSA awards Ryan White Part B Service Delivery funds to DSHS, and DSHS subsequently contracts a portion of those funds to UH
- State Funds and State Services funds are Texas general fund monies that are contracted to UH directly from DSHS to provide HIV services with Dr. Roberto Villarreal as the Principal Investigator for these programs
- The Housing Opportunities for Persons with HIV/AIDS (HOPWA) Program is the only federal program dedicated to the housing needs of PLWH. The US Department of Housing and Urban Development (HUD) awards HOPWA funds to DSHS, and DSHS subsequently contracts a portion of those funds to UH; UH acts as the AA for State HOPWA funds

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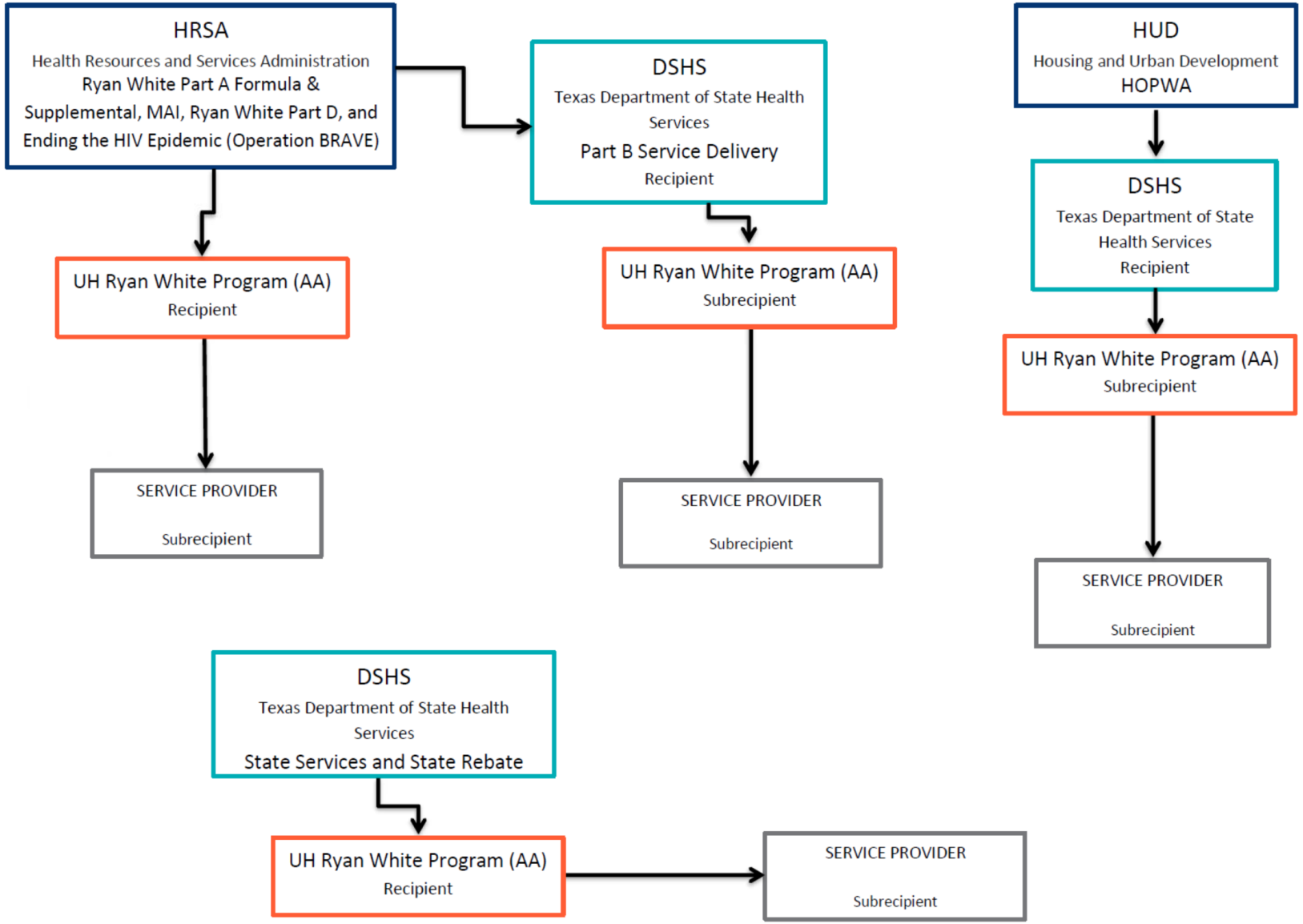
Funding Pathways



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Funding Cycles

- Ryan White Part A
  - March 1 – February 28
- Ryan White Minority AIDS Initiative (MAI)
  - March 1 – February 28
- Ending the Epidemic (EHE): Operation BRAVE
  - March 1 – February 28
- Ryan White Part B
  - April 1 – March 31
- State Funds
  - April 1 – March 31
- Ryan White Part D
  - August 1 – July 31
- State Services
  - September 1 – August 31
- HOPWA
  - September 1 – August 31

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Administrative Agency and the Planning Council

- The Administrative Agency (AA), also called Recipient, and the Planning Council (PC) are two SEPARATE entities, BOTH with Legislative Authority.
- Some roles/responsibilities belong to one entity and some roles/responsibilities are shared.
- HRSA recommends separation of duties to avoid confusion of roles/responsibilities.
- Effectiveness requires communication, information sharing, and collaboration between the AA, PC Support Staff and ongoing consumer and community involvement.

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Administrative Agency and the Planning Council Continued

Roles/Duties of the CEO, Recipient, and Planning Council

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council
Establishment of Planning Council/ Planning Body	✓		
Appointment of Planning Council/ Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	*Optional*
Development of Service Standards		✓	✓
Clinical Quality Management		✓	*Contributes but not responsible*
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

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San Antonio Area Administrative Agency

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Administrative Agency Basics

- The Ryan White Program Administration is housed at UH and acts as the AA for Ryan White Part A, MAI, Ryan White Part B Service Delivery, Ryan White Part D, State Funds (SF), State Services (SS), HOPWA, and Operation BRAVE funds.
- The Bexar County Judge (Judge Peter Sakai) serves as the Chief Elected Official (CEO) for the Ryan White Part A and MAI funds and appoints members to the Planning Council; Dr. Roberto Villarreal was appointed as the principal investigator for these funds.
- Dr. Villarreal is the principal investigator for Ryan White Part B Service Delivery (SD), Ryan White Part D, SF, SS, HOPWA, and EHE funds.
- The role of the AA includes, but is not limited to, contract negotiations, quality management, programmatic and fiscal monitoring, needs assessments, planning, and the formation of productive partnerships in support of the HIV Continuum of Care.

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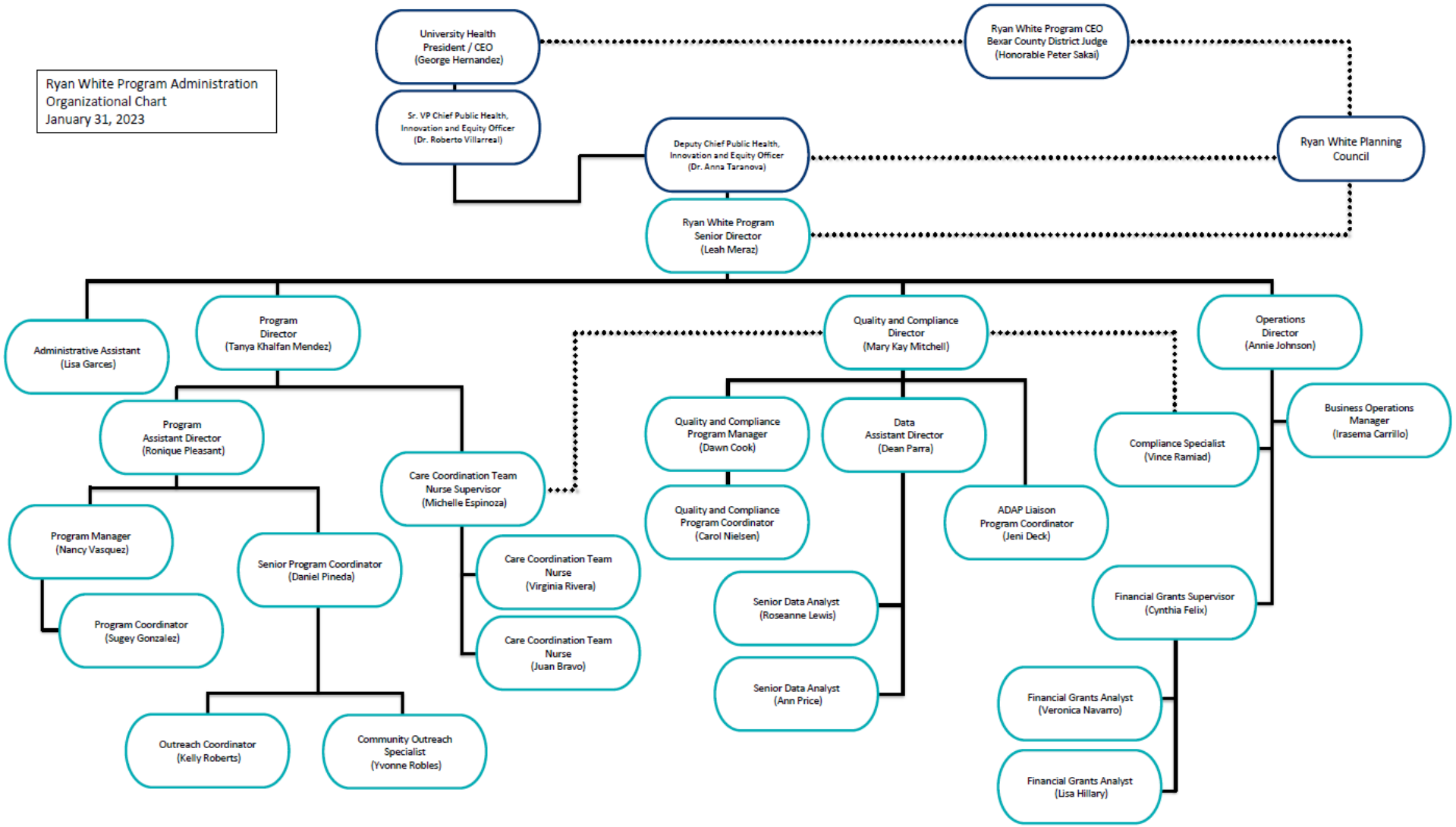
Administrative Agency Organizational Chart



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Procurement of Services

- The Recipient is responsible for identifying and selecting qualified service providers for delivering Ryan White, Operation BRAVE, and HOPWA services.
- The Recipient must award service funds to eligible providers (subrecipients) based on a fair and equitable system, usually through a competitive Request for Proposals (RFP) process.
- In contracting for services, the Recipient must distribute RWHAP Part A funds according to the priority setting and resource allocation decisions of the Planning Council.
- The Recipient can only spend the amount of money that the planning council decides should be used for each funded service category.
- The Planning Council may review sections of the RFP the Recipient develops for Ryan White Services, to ensure that directives are appropriately reflected, but it cannot be involved in any aspect of contractor selection (procurement) or in managing or monitoring Ryan White/Operation BRAVE contracts.

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Service Provider Subcontracting

- Service Provider must have a Contract/MOU in place with subcontractor and must be provide a copy to the AA for review/approval.
- It is allowable for service providers to execute subcontracts for the provision of certain services. (i.e. Oral Health)
- Subcontractors are held to the same standards and regulations as funded agencies, including payor of last resort.
- Funded agencies are responsible for monitoring subcontractors for program and quality management compliance on an annual basis

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Contract Monitoring

- Once subrecipient contracts have been awarded, the recipient must manage them and regularly monitor subrecipients.
- The Recipient must make sure that the providers who receive Ryan White/Operation BRAVE funds use the money according to the terms of the subrecipient contract they signed with the Recipient and meet Ryan White Legislation, HRSA National Monitoring Standards, other federal requirements established by HRSA, state requirements established by DSHS, local requirements set by the AA, and the Standards of Care.
- The Recipient monitors subrecipients to determine how quickly they spend RWHAP Part A funds, and if they are providing the contracted services, providing services only to eligible clients, using funds only as approved, and meeting reporting and other requirements.
- Contract monitoring is solely a Recipient responsibility.

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Standards of Care

- The Standards of Care (SOC) are living documents that are revised in response to HRSA HAB measures, Federal, State, and Local regulations, and the changing needs of HIV positive consumers in the San Antonio Delivery Area.
  - University Health Ryan White Part A & MAI Programs: Administrative Monitoring Standards
  - University Health Ryan White Part A & MAI Programs: Standards of Care
  - University Health Operation BRAVE Program : Administrative Monitoring Standards
  - University Health Operation BRAVE Program: Standards of Care
  - University Health Ryan White Part B Service Delivery, State Rebate, & State Services Programs: Administrative Monitoring Standards
  - University Health Ryan White Part B Service Delivery, State Rebate, & State Services Programs: Standards of Care
  - University Health Ryan White Part D Program : Administrative Monitoring Standards
  - University Health Ryan White Part D Program: Standards of Care

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Standards of Care Continued

- Developing service standards is usually a joint activity between the AA, Planning Council, and the CQM Committee; these include Providers, Consumers, and Experts on particular service categories.
- These service standards must be consistent with HHS guidelines on HIV care and treatment as well as HRSA/HAB standards and performance measures, including the National Monitoring Standards.
- Service standards guide providers in implementing funded services.
  - They typically address the elements and expectations for service delivery, such as service components, intake and eligibility, personnel qualifications, and client rights and responsibilities.
  - The SOCs function as the guiding document for the provision of services under the Ryan White Part A, MAI, Ryan White Part B Service Delivery, State Services, State Rebate, Ryan White Part D, and Operation BRAVE funding streams.
- The service standards set the minimum requirements of a service and serve as a base on which the Recipient's clinical quality management (CQM) program is built.
- The SOCs can be accessed at www.saplanningcouncil.org.

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Clinical Quality Management

- The Recipient must establish a ***clinical quality management (CQM)*** program, designed to improve patient care, health outcomes, and patient satisfaction. Components include infrastructure, performance measurement, and quality improvement.
  - An ideal ***infrastructure*** includes leadership, dedicated staffing and resources, a quality management plan that covers all funded medical and support services, a CQM committee, consumer and stakeholder involvement, and assessment of the CQM program.
  - ***Performance measurement*** is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes, and patient satisfaction with the services they receive. Recipients select a portfolio of performance measures based on funded services, local HIV epidemiology, the identified needs of PLWH, and the national goals to end the epidemic.
  - Based on performance measurement results, Recipients work with subrecipients in the development and implementation of ***quality improvement*** activities to make changes to the program to improve services.

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Clinical Quality Management Continued

- Subrecipients must be actively involved in CQM activities.
- Recipients are expected to ensure that subrecipients have the capacity to contribute to the CQM program, have the resources to conduct CQM activities, and implement a CQM program in their organization.

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Reimbursement Request Process

- Reimbursement Requests are submitted to the Ryan White Program on a monthly basis. All Reimbursement Requests must have an invoice sheet including an authorized person's signature and be a minimum of twenty dollars ($20.00).
- All supporting documentation is reviewed for the following:
  - To ensure the requested reimbursement is within the applicable grant period.
  - To verify that there are not any client names, addresses, social security numbers, etc. on any documentation.
  - To match the requested reimbursement amounts to copies of payroll checks, general ledgers, checks payable to pharmacies, utility companies, health insurance premiums, transportation, etc.
  - Personnel and salary percentages are compared to the approved budget and cost allocation plan for accuracy.
  - Reimbursements requested for AIDS Pharmaceutical Assistance (Local) are verified using the approved Ryan White Program Drug Formulary, ADAP, and the DSHS website.
  - A Ryan White Data System financial report is generated to support that services were provided for the month invoiced and to verify actual costs for direct services.

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Reimbursement Request Process Continued

- If a Reimbursement Request is outside the grant period, under the minimum amount allowed, lacking supporting documentation, and/or is questionable, an email is sent to the Service Provider informing them of what is needed to process their Reimbursement Requests ; if no response is received by Ryan White within the allotted time frame an adjustment is made to the invoice and the Service Provider will have the option of re-submitting for those costs within 5 days of adjustment notification.
- Once all documentation requested has been received and reviewed, detailed spreadsheets are prepared and updated then emailed to the Service Provider. Any adjustments made to the Reimbursement Requests will be noted and detailed on the last page of the detailed spreadsheet.
- Reimbursement Requests are then forwarded to management for review and approval, and then forwarded on for payment.

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Reimbursement Request Process Continued

- Per Policy, all supporting documentation is reviewed by the Financial Grants Analyst(s) to verify that there are not any HIPAA violations by including one of the Protected Health Identifiers (PHI) as defended by HIPAA.
- If the Reimbursement Request is found to contain any PHI, the Subrecipient will be notified and the Reimbursement Request will be redacted by the Financial Grants Analyst(s) for the first three (3) violations.
- If the Reimbursement Request continues to contain any PHI the Subrecipient will be notified and the Reimbursement Request will be disallowed and deleted from the system.
- The AA tracks all Policy Violations.

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Monthly Agency Review

- Subrecipients are required to submit monthly standardized reports and Reimbursement Requests. These reports help the AA recognize patterns and any contributing factors above or below goal expenditures by subrecipients during a Monthly Agency Review (MAR) process. Each month, program and financial staff review and discuss the expenditures and performance of each agency with key subrecipient staff. This monthly review facilitates tracking of expenditures, allows for reconciliations of funding including potential reallocations, and communication among staff so that corrections can be made quickly. Monthly meetings with the subrecipients also support open dialogue with the AA and helps to identify any obstacles that will hinder effective service delivery or difficulty in obtaining reimbursement.

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Monthly Agency Review Process

- The Monthly Agency Review (MAR) will be held every fourth Wednesday and Thursday of each month from 2-5 pm CST; holiday schedules may affect monthly meeting dates and subrecipients will be notified (at a minimum) two weeks prior if this date changes.
- Financial Grants Analysts will prepare the Monthly Agency Review (MAR) checklist and send to subrecipients via email for their review at least one week prior to the Monthly Agency Review (MAR) meeting.
- Subrecipients are to review, complete, and return the Monthly Agency Review (MAR) checklist three days prior to the scheduled Monthly Agency Review (MAR) meeting. The due date will be noted on the checklist each month.
- Financial Grants Supervisor will forward all provider responses to all pertinent Ryan White staff two days before the MAR.
- Ryan White staff will review provider responses and be prepared to make any recommendations.

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Monthly Agency Review Process Continued

- Each subrecipient will designate at least one staff member with knowledge of the financial aspects of the Ryan White Program to be available to answer any questions the AA has regarding any financial concerns. If the designated staff member is unavailable, subrecipients will select a designee in their place. If the designated staff member and their designee cannot be available during this time, the subrecipient must contact the AA via email to schedule an alternative meeting time.
- The Monthly Agency Review (MAR) meeting may be attended by the Director, Assistant Directors, Operations and Grants Manager, Compliance Specialist, Financial Grants Supervisor, Financial Grants Analysts, and relevant Program staff. If one of the staff members is unable to attend, they are responsible for reviewing the Monthly Agency Review (MAR) reports and providing any feedback to the Financial Grants Supervisor within a given timeframe prior to the monthly meeting.

University Health

Monthly Agency Review Process Continued

- Subrecipients will be called in alphabetical order and designated 30 minute time slots for the Monthly Agency Review (MAR) meeting; if more time is needed then Financial Staff will schedule a follow-up conference call with subrecipient for further discussion.
- Financial Grants Analysts will call designated staff of providers during the scheduled Monthly Agency Review (MAR). The Monthly Agency Review (MAR) checklist will be used for each subrecipient.
- Financial Grants Supervisor, Financial Grants Analysts, Compliance Specialist, and relevant Program staff will follow up with providers as needed and report back to Director, Assistant Directors, and Operations and Grants Manager.
- Financial Grants Supervisor will compose a summary of the meeting and any subsequent changes, and distribute to staff for review and/or action.

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Reporting Requirements

HRSA

- Ryan White Services Data Report (RSR)
- Ryan White Part A/MAI Annual Program Terms Report
- Ryan White Part A/MAI Annual Program Submission Report
- Ryan White Part A and MAI Final Expenditure Report
- Unobligated Balance Report
- Federal Financial Report (FFR)
- Ryan White Part A/MAI Annual Progress Report
- Carryover Request Report

DSHS

- Ryan White Part B/SS/SR Semi-Annual and Annual Reports
- HOPWA Semi-Annual and Annual Reports
- Ryan White Services Data Report (RSR)
- Financial Status Report (FSR)
- Quarterly Ryan White Data System Contract Specific Detail Report
- Quarterly Data Improvement Plan (DIP)

University Health

San Antonio Area HIV Health Services Planning Council

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Planning Council Basics

- The San Antonio Area HIV Health Services Planning Council
- Purpose: Ensure the availability of quality comprehensive health and social services to individuals affected by the HIV epidemic.
- Mission: to create a broad-based community response to the HIV epidemic affecting people within the Transitional Grant Area (TGA) and to ensure the availability and coordination of high quality, comprehensive health and social services to individuals infected with or affected by HIV.
- Governed by:
  - Planning Council Bylaws
  - Texas Open Meetings Act
  - Robert's Rules of Order
- **ALL** meetings are open to the public.
- The Planning Council is presided over by one of the two Co-Chairs Committee Chairs preside over their individual respective committees.
- A **quorum** is required at any meeting before action items may be voted on.

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Establishment of Planning Council/Appointment of Planning Council Members

- The CEO (Judge Peter Sakai) must establish and maintain the Planning Council.
  - This includes making sure that the Planning Council membership meets requirements related to representation, reflectiveness, and participation of unaffiliated consumers.
  - The CEO should ensure that these requirements are specified in Planning Council Bylaws.
- The Planning Council itself is responsible for identifying and screening candidates and forwarding their names, the membership categories they will fill, and other requested information to the CEO so they can be considered for appointment.
  - The CEO retains sole responsibility for appointment and removal of Planning Council members.

University Health

Needs Assessment

- The Needs Assessment should be a joint effort of the Planning Council and Recipient, with the Planning Council having lead responsibility.
  - It is sometimes implemented by an outside contractor under the supervision of the Planning Council.
- The Planning Council works with the Recipient to identify service needs by conducting a Needs Assessment.
  - This involves first finding out how many persons living with HIV (both HIV/non-AIDS and AIDS) are in the area through an epidemiologic profile.
- The Planning Council determines the needs of populations living with HIV and the capacity of the service system to meet those needs.
  - This assessment of needs is done through surveys, interviews, key informant sessions, focus groups, or other methods.
- The Needs Assessment must include direct input from people living with HIV.
- The Needs Assessment is usually a multi-year task, with different components updated each year.

University Health

Needs Assessment Continued

- The Needs Assessment seeks to determine:
  - Service needs and barriers for people living with HIV who are in care.
  - The number, characteristics, and service needs and barriers of people living with HIV who know their HIV status and are not in care.
  - The estimated number, probable characteristics, and barriers to testing for individuals who are HIV-infected but unaware of their status.
  - The number and location of agencies providing HIV-related services in the EMA or TGA—a resource inventory of the local “system of care”.
  - Local agencies’ capacity and capability to serve people living with HIV, including capacity development needs.
  - Service gaps for all people living with HIV and how they might be filled, including how RWHAP service providers need to work with other providers, like substance abuse treatment services and HIV prevention agencies.

Integrated/Comprehensive Planning

- The Planning Council works with the Recipient in developing a written plan that defines short- and long-term goals and objectives for delivering HIV services and strengthening the system of care in the TGA.
- This is called a comprehensive plan in the legislation, but is now called the CDC and HRSA Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN).
- The legislation gives the Planning Council a lead role in the planning process, which must be carried out in close coordination with the Recipient.
  - The TGA may submit a joint plan with the state RWHAP Part B program.

Integrated/Comprehensive Planning Continued

- The plan is based, in part, on the results of the needs assessment and other information such as client utilization data.
- It is used to guide decisions about how to deliver HIV services for people living with HIV.
- The plan should be consistent with other existing local or state plans and with national goals to end the HIV epidemic.
- The plan should ensure attention to each stage of the HIV care continuum, which measures the steps or stages of HIV medical care from diagnosis to linkage to care, retention in care and treatment, prescribing of HIV medications, and achieving the goal of viral suppression (a very low level of HIV in the body).

Priority Setting and Resource Allocations

- The Planning Council uses needs assessment data as well as data from a number of other sources to set priorities and allocate resources.
  - This means the members decide which services are most important to people living with HIV in the TGA (priority setting) and then agree on which service categories to fund and how much funding to provide (resource allocations).
  - In setting priorities, the Planning Council should consider what service categories are needed to provide a comprehensive system of care for people living with HIV in the TGA, without regard to who funds those services.

Priority Setting And Resource Allocations Continued

- The Planning Council must prioritize only service categories that are included in the RWHAP legislation as core medical services or support services.
- After it sets priorities, the Planning Council must allocate resources, which means it decides how much RWHAP Part A funding will be used for each of these service priorities.
  - For example, the planning council decides how much funding should go for outpatient/ambulatory health services, mental health services, etc.
  - In allocating resources, Planning Councils need to focus on the legislative requirement that at least 75 percent of funds must go to cover medical services and not more than 25 percent to support services, unless the TGA has obtained a waiver of this requirement.

University Health

Priority Setting And Resource Allocations Continued

- The Planning Council makes decisions about priorities and resource allocations based on many factors, including:
  - Needs assessment findings
  - Information about the most successful and economical ways of providing services
  - Actual service cost and utilization data (provided by the recipient)
  - Priorities of people living with HIV who will use services
  - Use of RWHAP Part A funds to work well with other services like HIV prevention and substance abuse treatment services, and within the changing healthcare landscape
  - The amount of funds provided by other sources like Medicaid, Medicare, state and local government, and private funders—since RWHAP is the “payor of last resort” and should not pay for services that can be provided with other funding.

University Health

Directives

- The Planning Council also has the right to provide directives to the Recipient on how best to meet the service priorities it has identified.
  - It may direct the recipient to fund services in particular parts of the TGA (such as outlying counties), or to use specific service models. It may tell the recipient to take specific steps to increase access to care (for example, require that Medical Case Management providers have bilingual staff or that primary care facilities be open one evening or weekend a month).
  - It may also require that services be appropriate for particular subpopulations—for example, it may specify funding for medical services that target young gay men of color.
- However, the Planning Council cannot pick specific agencies to fund, or make its directives so narrow that only one agency will qualify.

University Health

Coordination of Services

- The Planning Council is responsible for ensuring that RWHAP Part A resource allocation decisions account for and are coordinated with other funds and services.
- The planning tasks described earlier (needs assessment, priority setting and resource allocation, integrated/comprehensive planning) require getting lots of input, including finding out what other sources of funding exist.

University Health

Evaluation of Services: Performance, Outcomes, and Cost-effectiveness

- The Planning Council may choose to evaluate how well services funded by RWHAP Part A are meeting identified community needs, or it can pay someone else to do such an evaluation.
- The Part A Recipient's CQM program can provide information on clinical outcomes that informs the planning council about the impact of services.
  - The Recipient may include Planning Council members on its CQM committee. In addition, most planning councils regularly review TGA performance along the HIV care continuum.
- The Planning Council uses evaluation findings in considering ways to improve the system of care, including changing service priorities and allocations and developing directives

University Health

Assessment of the Efficiency of the Administrative Mechanism

- The Planning Council is responsible for evaluating how rapidly RWHAP Part A funds are allocated and made available for care.
  - This involves ensuring that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner.
  - It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether the amounts contracted for each service category are the same as the planning council's allocations.
- The results of this assessment of the efficiency of the administrative mechanism are shared with the Recipient, who develops a response including corrective actions if needed.
- Both the results of the assessment and the recipient response are summarized in the RWHAP Part A funding application for the following year.

University Health

Assessment of the Efficiency of the Administrative Mechanism Continued

- The purpose of the Assessment is also to ensure that the service prioritization and allocation, contracting and reimbursement processes facilitate the access to primary medical care and other ancillary services by persons living with HIV/AIDS.
- The Assessment has to answer the following at a minimum:
  - Part A funds were expended in a timely manner (Net 30?).
  - Part A contracts with service providers were signed in a timely manner.
  - During FY XXXX, the TGA had less than 5%(?) carryover in Part A funds.
  - Part A resources were reallocated in a timely manner to ensure the needs of the community are met.
  - Part A Programs funded in FY XXXX matched the service categories and percentages identified during the Council's Priority Setting and Resource Allocation process
  - Planning Council Directives were reflected in Part A programs funded in FY XXXX

University Health

Planning Council Operations and Support

- The Recipient must cooperate with the Planning Council by negotiating and managing its budget, providing staff expertise to support committees, and providing information the planning council needs to carry out its responsibilities.
  - This includes data on client characteristics, service utilization, and service costs, as well as information for assessing the efficiency of the administrative mechanism.
- Both the Planning Council and the Recipient have the responsibility to support participation of people living with HIV on the planning council, although primary responsibility lies with the Planning Council.
  - Examples include reimbursing expenses of consumer members such as travel and child care costs.
- The Planning Council establishes reimbursement policies; the Recipient helps to ensure timely payment of reimbursements.
- The Recipient assists in training Planning Council members by explaining Recipient roles and helping Planning Council members understand information provided by the Recipient such as data on service costs and client utilization of funded services.

University Health

San Antonio Area Ryan White and Operation BRAVE Program(s) Eligibility

University Health

Part A Program Eligibility

- Eligibility Criteria for RWHAP Part A:
  - Have a diagnosis of HIV;
  - Provide documentation of applicable county residency; and
  - Provide complete and accurate income documentation.
- Required Documentation:
  - HIV/AIDS diagnosis
  - Proof of Residence
  - Proof of Income
  - Proof of Insurance
- Must be completed yearly or as client circumstances change.
- Clients eligible for the Part A Program are medically underserved individuals diagnosed with HIV.

University Health

Part A Program Eligibility Continued

- Residency Requirement:
  - Must be a resident of the Transitional Grant Area (TGA) which consists of Bexar, Comal, Guadalupe, or Wilson Counties in order to receive Part A services.
- Income Requirement:
  - Not more than 300% of Federal Poverty Level (FPL) for a client to be eligible for the Part A Program.
  - Subrecipients and providers must use the DSHS provided Income Calculation Worksheet (XLS) to calculate an applicant's income. These worksheets can be found online on the MAGI documents page.
- Insurance Requirement:
  - Copy of Insurance Document and
  - Completed AA created *Health Insurance Verification Form.*

University Health

MAI Program Eligibility

- Eligibility Criteria for RWHAP MAI:
  - Have a diagnosis of HIV;
  - Provide documentation of applicable county residency; and
  - Provide complete and accurate income documentation.
- Required Documentation:
  - HIV/AIDS diagnosis
  - Proof of Residence
  - Proof of Income
  - Proof of Insurance
- Must be completed yearly or as client circumstances change.
- Clients eligible for the MAI Program are medically underserved minorities, specifically Hispanic/Latino and Black/African Americans diagnosed with HIV.

University Health

MAI Program Eligibility Continued

- Residency Requirement:
  - Must be a resident of the Transitional Grant Area (TGA) which consists of Bexar, Comal, Guadalupe, or Wilson Counties in order to receive MAI services.
- Income Requirement:
  - Not more than 300% of Federal Poverty Level (FPL) for a client to be eligible for the MAI Program.
  - Subrecipients and providers must use the DSHS provided Income Calculation Worksheet (XLS) to calculate an applicant's income. These worksheets can be found online on the MAGI documents page.
- Insurance Requirement:
  - Copy of Insurance Document and
  - Completed AA created *Health Insurance Verification Form.*

University Health

Part B Service Delivery, State Funds, and State Services Programs Eligibility

- Eligibility Criteria for RWHAP Part B Service Delivery, State Funds, and State Services:
  - Have a diagnosis of HIV;
  - Provide documentation of applicable county residency; and
  - Provide complete and accurate income documentation.
- Required Documentation:
  - HIV/AIDS diagnosis
  - Proof of Residence
  - Proof of Income
  - Proof of Insurance
- Must be completed twice per year (Half Birth Month and Birth Month).

University Health

Part B Service Delivery, State Funds, and State Services Programs Eligibility Continued

- Residency Requirement:
  - Must be a resident of the Health Services Delivery Area (HSDA) which consists of Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, or Wilson Counties in order to receive Part B Service Delivery, State Funds, and State Services Program(s) services.
- Income Requirement:
  - Not more than 500% of Federal Poverty Level (FPL) for a client to be eligible for the Part B Service Delivery, State Funds, and State Services Program(s).
  - Subrecipients and providers must use the DSHS provided Income Calculation Worksheet (XLS) to calculate an applicant's income. These worksheets can be found online on the MAGI documents page.
- Insurance Requirement:
  - Copy of Insurance Document and
  - Completed AA created *Health Insurance Verification Form.*

University Health

Part D Program Eligibility

- Eligibility Criteria for RWHAP Part D:
  - Have a diagnosis of HIV;
  - Provide documentation of applicable county residency; and
  - Provide complete and accurate income documentation.
- Required Documentation:
  - HIV/AIDS diagnosis
  - Proof of Residence
  - Proof of Income
  - Proof of Insurance
- Must be completed yearly or as client circumstances change.
- Clients eligible for the Part D Program are medically underserved women (25 years and older) diagnosed with HIV, infants (up to two years of age) exposed to or diagnosed with HIV, children (ages two to 12) diagnosed with HIV, and youth (ages 13 to 24) diagnosed with HIV, Transgender person diagnosed with HIV, or Men up to the age of 24 years old diagnosed with HIV.

University Health

Part D Program Eligibility Continued

- Residency Requirement:
  - Must be a resident of the Service Delivery Area (SDA) which consists of Atascosa, Bandera, Bexar, Calhoun, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, or Zavala Counties in order to receive Part D services.
- Income Requirement:
  - Not more than 300% of Federal Poverty Level (FPL) for a client to be eligible for the Part D Program.
  - Subrecipients and providers must use the DSHS provided Income Calculation Worksheet (XLS) to calculate an applicant's income. These worksheets can be found online on the MAGI documents page.
- Insurance Requirement:
  - Copy of Insurance Document and
  - Completed AA created *Health Insurance Verification Form.*

University Health

HOPWA Program Eligibility

- HOPWA Respondents will be required to obtain, verify, and maintain documentation of the following information for clients receiving HOPWA funded services:
  - Proof of HIV Positivity
  - Proof of Income - Household annual gross income cannot exceed 80 percent of area median income per the household's county of residence (24 CFR §574.3).
  - Proof of current residency for all household members 18 years of age and older.
  - Must be a resident of the Health Service Delivery Area (HSDA) which consists of Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, or Wilson Counties in order to receive HOPWA services.
- More information about HOPWA eligibility can be found in the *DSHS HOPWA Program Manual*.

University Health

Operation BRAVE Program Eligibility

- Eligibility Criteria for Operation BRAVE:
  - Have a diagnosis of HIV; and
  - Provide documentation of applicable county residency.
- Required Documentation:
  - HIV/AIDS diagnosis
  - Proof of Residence
  - Proof of Insurance
- Must be completed yearly or as client circumstances change.
- Clients eligible for the Operation BRAVE Program are newly diagnosed within the previous six months, new to the State of Texas and/or local SDA for Operation BRAVE and in need of medical services, engaging in care for the first time after being diagnosed for longer than six months, returning to medical care after an absence of six months or longer, in care but have not achieved viral suppression, and/or in need of Early Intervention Services.

University Health

Operation BRAVE Program Eligibility Continued

- Residency Requirement:
  - Must be a resident of the Service Delivery Area (SDA) which consists of Bexar, County in order to receive Operation BRAVE services.
- Insurance Requirement:
  - Copy of Insurance Document and
  - Completed AA created *Health Insurance Verification Form.*

University Health

San Antonio Area Ryan White and Operation BRAVE Program(s) Funded Services

University Health

Part A Funded Service Categories

- AIDS Pharmaceutical Assistance (Local) {LPAP}
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance (HIPCSA)
- Medical Case Management (MCM)
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services (OAHS)
- Substance Abuse - Outpatient Care

- Emergency Financial Assistance (EFA)
- Food Bank /Home-Delivered Meals
- Medical Transportation Services
- Non-Medical Case Management (NMCM)
- Referral for Health Care and Support

- Core
- Supportive

University Health

MAI Funded Service Categories

- Early Intervention Services (EIS)
- Mental Health Services
- Substance Abuse - Outpatient Care

- Non-Medical Case Management (NMCM)

- Core
- Supportive

University Health

Part B Funded Service Categories

- AIDS Pharmaceutical Assistance (Local) {LPAP}
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance (HIPCSA)
- Medical Case Management (MCM)
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services (OAHS)
- Substance Abuse - Outpatient Care

- Emergency Financial Assistance (EFA)
- Food Bank /Home-Delivered Meals
- Medical Transportation Services
- Non-Medical Case Management (NMCM)
- Referral for Health Care and Support

- Core
- Supportive

University Health

Part D Funded Service Categories

- Health Insurance Premium and Cost Sharing Assistance (HIPCSA)
- Medical Case Management (MCM)
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services (OAHS)
- Substance Abuse - Outpatient Care

- Emergency Financial Assistance (EFA)
- Food Bank /Home-Delivered Meals
- Medical Transportation Services
- Non-Medical Case Management (NMCM)
- Outreach Services
- Referral for Health Care and Support

- Core
- Supportive

University Health

Operation BRAVE Funded Service Categories

- Early Intervention Services (EIS)
- Medical Case Management (MCM)
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services (OAHS)
- Substance Abuse - Outpatient Care

- Emergency Financial Assistance (EFA)
- Initiative Services
- Housing Services
- Non-Medical Case Management (NMCM)
- Outreach Services
- Referral for Health Care and Support

- Core
- Supportive

University Health

HOPWA Funded Service Categories

- Administration
- Permanent Housing Placement (PHP)
- Short Term Rent, Mortgage, and Utilities (STRMU)
- Housing Case Management (used to be Support Services)
- Tenant-Based Rental Assistance (TBRA)

University Health

FY22-23 Ryan White Service Category Comparison Chart - All funded Parts as of August 2022

AIDS Pharmaceutical Assistance (Local) {LPAP}					
A	MAI	EHE	B	D	SS
AARC			AARC		AARC
BEAT			BEAT		BEAT
Centro			Centro		
SAAF			SAAF		SAAF
FFACTS			FFACTS		FFACTS

Early Intervention Services (EIS)					
A	MAI	EHE	B	D	SS
AARC	AARC		AARC		AARC
BEAT	BEAT	BEAT	BEAT		BEAT

Emergency Financial Assistance (EFA)					
A	MAI	EHE	B	D	SS
AARC		AARC	AARC		AARC
BEAT		BEAT	BEAT	BEAT	BEAT
Centro			Centro		
SAAF			SAAF	SAAF	SAAF
FFACTS			FFACTS		FFACTS

Food Bank /Home-Delivered Meals					
A	MAI	EHE	B	D	SS
AARC		AARC	AARC		AARC
		BEAT			
SAAF			SAAF		SAAF
FFACTS				FFACTS	FFACTS
				MCHD	

Health Insurance Premium and Cost Sharing Assistance (HIPCSA)					
A	MAI	EHE	B	D	SS
AARC			AARC	AARC	AARC
				MCHD	

Medical Case Management (MCM)					
A	MAI	EHE	B	D	SS
AARC			AARC		AARC
BEAT			BEAT	BEAT	BEAT
Centro			Centro		
SAAF			SAAF	SAAF	SAAF
FFACTS			FFACTS	FFACTS	FFACTS
				MCHD	

Medical Nutrition Therapy					
A	MAI	EHE	B	D	SS
FFACTS					FFACTS

Medical Transportation Services					
A	MAI	EHE	B	D	SS
AARC			AARC		AARC
BEAT		BEAT	BEAT	BEAT	BEAT
SAAF			SAAF		SAAF
FFACTS			FFACTS	FFACTS	FFACTS
				MCHD	

University Health

FY22-23 Ryan White Service Category Comparison Chart - All funded Parts as of August 2022

Mental Health Services					
A	MAI	EHE	B	D	SS
AARC	AARC	AARC	AARC	AARC	AARC
BEAT	BEAT	BEAT	BEAT	BEAT	BEAT
Centro	Centro		Centro		
SAAF	SAAF		SAAF	SAAF	SAAF
FFACTS	FFACTS		FFACTS	FFACTS	FFACTS
				MCHD	

Non-Medical Case Management (NMCM)					
A	MAI	EHE	B	D	SS
AARC	AARC		AARC		AARC
BEAT	BEAT		BEAT	BEAT	BEAT
Centro	Centro		Centro		
SAAF	SAAF		SAAF	SAAF	SAAF
FFACTS	FFACTS		FFACTS	FFACTS	FFACTS
				MCHD	

Outreach Services					
A	MAI	EHE	B	D	SS
				BEAT	
				MCHD	

Oral Health Care					
A	MAI	EHE	B	D	SS
SAAF		SAAF	SAAF	SAAF	SAAF

Outpatient/Ambulatory Health Services (OAHS)					
A	MAI	EHE	B	D	SS
AARC			AARC	AARC	AARC
BEAT		BEAT	BEAT	BEAT	BEAT
Centro			Centro	Centro	
SAAF			SAAF		SAAF
FFACTS			FFACTS	FFACTS	FFACTS
				MCHD	

Referral for Healthcare and Supportive Services					
A	MAI	EHE	B	D	SS
AARC				AARC	AARC
BEAT		BEAT	BEAT	BEAT	BEAT
Centro			Centro		
SAAF			SAAF	SAAF	SAAF
FFACTS			FFACTS	FFACTS	FFACTS

Substance Abuse - Outpatient Care					
A	MAI	EHE	B	D	SS
AARC	AARC	AARC	AARC	AARC	AARC
BEAT	BEAT		BEAT	BEAT	BEAT
FFACTS	FFACTS		FFACTS	FFACTS	FFACTS

University Health

FY22-23 Ryan White Service Category Comparison Chart - All funded Parts as of August 2022

STATE HOPWA			
TBRA	STRMU	PHP	Case Management
AARC	AARC	AARC	AARC

San Antonio Area Ryan White and Operation BRAVE Program(s) Services Basics

University Health

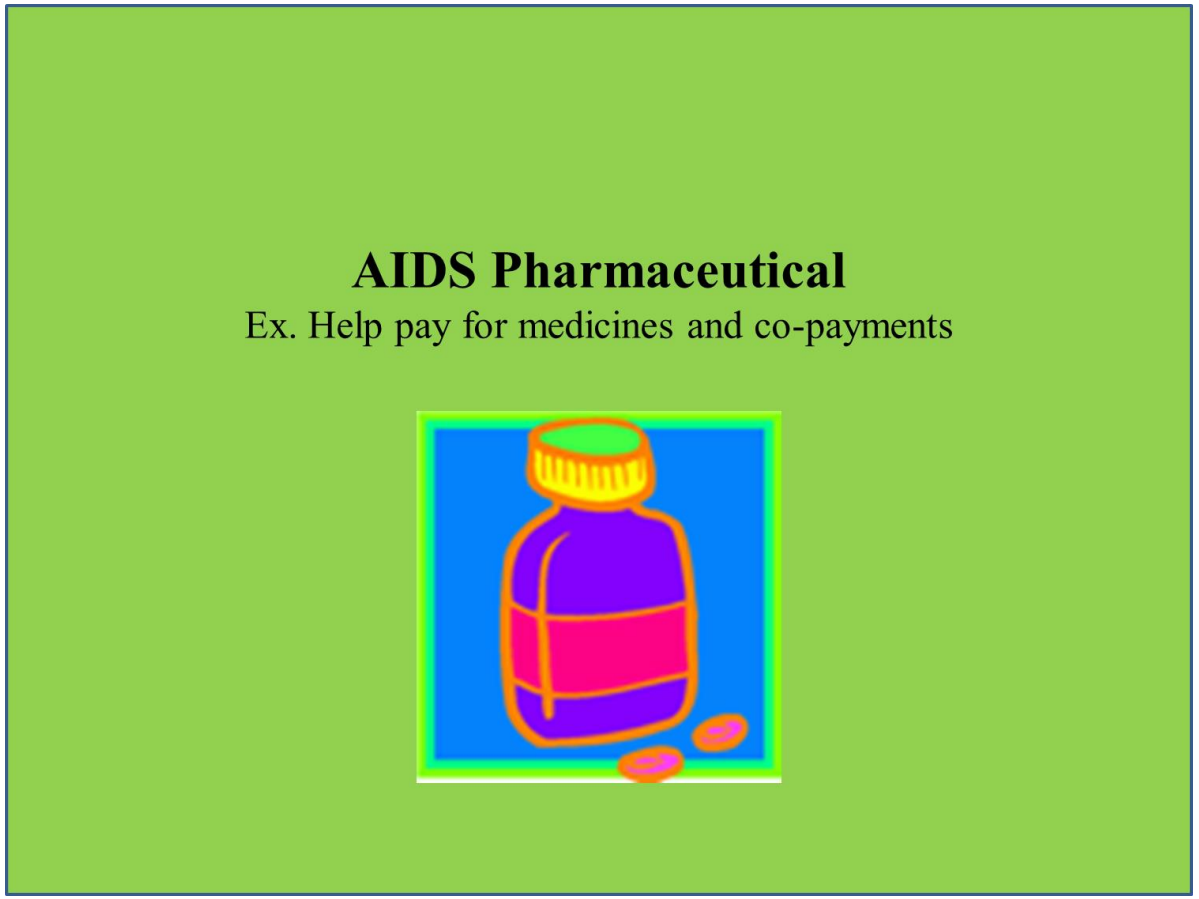
Ryan White Service Categories Descriptions

- The following slides give a brief overview of each of the 16 service categories we fund in San Antonio/Bexar County.
- If you would like more details, please go to www.saplanningcouncil.org and review the most recent version of the Standards of Care.

University Health

AIDS Pharmaceutical Assistance (Local) {LPAP}

Local Pharmaceutical Assistance (LPAP) is operated by a HRSA Ryan White HIV/AIDS Program (RWHAP) (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when a HRSA RWHAP AIDS Drug Assistance Program (ADAP) has a restricted formulary, waiting list, and/or restricted financial eligibility criteria.



LPAPs do not dispense medications as:

- A result or component of a primary medical visit;
- A single occurrence of short duration (an emergency);
- Vouchers to clients on an emergency basis. (Emergency Financial Assistance service category funds should be used for the above situations)

Core Medical Service Category

University Health

Early Intervention Services (EIS)

Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected;
  - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts;
  - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources;
- Referral services to improve HIV care and treatment services at key points of entry;
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

Early Intervention Services

Ex. Targeted testing, referral services, linkage to care, health education and literacy training

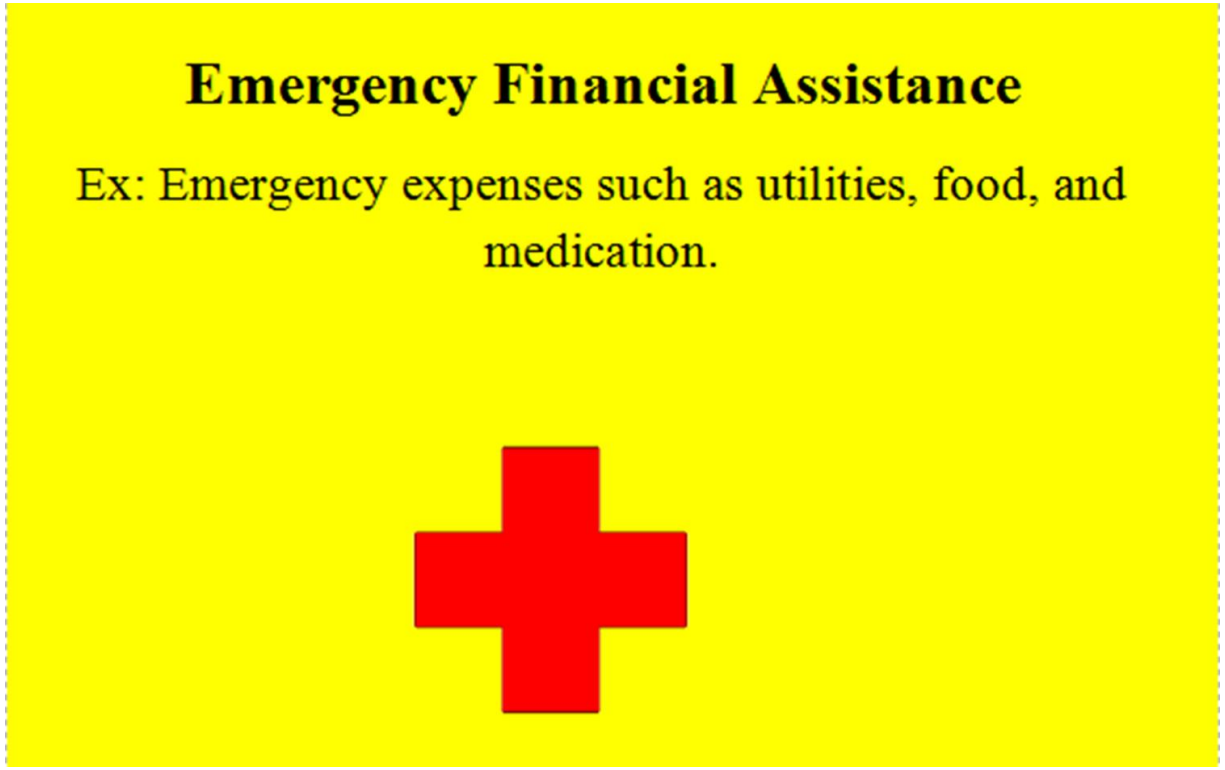
Core Medical Service Category

University Health

Emergency Financial Assistance (EFA)

EFA provides limited **one-time** or **short-term** payments to assist a client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance Program (LPAP), or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency financial assistance must occur as a direct payment to an agency or through a voucher program.

- Can be used during ADAP eligibility determination
- Can be used to reimburse a dispensing fee associated with purchased medications and are not subject to cap
- Essential services/subcategories include
    - Utilities such as gas, electricity, propane, water, and required fees
    - Housing such as rent or temporary shelter (only if HOPWA assistance is NOT available)
    - Food/food vouchers
    - Rx medication assistance as a short-term, one-time assistance



Caps:

- $800/year/client cap

Support Service Category

University Health

Food Bank/Home Delivered Meals (FB)

Food Bank/Home-Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products;
- Household cleaning supplies;
- Water filtration/purification systems in communities where issues of water safety exist.

Includes the provision of actual food, prepared meals, or food vouchers to purchase prepared meals. This category also includes the provision of fruit, vegetables, dairy, canned meat, staples, and personal care products in a food bank setting.

- ***Food Bank***: Food Bank services are the provision of actual food and personal care items in a food bank setting.
- ***On-site/Home-Delivered Meals***: On-site/Home-Delivered Meals are the provision of prepared meals or food vouchers for prepared meals, in either a congregate dining setting or delivered to clients who are homebound and cannot shop for or prepare their own food. This service includes the provision of both frozen and hot meals.

Food Bank

Ex: Food, meals, and vouchers or gift cards to purchase prepared food or meals.

Support Service Category

University Health

Health Insurance Premium And Cost-sharing Assistance (HIPCSA)

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services (OAHS), and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

Caps:

- Part A & MAI
  - The annual cap for Health Insurance is $12,343.05 per calendar year and for stand-alone Oral Health Insurance is $2,500.00.
- Part B
  - The annual cap for Health Insurance is $10,500.00 per calendar year and for stand-alone Oral Health Insurance is $2,500.00.
- Part D
  - The annual cap for Health Insurance is $12,343.05 per calendar year and for stand-alone Oral Health Insurance is $2,500.00.

Health Insurance

Ex: Help paying premium payments, co-payments and deductibles.

Core Medical Service Category

University Health

Housing Services

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Funded under Operation BRAVE only. Please refer to Operation BRAVE Standards of Care for eligibility and services information.

Support Service Category

University Health

Medical Case Management (MCM)

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on ***improving health outcomes*** in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that include other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

- Coordination of medical care – scheduling appointments for various treatments and referrals including labs, screenings, medical specialist appointments, mental health, oral health care and substance abuse treatment
- Follow-up of medical treatments (e.g. accompanying client to medical appointments, calling, emailing, texting or writing letters to clients with respect to various treatments to ensure appointments were kept or rescheduled as needed
- Treatment adherence-the provision of counseling or special programs to ensure readiness for, and adherence to, HIV/AIDS treatment

Medical Case Management

Ex: Medical Case Manager who provides client specific medical coordination, through face to face and phone contact.

Core Medical Service Category

University Health

Medical Nutrition Therapy (MNT)

MNT is individualized dietary instruction that incorporates diet therapy counseling for a nation-related problem. This level of specialized instruction is above basic nutrition counseling and includes an individualized dietary assessment performed by a registered dietitian.

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV OAHS.

Core Medical Service Category

Medical Nutrition Therapy

Ex: Licensed dietitian provides educational counseling for nutrition needs

University Health

Medical Transportation

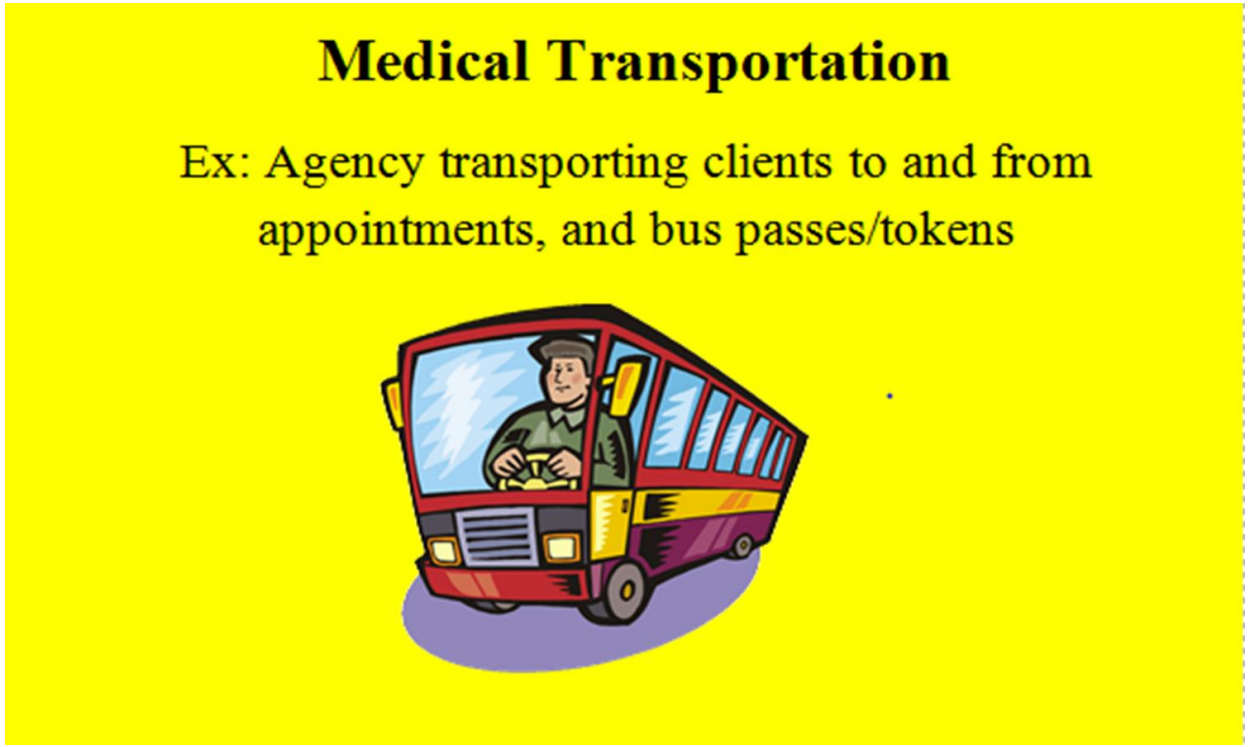
The provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

- To public and private outpatient medical care and physician services
- Case management
- Substance abuse and mental health services
- Pharmacies

Limitations

- No cash payments or cash reimbursements to clients
- Direct maintenance expenses or privately-owned vehicle
- Any other costs associated with privately owned vehicle (i.e. lease, loan payments, insurance, license, or registration fees)
- Cannot transport client in need of emergency medical care

Support Service Category



University Health

Mental Health Services (MH)

The provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licenses or authorized with the state to render such services.

- Mental Health Assessment
- Treatment Planning / Provision
- Individual or conjoin psychotherapy
- Psychiatric medication assessment, Rx and monitoring, and psychotropic medication management
- Drop-In psychotherapy groups
- Emergency/Crisis Intervention

Mental Health Services

Ex: Counseling, therapy, and bereavement support

Core Medical Service Category

University Health

Non-Medical Case Management (NMCM)

The provision of a range of client-centered activities focused on ***improving access to and retention in needed core medical and support services***. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible.

- Advice and assistance in obtaining medical, social, community, legal, financial and other needed services.
- Providing specific services such as housing assistance or transportation are not case management; but identifying and arranging to have that assistance provided is case management.

Non Medical Case Management

Ex: Case manager provides help with community, financial, legal, and social services needed.

Support Service Category

University Health

Oral Health Care (OH)

Oral Health Care provides outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

- Routine dental exams
- Prophylaxes
- Radiographs
- Restorative therapies
- Basic oral surgery (extractions or biopsy)
- Endodontics
- Prosthodontics

Expenditure cap of $3,000/client per calendar year

Limitations: cosmetic dentistry for cosmetic purposes only is prohibited

Core Medical Service Category

University Health

Outpatient Ambulatory Health Services (OAHS)

OAHS are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting (clinics, medical offices, and mobile vans where clients do not stay overnight)

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric development assessment
- Prescription, and management of medication therapy
- Treatment adherence services provided during an OAHS visit
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Outpatient Ambulatory Health Services

Ex: testing, doctor's exam, well baby care, preventive care, screenings, medical history, health assessments

Core Medical Service Category

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Outreach Services

The Outreach Services category has as its principal purpose identifying people living with HIV who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities:

- Identification of people who do not know their HIV status;
- Linkage or re-engagement of people living with HIV who know their status into Ryan White or Operation BRAVE services, including provision of information about health care coverage options.

May include both case finding and consumer recruitment through street outreach. Must be:

- Planned and delivered in coordination with State and local HIV Prevention Program to avoid duplication of effort
- Targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection
- Targeted to communities or local establishments that are frequented by individuals exhibiting high risk behaviors

Support Service Category

Outreach

Ex. Identifying people who do not know their HIV status and linking into OAHS, education, and re-engagement in OAHS

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Referral for Health Care Services (RHCS)

RFHCS directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. May include referrals to assist eligible clients to obtain access to other public or private programs for which they may be eligible.

- Benefits Counseling
- Health Care services

- Clients who do not need case management but require a voucher for a service.
- Needs help with transportation for medical appointments.
- Client requires general financial assistance.
- Client needs referrals for health services.

Support Service Category

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Substance Abuse – Outpatient Services (SA-O)

SA-O is the provision of outpatient services for the treatment of drug or alcohol use disorders.

- Screening
- Assessment
- Diagnosis
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Limitations:

- Funds cannot be used to carry out any program of distributing sterile needles or syringes for hypodermic injection of any illegal drugs.

Core Medical Service Category

Substance Abuse - Outpatient

Ex: counseling and treatment to address alcohol and/or illegal drug abuse

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HIV Care Continuum

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HIV Care Continuum Basics

- The HIV Care Continuum is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body).
- It also shows the proportion of individuals living with HIV who are engaged at each stage.
- By closely examining the proportion of people living with HIV engaged in each stage of the HIV Care Continuum, policymakers and service providers are able to pinpoint where gaps may exist in connecting people living with HIV to sustained, quality care, and to implement system improvements and service enhancements that better support individuals as they move from one stage in the continuum to the next.

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HIV Care Continuum Basics Continued

- The San Antonio Service Delivery Area's HIV Care Continuum has four stages, or bars:
  - Diagnosed with HIV
    - Number of HIV+ individuals (alive) residing in San Antonio at the end of a specific calendar year
  - Linked to Care
    - Number of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) at the end of a specific calendar year.
  - Retained in Care
    - Number of PLWH with at least 2 visits or labs, at least 3 months apart or suppressed at the end of a specific calendar year.
  - Achieved Viral Suppression
    - Number of PLWH whose last viral load test value of the calendar year was <= 200 copies/mL at the end of a specific calendar year.

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HIV Care Continuum Basics Continued

- Per HRSA: The **HIV Care Continuum** is a model that outlines the sequential steps or stages of HIV medical **care** that people living with HIV go through from initial **diagnosis** to achieving the goal of **viral suppression**.

Stage 1	Stage 2	Stage 3	Stage 4
Diagnosed	Linked to Care	Retained in Care/Prescribed ART	Achieve Viral Suppression

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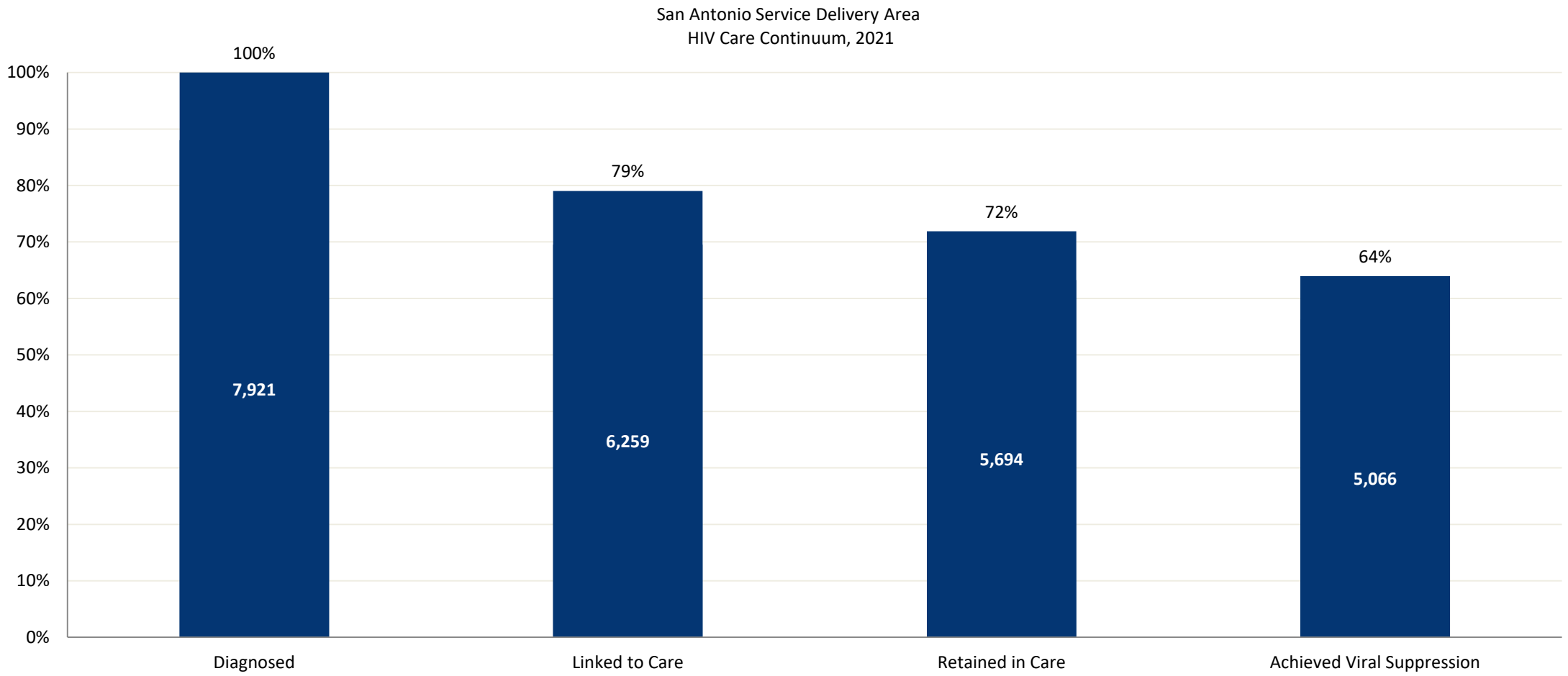
2021 San Antonio Area HIV Care Continuum



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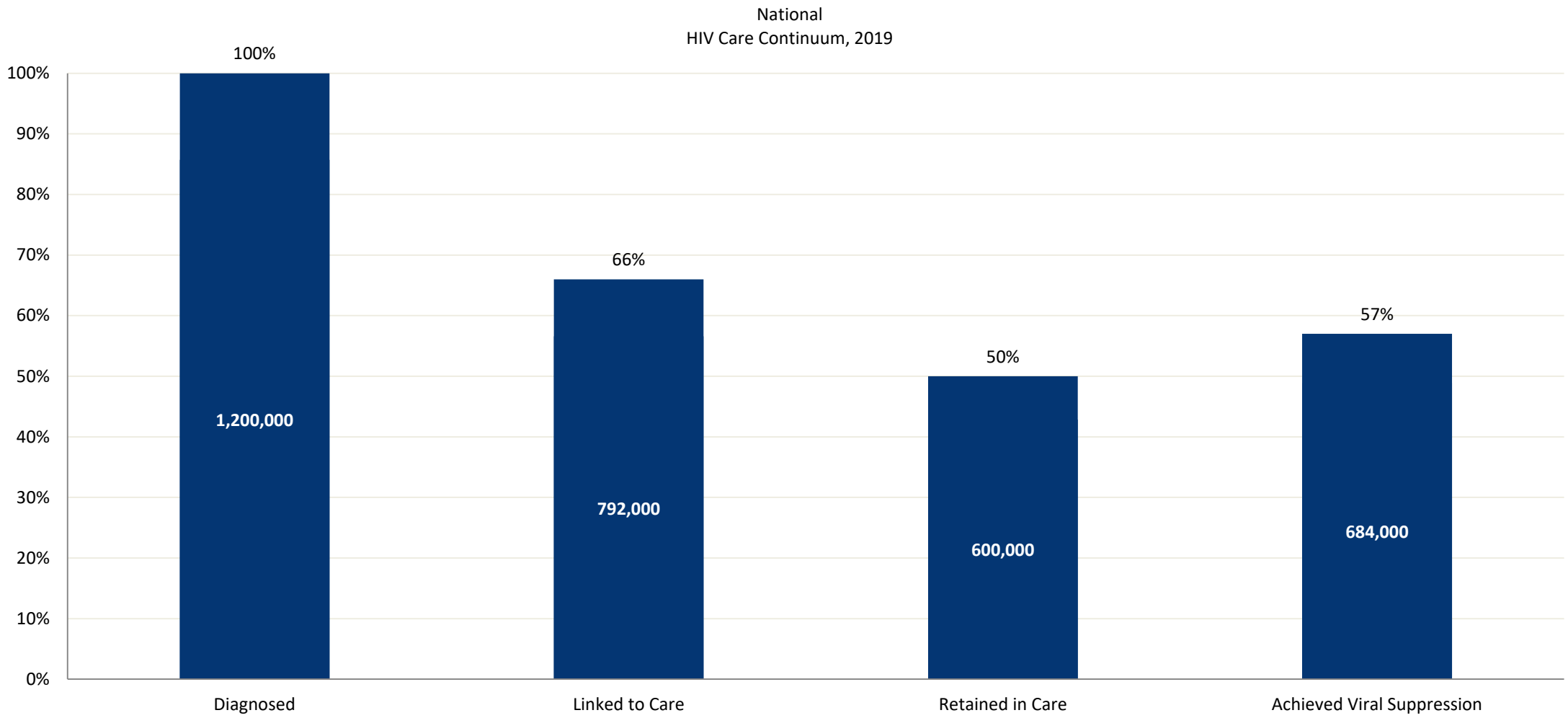
2019 National HIV Care Continuum



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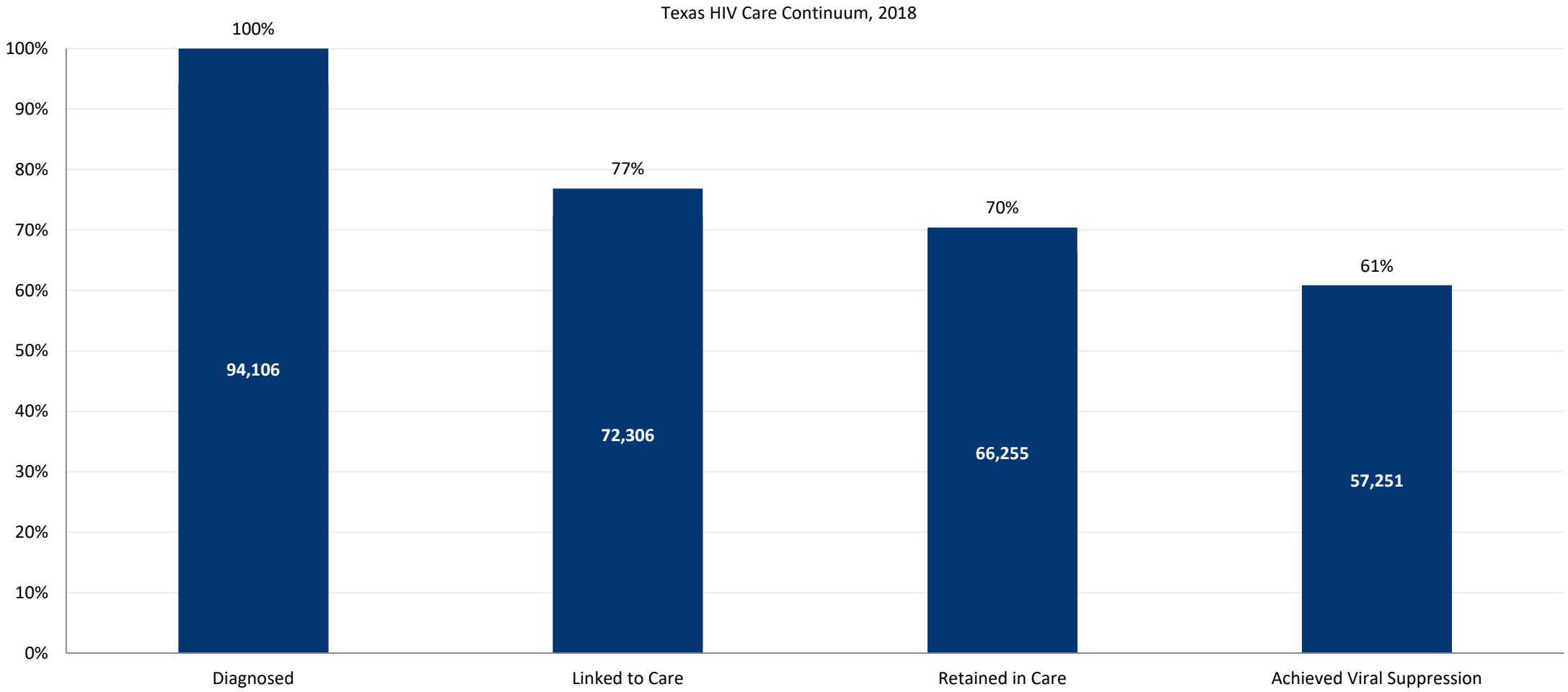
2018 Texas HIV Care Continuum



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San Antonio Area Demographics

Trending Epidemiological Data, 2011-2021

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Demographics Basics

- **Prevalence** : the proportion of cases in the population at a given time; conveys information about the risk of contracting the disease

- **Incidence** : the rate of occurrence of new cases; indicates how widespread the disease is

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Persons Living with HIV in the San Antonio Service Area

Incidence	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
HIV Incidence	349	344	385	339	370	378	374	356	355	308	360
AIDS Incidence	199	168	167	141	148	155	158	149	117	105	136
Total	548	512	552	480	518	533	532	505	472	413	496

Prevalence	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
HIV Prevalence	2070	2225	2463	2628	2907	3096	3255	3413	3652	3931	4133
AIDS Prevalence	2921	3049	3145	3186	3260	3343	3423	3480	3527	3735	3788
Total	4991	5274	5608	5814	6167	6439	6678	6893	7179	7666	7921

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San Antonio Area: HIV Incidence

Race/Ethnicity	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
White, not Hispanic	58	65	66	60	58	59	60	64	46	51	44
African-American, not Hispanic	47	45	51	44	56	41	59	61	56	40	50
Hispanic	226	218	256	220	244	258	237	213	226	205	256
Multi-race	2	4	3	2	7	15	11	15	21	10	8
Other	16	12	9	13	5	5	7	3	6	2	2
Total	349	344	385	339	370	378	374	356	355	308	360

Age at Diagnosis (Years)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<13 years	1	2	0	4	1	1	1	2	0	0	0
13-24 years	94	77	90	105	95	93	73	70	72	75	77
25-34 years	97	109	144	129	135	150	152	134	137	117	129
35-44 years	68	72	62	43	66	65	74	67	76	61	96
45-54 years	62	58	64	42	52	49	36	56	35	30	40
55+ years	27	26	25	16	21	20	38	27	35	25	18
Total	349	344	385	339	370	378	374	356	355	308	360

Gender	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male	298	304	347	291	328	332	328	307	308	261	307
Female	51	40	38	48	42	46	46	49	47	47	53
Total	349	344	385	339	370	378	374	356	355	308	360

Exposure Category	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male-Male Sexual Contact	243	274	296	259	296	290	289	262	266	228	272
Injection Drug Use	30	24	32	24	23	22	21	19	16	26	21
Male-Male Sexual Contact/Injection Drug Use	25	4	15	10	10	17	15	19	28	10	14
Heterosexual	50	40	42	42	40	48	47	54	45	43	53
Perinatal Transmission	1	2	0	4	1	1	2	2	0	1	0
Adult/Other	0	0	0	0	0	0	0	0	0	0	0
Total	349	344	385	339	370	378	374	356	355	308	360

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San Antonio Area: AIDS Incidence

Race/Ethnicity	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
White, not Hispanic	28	36	31	21	31	22	28	27	13	14	11
African-American, not Hispanic	26	25	21	8	29	25	24	14	28	9	14
Hispanic	133	96	107	103	83	105	96	100	71	77	101
Multi-race	1	2	2	0	1	3	7	7	5	3	8
Other	11	9	6	9	4	0	3	1	0	2	2
Total	199	168	167	141	148	155	158	149	117	105	136

Age at Diagnosis (Years)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<13 years	0	0	0	1	0	0	0	0	0	0	0
13-24 years	30	15	12	12	10	21	10	19	6	22	24
25-34 years	55	42	56	45	47	52	54	47	35	33	32
35-44 years	49	39	38	33	44	35	42	35	31	20	47
45-54 years	52	49	41	34	34	28	28	35	19	15	23
55+ years	13	23	20	16	13	19	24	13	26	15	10
Total	199	168	167	141	148	155	158	149	117	105	136

Gender	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male	161	146	144	116	127	133	133	22	100	89	115
Female	38	22	23	25	21	22	25	127	17	16	21
Total	199	168	167	141	148	155	158	149	117	105	136

Exposure Category	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male-Male Sexual Contact	135	124	113	97	102	108	111	102	76	74	98
Injection Drug Use	25	18	21	16	20	18	16	15	11	10	9
Male-Male Sexual Contact/Injection Drug Use	7	4	7	4	7	9	5	8	13	7	7
Heterosexual	31	21	26	22	18	20	26	23	17	14	22
Perinatal Transmission	1	1	0	2	1	0	0	1	0	0	0
Adult/Other	0	0	0	0	0	0	0	0	0	0	0
Total	199	168	167	141	148	155	158	149	117	105	136

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San Antonio Area: HIV Prevalence

Race/Ethnicity	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
White, not Hispanic	552	519	557	601	610	615	620	637	657	707	735
African-American, not Hispanic	372	377	426	446	493	488	517	551	586	596	631
Hispanic	1085	1,233	1,368	1466	1683	1832	1951	2052	2216	2419	2557
Multi-race	32	73	84	86	88	126	130	136	153	171	172
Other	29	23	28	29	33	35	37	37	40	38	38
Total	2070	2225	2463	2628	2907	3096	3255	3413	3652	3931	4133

Age at Diagnosis (Years)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<13 years	19	16	14	15	14	10	10	7	5	5	7
13-24 years	209	219	244	274	295	281	270	247	242	256	250
25-34 years	570	639	714	757	865	961	993	1044	1118	1186	1224
35-44 years	517	546	585	606	650	688	772	810	892	1011	1083
45-54 years	504	532	576	618	650	676	673	685	713	719	741
55+ years	251	273	330	358	433	480	537	620	682	754	828
Total	2070	2225	2463	2628	2907	3096	3255	3413	3652	3931	4133

Gender	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male	1,691	1,832	2,038	2189	2455	2618	2769	2900	3115	3347	3517
Female	379	393	425	439	452	478	486	513	537	584	616
Total	2070	2225	2463	2628	2907	3096	3255	3413	3652	3931	4133

Exposure Category	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male-Male Sexual Contact	1,400	1,526	1,718	1861	2113	2257	2386	2503	2705	2894	3051
Injection Drug Use	198	194	212	225	220	216	229	230	227	245	253
Male-Male Sexual Contact/Injection Drug Use	99	97	97	101	114	144	154	161	175	198	196
Heterosexual	349	380	405	407	431	451	456	488	518	562	596
Perinatal Transmission	23	26	29	32	28	27	29	30	26	31	36
Adult/Other	1	2	2	2	1	1	1	1	1	1	1
Total	2070	2225	2463	2628	2907	3096	3255	3413	3652	3931	4133

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San Antonio Area: AIDS Prevalence

Race/Ethnicity	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
White, not Hispanic	756	712	716	698	681	661	660	692	681	725	731
African-American, not Hispanic	414	422	429	430	462	453	469	471	499	479	490
Hispanic	1,684	1,811	1,891	1945	2000	2095	2147	2172	2199	2362	2391
Multi-race	50	89	92	97	100	119	128	123	127	146	149
Other	17	15	17	16	17	15	19	22	21	23	27
Total	2921	3049	3145	3186	3260	3343	3423	3480	3527	3735	3788

Age at Diagnosis (Years)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<13 years	1	1	1	2	2	1	1	1	1	1	1
13-24 years	69	73	69	58	58	59	43	41	36	43	31
25-34 years	329	338	365	370	389	405	420	416	399	404	385
35-44 years	757	736	720	659	643	640	665	654	633	654	683
45-54 years	1,176	1,241	1,254	1273	1253	1190	1148	1113	1040	1013	961
55+ years	589	660	736	824	915	1048	1146	1255	1418	1620	1727
Total	2921	3049	3145	3186	3260	3343	3423	3480	3527	3735	3788

Gender	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male	2,479	2601	2691	2730	2785	2861	2926	2978	3010	3191	3220
Female	442	448	454	456	475	482	497	502	517	544	568
Total	2921	3049	3145	3186	3260	3343	3423	3480	3527	3735	3788

Exposure Category	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male-Male Sexual Contact	1,911	2,022	2,101	2146	2193	2256	2304	2355	2386	2519	2549
Injection Drug Use	346	348	346	342	341	325	332	322	316	338	336
Male-Male Sexual Contact/Injection Drug Use	176	180	176	172	177	217	230	233	236	251	252
Heterosexual	462	473	496	496	516	511	525	537	556	594	620
Perinatal Transmission	16	15	16	20	24	26	24	25	26	25	23
Adult/Other	10	11	10	10	9	8	8	8	7	8	8
Total	2921	3049	3145	3186	3260	3343	3423	3480	3527	3735	3788

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Nationwide Demographics

2019 Data

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Nationwide Demographics

- In 2019, there were approximately 1,200,000 people living with HIV (Prevalence) in the U.S.
- In 2019, 36,801 people were newly diagnosed with HIV.
- Gay, bisexual and other men who have sex with men (MSM) are the population most affected by HIV in the U.S. In 2019:
  - MSM accounted for 69% of the 36,801 new HIV diagnoses in the United States.
  - Black/African American MSM accounted for 26% (9,123) of new HIV diagnoses and 37.9% of diagnoses among all MSM.
  - Hispanic/Latino MSM made up 22% (7,820) of new HIV diagnoses and 32.5% of diagnoses among all MSM.

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Living with HIV (Prevalence)

- According to current CDC data, about 13% of people with HIV in the U.S. don't know it and so need testing. Early HIV diagnosis is crucial. Everyone aged 13-64 should be tested at least once. People at higher risk of acquiring (or exposure to) HIV should be tested at least annually. Sexually active gay and bisexual men may benefit from more frequent testing (e.g., every 3-6 months).
- According to another CDC report, of the estimated 1.2 million people with HIV (diagnosed and undiagnosed) in 2019, about 65.9% **received some HIV care**, 50.1% **were retained in care**, and 56.8% **were virally suppressed** or **undetectable**. Having a suppressed or undetectable viral load protects the health of a person living with HIV, preventing disease progression. There is also a major prevention benefit. A person living with HIV who takes HIV medicine daily as prescribed and gets and stays virally suppressed can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

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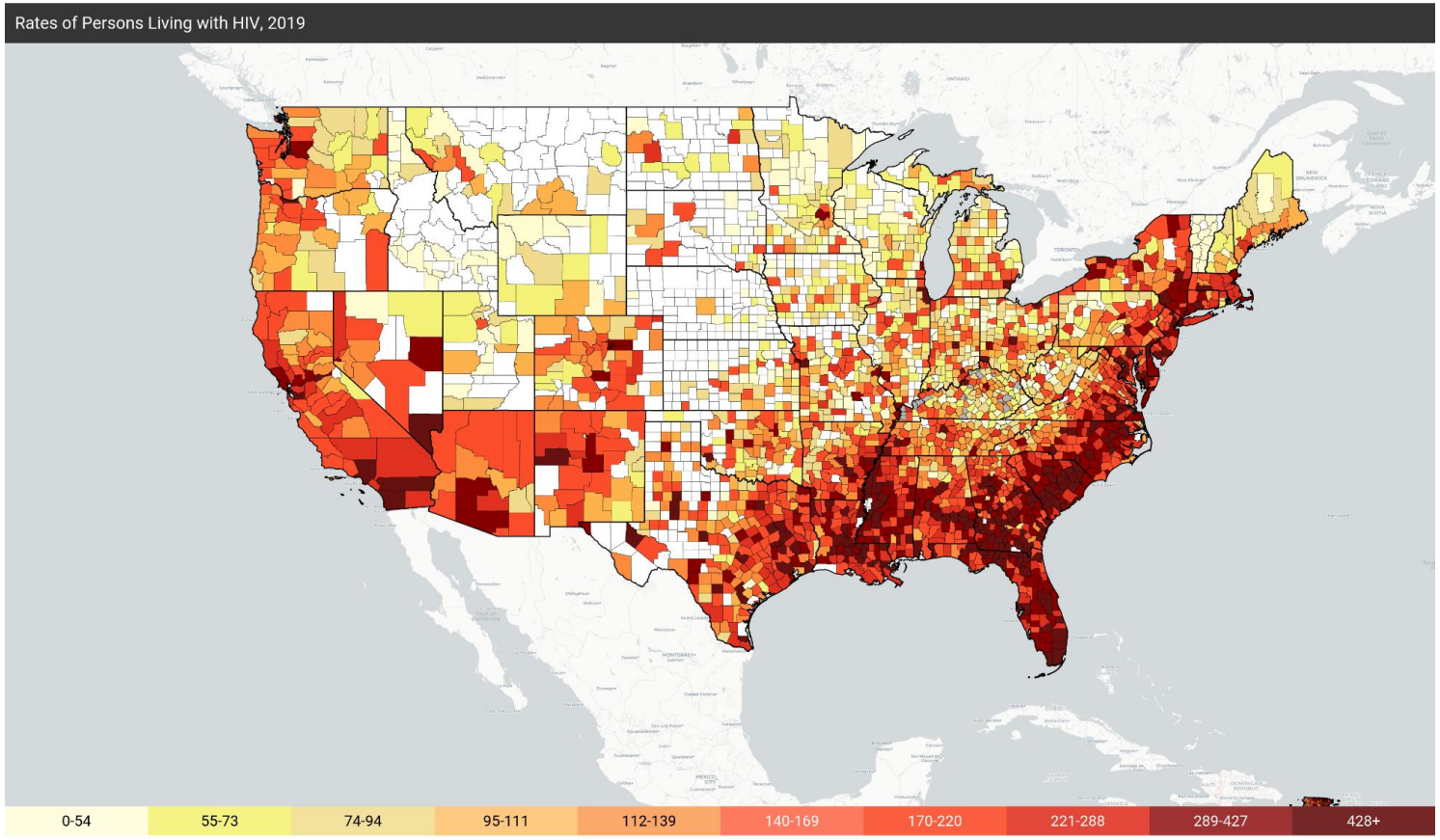
Nationwide Prevalence 2019

AIDSVu



* Data not shown to protect privacy because of a small number of cases and/or a small population.

** State health department, per its HIV data re-release agreement with CDC, requested not to release data to AIDSVu. See Data Methods for more information.

NOTE: There are no county-level maps for Alaska. District of Columbia, and Puerto Rico because there are no counties in these states.

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Key Points: HIV Incidence

- HIV incidence **declined** 8% from 2015 to 2019. In 2019, the estimated number of HIV infections in the U.S. was 34,800 and the rate was 12.6 (per 100,000 people).
- **By age group**, the annual number of HIV infections in 2019, compared with 2015, decreased among persons aged 13–24 and persons aged 45-54, but remained stable among all other age groups. In 2019, the rate was highest for persons aged 25-34 (30.1), followed by the rate for persons aged 35-44 (16.5).
- **By race/ethnicity**, the annual number of HIV infections in 2019, compared with 2015, decreased among persons of multiple races, but remained stable for persons of all other races/ethnicities. In 2019, the highest rate was for Blacks/African American persons (42.1), followed by Hispanic/Latino persons (21.7) and persons of multiple races (18.4).
- **By sex at birth**, the annual number of new HIV infections in 2019, as compared to 2015, decreased among males, but remained stable among females. In 2019, the rate for males (21.0) was 5 times the rate for females (4.5).
- **By HIV transmission category**, the annual number of HIV infections in 2019, compared with 2015, decreased among males with transmission attributed to male-to-male sexual contact, but remained stable among all other transmission categories. In 2019, the largest percentages of HIV infections were attributed to male-to-male sexual contact (66% overall and 81% among males.)

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Key Points: HIV Incidence Continued

- Blacks/African Americans and Hispanics/Latinx continue to be severely and disproportionately affected by HIV:
  - In 2019, Blacks/African Americans represented 13% of the U.S. population but accounted for 44% of new HIV diagnoses.
  - In 2019, Hispanics/Latino represented 18% of the U.S. population but accounted for 30% of new HIV diagnoses.
  - From 2015-2019, the number of HIV diagnoses decreased among Black/African American, white, and Asian persons, and persons of multiple races. HIV diagnoses increased among American Indian/Alaska Natives, and remained stable among Hispanic/Latinos and Native Americans/other Pacific Islander persons.

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Texas Demographics

2018 Data

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Texans Living with HIV in 2018 (Prevalence)

- As of the end of 2018, over 94,000 Texans were living with a diagnosed HIV infection. The number of people living with HIV (PLWH) increased by 16% over the past 5 years, but this is not due to increases in the annual number of Texans getting diagnosed. The number of Texans diagnosed each year has been flat over the last decade at about 4,500.
- The profile of Texans living with HIV in 2018 shows:
  - Almost four out of five PLWH were male;
  - About 1% identified as transgender women;
  - About 7 out of 10 of the PLWH were Black or Hispanic;
  - About half of the PLWH were 45 or older;
  - About three out of five were gay and bisexual men or other men who have sex with men (MSM);
  - About half of all Texas PLWH lived in the Dallas and Houston areas; and that
  - Black Texans and MSM were disproportionately affected by HIV.

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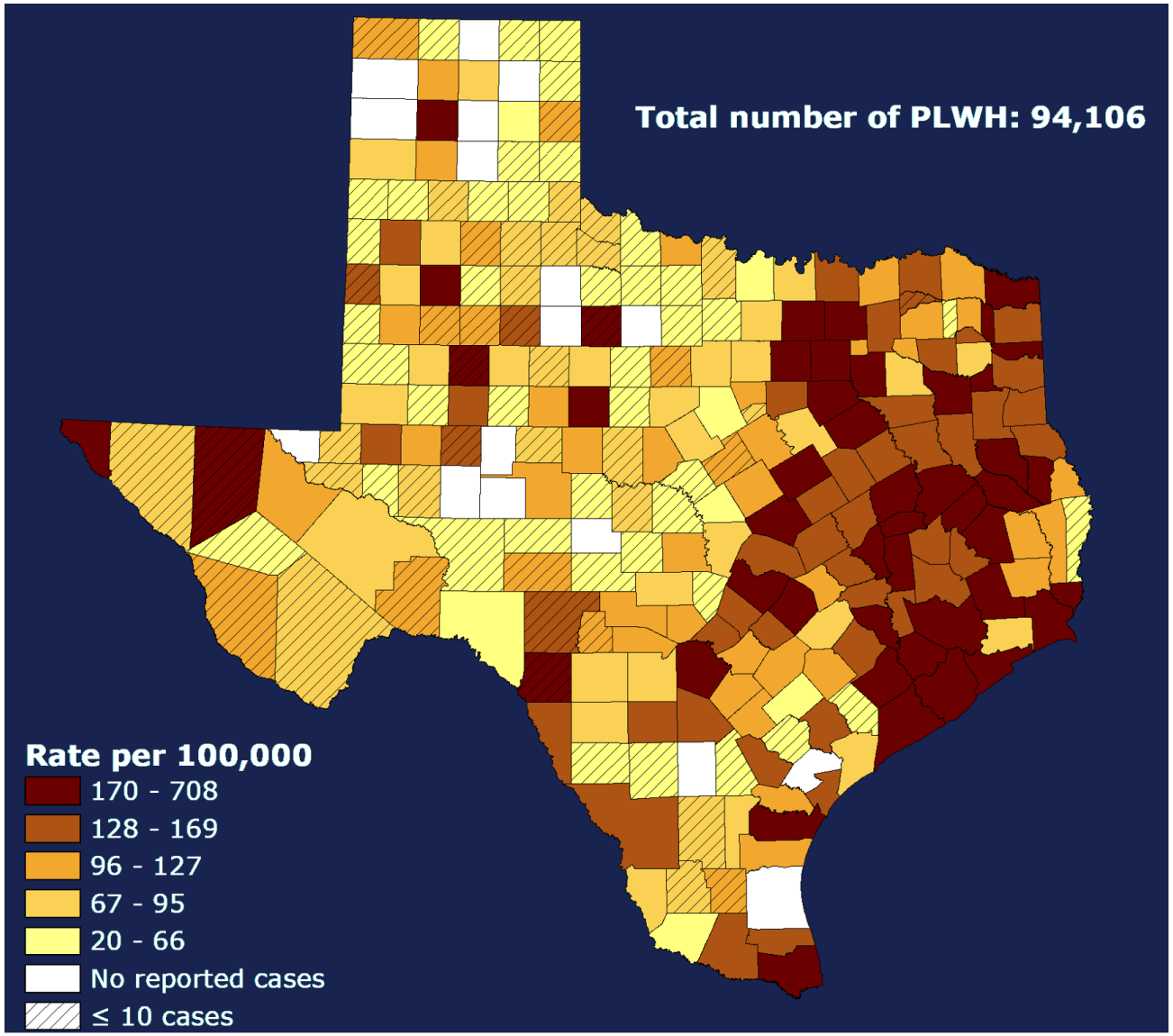
Texas Prevalence 2018



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Key Points: HIV Incidence

- Rates of new HIV diagnoses have slightly decreased from 17.7/100,000 in 2009 to 15.7/100,000 in 2018
- **Rates of new HIV diagnoses are highest among males (26.0/100,000), Blacks (46.0/100,000), and those between 25 and 29 years of age (45.2/100,000)**
- Between 2009 and 2018, the proportion of new HIV diagnoses increased for Hispanic MSM, from 23.6% to 30.3%
- Within the last ten years, among those newly diagnosed with HIV, **the proportion of those with a late diagnoses (3 months between HIV diagnosis and AIDS**) has declined from 29.1% in 2009 to 19.9% in 2018
- **Over half (61%) of people living with HIV (PLWH) acquired it through male-male sexual contact.**
- **By 2018, over half of PLWH were 45 years of age or older**
- Between 2009 and 2018, the total number of PLWH increased by 46% and proportion of PLWH within priority populations increased by 6.1%
- A majority of people living with HIV live in urban areas of Texas; The counties with the largest numbers of PLWH were Harris and Dallas, followed by Bexar, Travis, and Tarrant counties

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Questions?

Thank you for attending today's presentation. Please make sure to put your name, title, agency, and email information in the chat box. This will ensure we are able to send you a copy of today's slides and any follow-up information, as well as report attendance information to HRSA and DSHS.

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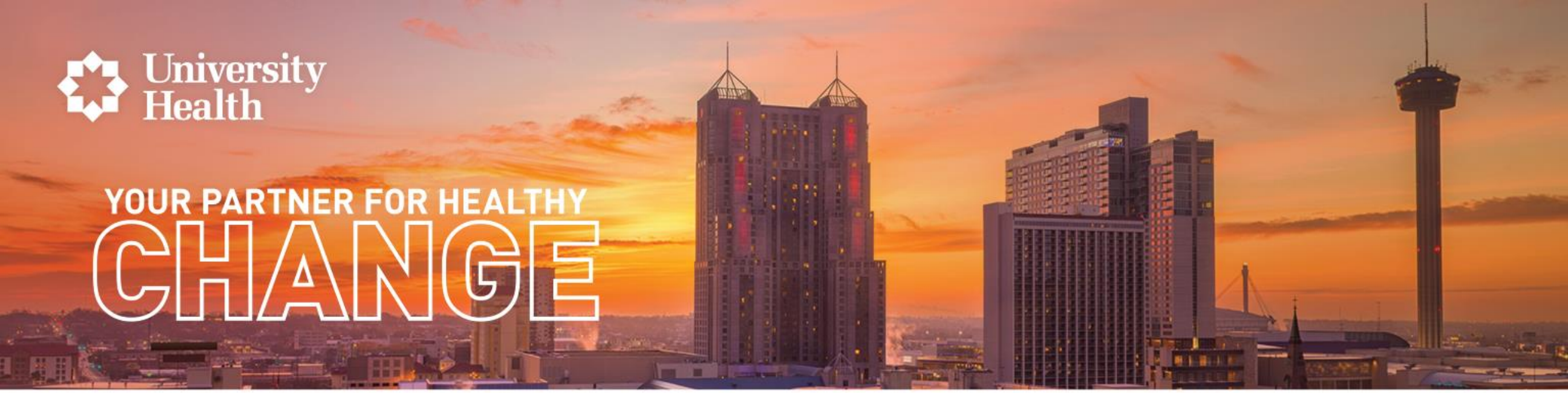

Ryan White and Operation BRAVE Programs Administration Overview (101)

Updated: February 9, 2023