Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

EXECUTIVE OPERATIONS COMMITTEE
MEETING MINUTES

THURSDAY, NOVEMBER 29, 2018 – 5:00PM TO 6:00PM

ONE JUDICIARY SQUARE – 441 4TH ST. 11 FLOOR; WASHINGTON, DC 20002

ATTENDEES/ROLL CALL					
COMMISSIONERS	PRESENT	ABSENT	COMMISSIONERS	PRESENT	ABSENT
Clay, Cyndee	X				
Hickson, DeMarc	X				
Massie, Jenné		X			
Morse, Kaleef	X				
Padmore, Gerald		X			
Zoerkler, Jennifer	X				
ADMINISTRATIVE AGENT REPRESENTATIVES	PRESENT	ABSENT	ADMINISTRATIVE AGENT REPRESENTATIVES	PRESENT	ABSENT
Avellanet, Felix	X		Barnes, Clover	X	
Barmer, David		X			
Hayes-Cozier, Ravinia	X				
Moore, Tarsha	X				
HAHSTA STAFF	PRESENT	ABSENT	COMMISSION STAFF	PRESENT	ABSENT
			Bailey, Patrice	X	
			Clark, Lamont	X	

HIGHLIGHTS

AGENDA

Item	Discussion
Call to Order	Kaleef Morse called the meeting to order at 5:30 pm, followed by a moment of silence and introductions.
Review and Approval of the Agenda	N/A

Review and Approval of the Minutes	N/A
Ryan White HIV/AIDS Program (RWHAP) Updates/Concerns	*Suburban Maryland* Ravinia Hayes-Cozier reported no concerns. *Northern Virginia* Felix Avellanet reported no concerns. *DC and West Virginia Administrative Agent* Clover Barnes reported no concerns in DC or West Virginia. *Recipient* Clover B. reported receiving an award for over $1,000,000 in Minority AIDS Initiative (MAI) carryover money and she will submit a motion to reprogram funds from DC and the Unit Based Cost funds into other DC and EMA wide services. The Recipient motioned to reallocate $8,486,335 awarded in Fee for Service (FFS) and $734,491 awarded to DC to the following: Substance Abuse Outpatient Services by purchasing Narcan to address the opioid epidemic based on information given by providers that want more Narcan than what's currently provided, and epidemiological presentations about the opioid epidemic given by the various health departments in the region. Training in administering Narcan Intranasal Spray can be obtained by the HAHSTA, Targeted Testing Coordinator, twice a month. A stand-alone dental program based on recent information issued by Health Resources and Services Administration (HRSA). Co-pay assistance that is different from the premiums that are paid by AIDS Drugs Assistance Program (ADAP). Impact Specialist (Community Health Workers). Extend their term of employment by six (6) months and add 6 additional specialist to the cohort that is starting. Early Intervention Services (EIS) pilot to start Rapid Anti-Retroviral Therapy (ART), introduced at the Grantee Forum by the Chief Medical Officer. The Recipient further proposes to use MAI money to create a pilot youth focused housing program for the Eligible Metropolitan Area (EMA), based on Housing Opportunities for Persons With AIDS (HOPWA) data, which covers the Eligible Metropolitan Statistical Area (EMSA), needs assessment data, waitlist information, client documentation for who needs housing, where and when, and information received from MAI providers.

	Cyndee Clay seconded the motion presented by the Recipient. The motion was voted on and approved with one (1) abstention.
Commission Administrative Business	Kaleef M. called for an Executive Session.
HANDOUTS	
• Executive Operations Committee Agenda • Executive Operations Committee Minutes for July, August, September and October	

MEETING ADJOURNED	6:10 PM
NEXT MEETING	December 20, 2018 5PM-6PM Judiciary Square – Citywide Conference Center 441 4th St. NW; 11th Floor Washington, DC 20001

I, as Planning Commission Government Co-Chair, hereby certify the accuracy of the above minutes:	
Signature of: ***Kaleef Stanton Morse, MHS*** ***Government Co-Chair***	***Date:***
Date the Minutes were approved by the Executive Operations Committee:	

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EXECUTIVE OPERATIONS COMMITTEE (EOC) MEETING AGENDA

THURSDAY, NOVEMBER 29, 2018 – 5:00PM TO 6:00PM

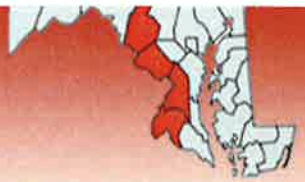
JUDICIARY SQUARE – CITYWIDE CONFERENCE CENTER
441 4TH STREET, NW; 11TH FLOOR; WASHINGTON, DC 20001

Note: all times are approximate

5:00pm	**1. Call To Order, Moment of Silence, and Roll Call** **2. Welcome and Introductions**
5:05 pm	**3. Ryan White HIV/AIDS Program (RWHAP) - Updates/Concerns** • *Suburban Maryland Administrative Agent* • *Northern Virginia Administrative Agent* • *DC and West Virginia Administrative Agent* • *Recipient*
5:20 pm	**4. Commission Administrative Business** • *Review and Approval of COHAH Meeting Agenda for November 29, 2018* • *Review Bylaws revision* • *Need for 2 Commissioners to be voted onto EOC – Elections in November* • *Discussion around extending the COHAH meetings.* • *Recipient Motion – Reprogramming Request*
5:35 pm	**5. Standing Committee Updates** • *Research & Evaluation Committee (REC) {Next mtg.: Tue. Dec. 18th at 3pm}* • *Integrated Strategies Committee (ISC) {Next mtg.: Wed. Dec. 19th at 4pm}* • *Community Engagement & Education Committee (CEEC) {Next mtg.: Thu. Dec. 6th at 5pm}* • *Comprehensive Planning Committee (CPC) {Next mtg.: Wed. Dec. 19th at 3pm}*
5:45 pm	**6. Old Business** **7. New Business**
5:50 pm	**8. Announcements and Adjournment**

NEXT EXECUTIVE OPERATIONS COMMITTEE (EOC) MEETING:	**THURSDAY DECEMBER 20, 2018** **5PM-6PM** **JUDICIARY SQUARE – CITYWIDE CONFERENCE CENTER** **441 4TH ST. NW; 11TH FLOOR** **WASHINGTON, DC 20001**

Suburban Maryland Ryan White Part A



Date: November 26, 2018

To: Comprehensive Planning Committee

From: Suburban Maryland Ryan White Part A
Re: Fiscal Narrative Report (Part A and Part A MAI Funding)
Year 28 - Reporting Period: September 1 thru September 30, 2018

Available Funding / Status of Contracts / Implementation Progress

This Suburban Maryland report represents expenses for September 2018, 9 of 9 invoices have been received and are being processed. All contracts for this period have been processed and approved and payments have been rendered. The expenditure percentages below reflect funds from our first grant award.

Fiscal Summary

In September 2018, financial report submission includes expenses from 9 of our 9 sub recipients. Our overall expense at the end of September is 49.8% and should be 58.3%

Part A expenditures are 47.8 % and should be 58.3%. (Overall Expenditure rates by funding source for the reporting period). "Suburban Maryland received an additional 1,094,819 in Medical Case Management during the month of September. We anticipate the underspent expenditure percentage rate to level off during the course of the next couple of months as the MCM dollars have now been placed into the agencies budget.

Service areas affected by unprocessed invoices (N/A)

Services 30% below expected:

Linguistic Services: (Utilized as needed), however agencies have many different resources for linguistic services in the state. We will utilize some of the funds for bilingual materials and information sharing through mass media.

Services 30% above expected: None

Part A MAI expenditures are 55.6% and should be 58.3%. (Overall Expenditure rates by funding source for the reporting period)

Service areas affected by unprocessed invoices (N/A)

Services 30% below expected: None

Services 30% above expected: None

Northern Virginia Regional Commission
3040 Williams Drive, Suite 200, Fairfax, VA 22031
703/642-0700

Date: November 28, 2018

To: Comprehensive Planning Committee

From: Northern Virginia Regional Commission

Re: Fiscal Narrative Report (Part A and Part A MAI Funding)
Year 28 - Reporting Period: September 01, 2018-
September 30, 2018

Available Funding / Status of Contracts / Implementation Progress

Sub-recipient initial awards based on the first and second partial awards were made, and the Schedules were finalized. The Sub-recipient Part A awards based on the Final award received from HAHSTA have been made and the Schedules have been finalized and the fully executed contracts have been issued to the Sub-recipients. Services were implemented March 1, 2018.

Challenges to Service Delivery: None noted.

Fiscal Summary:

Overall spending thru September is at 39.6% for Part A and 70.7% for MAI of the full 12-month award.
Part A spending is at or near target for Early Intervention Services, Health Insurance co-pays, Legal Services, and Outreach. Spending is higher than expected in Linguistic services. Spending is much lower than expected in EFA and Medical Transportation. One of our Medical transportation provider transitioned from using yellow cabs to primarily using Lyft for some cost savings and also spent down other sources of funds ahead of Part A. EFA funds have been used for medicine but not reported in this month. EFA food vouchers will be purchased in December by the providers as the stockpiled food vouchers are now depleting. EFA spending increased in the months of August and September since the expansion of EFA in August to include the remainder of the allowable types of EFA (e.g. everything except food and prescription drugs).

The MAI June through September expenses have now been billed to HAHSTA after receiving revised budgets and invoices from the MAI provider, as a result of the actions taken by the MAI provider to resolve the corrective action plan that was in place. NVRC staff reviewed the revised material and disallowed Early Intervention and Psychosocial services expenses for the months of March through September as there were no service delivery reported in CAREWare. EIS-like services are being offered through other sources of funding for MAI clients by the provider and a copy of the service delivery report has been requested to be submitted to NVRC for the MAI clients on a monthly basis. The disallowance of EIS and Psychosocial support services will free up about $40,087 allocated to these services and will be reprogrammed to Mental Health and Substance Abuse services as these services are spending ahead of target.

MAI spending is at or near target for Medical Case Management and Linguistic Services. MAI spending is higher than expected in Ambulatory Outpatient Medical Care, Mental Health Services and Substance Abuse services. Ambulatory Outpatient Medical care is temporarily being sustained by Part B funds and will not need any reprogramming of funds at this time.

Date: **November 27, 2018**

To: **Fiscal Oversight and Allocations Committee**

From: **DC (Grantee)**

Re: **Fiscal Narrative Report (Part A and Part A MAI Funding)**
Year 28 - Reporting Period: September

Available Funding / Status of Contracts/Implementation Progress

The District of Columbia and West Virginia will report expenses through September 01, 2018 through September 31, 2018. For the month of September (12) of (12) invoices have been received. Due to the end of DC's fiscal year, all outstanding invoices were processed through September.

Challenges to Service Delivery

Since the fiscal year closed September 30, 2018, there were additional provider modifications and resubmissions of invoices, which have ensured that we have fully processed and paid all outstanding costs through the first seven months of the grant. Any delays that did arise were reconciled during our accrual period.

Fiscal Summary

Service areas affected by unprocessed invoices

N/A

District of Columbia Part A expenditures are 46.7% and should be 58.3%. (Overall Expenditure rates by funding source for the reporting period)

Services 30% below expected

Early Intervention Services
Other Professional Services
Medical Transportation
Psychosocial Support Services

Services 30% above expected

N/A

District of Columbia Part A MAI expenditures are 55.6% and should be 58.3%. (Overall Expenditure rates by funding source for the reporting period)

Services 30% below expected

Other Professional Services

Services 30% above expected

N/A

West Virginia Part A expenditures are 54.4% and should be 58.3%. (Overall Expenditure rates by funding source for the reporting period)

Service areas affected by unprocessed invoices

N/A

Services 30% below expected

N/A

Services 30% above expected

N/A

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
HIV/AIDS, Hepatitis, STD, and TB
Administration

RECIPIENT REPORT

October 24, 2018

To: Comprehensive Planning Committee (CPC)

From: Ryan White Recipient Staff

Re: Monthly Recipient Report

Attached are the monthly fiscal reports for Grant Year 28 (March 1, 2018 - February 28, 2019). This report is based on the allocations of funds by jurisdiction, sub-part (Part A and Part A MAI) and service categories developed by the Recipient from information provided by the former RW Planning Council.

Part A and Part A MAI. The Ryan White HIV/AIDS Program (RWHAP) Part A Grant Year 28 includes two components: Part A and Part A Minority AIDS Initiative (MAI). These reports are designed to report distinctly on the associated program activities. The final RWHAP Part A Grant award for Year 28 was received on May 22, 2018. The total Part A award for Grant Year 28 is **$32,068,315**.

Notes on Overview. The fiscal spreadsheets list the service categories by Part and jurisdiction, and identifies the reported expenditure as a proportion of expected-to-date. The Planning Council has requested an explanation of those service categories with a discrepancy greater than 30%.

Regional Services *(Unit Based Costs)*. All vendors with unit based costs contracts in GY 27 have executed option year contracts for GY 28. Expenditures through August 2018 are reflected in the EMA wide fiscal roll up. Overall expenditures for UBC are at 74.2% through August 2018 and is expected to be 50%. Substance abuse is lower than expected due to underutilization and billing. Food Bank/Home Delivered Meals is higher than expected due to high utilization. An increase for this service category is in process, awaiting approval through the DC Office of Contracts and Procurement. A new solicitation for entrance into the RW Provider Network for Regional Services closed in September. Evaluation of that submission is underway and results are expected to be released at the end of October.

Note. The amounts in the current column reflect the amount of funds that are loaded to current vendor contracts. All funding available for unit-based costs will not be awarded at this time because a portion of those funds are earmarked for the new solicitation, additionally funds are added to contracts based on utilization and expenditure rates.

1. **HRSA Site Visit**. The DC EMA is currently scheduled for a comprehensive site visit May 21-24, 2019.

The schedule for quarterly utilization reports

Quarter	Months	To be Reported
First	March – May	July 2018
Second	June -- August	October 2018
Third	September – November	January 2019
Fourth	December – February	April 2019

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MOTION FORM

***Instructions:** The Committee Chair or another Commissioner making a motion for consideration by the Planning Commission shall complete this form and submit it to Planning Commission staff.*

Standing Committee of Origin:	CPC	**Date Moved:**	
Motion Made By:			
Subject:	***Reprogramming Request***		

MOTION STATUS			**AYES**	**NAYES**	**ABST.**	**DATE OF VOTE:**	**CHAIR SIGNATURE:**
Committee:	☐ **Passed**	☐ **Failed**					
EOC Action:	☐ **Passed**	☐ **Failed**					
COHAH Action:	☐ **Passed**	☐ **Failed**					
Documents Attached:							

1. Text of the motion:

The Recipient proposes to reprogram funds from DC and UBC into Substance Abuse Outpatient, HIPCSA, Outreach, EIS and MAI. Substance Abuse Outpatient - Narcan kits would be purchased for dissemination to any RW funded provider within the EMA. Any provider receiving Narcan kits will be required to attend a free training class provided by HAHSTA and document its use in CareWare. Narcan, or naloxone, is a medication used to block the effects of opioids and is used to prevent death by overdose. **Request - $4.5M.** HIPCSA – funds would be used to increase copay assistance already provided by ADAP as well as cover standalone dental premiums for eligible clients across the EMA. ADAP cannot pay premiums for standalone dental programs, per Ryan White regulations. Premiums are paid through Ramsell, the pharmacy benefits manager for ADAP. DC has created a process to approve requests from other jurisdictions by MD/VA/WVa by verifying enrollment in home jurisdiction ADAP program to reduce the burden for clients. **Request - $2M.** Outreach – IMPACT Specialists are gay men and transgender men and women who are hired as staff at the health department and imbedded in organizations throughout the EMA for 6 months. The activities done by the IMPACT specialists at their assigned organization include outreach, case management assistance (CHW), navigation, and linkage to care. Each IMPACT specialist is training and paid for by DC Health. RW Part A would increase the length of time the most recent cohort is employed, from 6 months to 12 months as well as allow for 6 additional IMPACT specialists to be hired in the following cohort. **Request - $300,000.** EIS – A Rapid ART pilot in DC to treat newly diagnosed clients with ART immediately at diagnosis. Protocol includes 0.3FTE physician, 1.0 FTE Linkage to Care Coordinator, 1.0 FTE LPC/LICSW. Please see attached protocol. Meetings scheduled for January to inform and gauge interest from other providers around the EMA implement a Rapid ART program. **Request - $730,000, DC Funds**. MAI – Carryover funds were received from HRSA in early November 2018. The Recipient requests to use these funds to create an EMA wide youth focused housing program. **Request $1M.**

HWC Rapid ART Policy and Procedures

Introduction

Rapid ART at the Health and Wellness Center is an attempt to achieve the goals of the 90/90/90/50 plan -- 90% of DC residents knowing their status, 90% of HIV positive DC residents in treatment, 90% of those with HIV reaching viral load suppression, and 50% of reduction in new HIV diagnosis. Rapid ART is paired with immediate linkage to HIV care and initiation of ART at the time of HIV diagnosis. The potential benefits of rapid ART are: 1) Improving individual patient health by decreasing the time to virologic suppression and 2) Improving rates of early engagement and possibly long-term in retention in care.

This document is intended to provide both a public health rationale for rapid ART and serve as a practical guide for medical, counseling, and care planning for those within the Health and Wellness Clinic.

Background of Rapid ART

National and District guidelines currently recommend universal ART (ART initiation for all HIV-infected patients regardless of CD4 count) (1) . The main rationale for rapid initiation of ART is the health benefit to HIV-infected individuals conferred by immediate ART. Rapid start on ART also may confer a community level public health benefit by reducing HIV transmission.

With regards to the individual patient, there are increasing data showing that there may be direct benefits to the individual patient if ART is initiated as soon as possible, particularly during acute/early HIV infection. This means not waiting between HIV diagnosis and start antiretroviral therapy. It should be noted that initiating ART later in chronic HIV infection is associated with dampened CD4+ T cell recovery. In one study, 25% of patients who start ART at CD4+ T cell counts 500 cells/mm3 even after >7 years of suppressive ART (2). Not restoring a normal CD4 T cell count in the setting of ART is associated with an increased risk of AIDS and non-AIDS related complication, with the risk persisting even with restoration of CD4 T cell counts above 500 cells/mm (3,4).
In addition, initiating ART during acute/early infection may improve CD4 T cell recovery and decrease overall size of the HIV reservoir. When ART is initiated during chronic HIV infection, there is ongoing low-level viral replication detected by sensitive assays despite long-term,

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[1] Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents for HIV-1-infected adults and adolescents. Available at: https://aidsinfo.nih.gov/guidelines/html/1/adultand-adolescent-arv-guidelines/0 Accessed 29 August 2016

[2] Kelley CF, Kitchen CM, Hunt PW, et al. Incomplete peripheral CD4+ cell count restoration in HIV-infected patients receiving long-term antiretroviral treatment. Clin Infect Dis. Mar 15 2009;48(6):787-794.

[3] Moore DM, Hogg RS, Chan K, Tyndall M, Yip B, Montaner JS. Disease progression in patients with virological suppression in response to HAART is associated with the degree of immunological response. Aids. Feb 14 2006;20(3):371-377

[4] El-Sadr WM, Lundgren JD, Neaton JD, et al. CD4+ count-guided interruption of antiretroviral treatment. N Engl J Med. Nov 30 2006;355(22):2283-2296.

- **Patients with known HIV infection who are re-engaging in care** with CD4 count < 200 cells / mm3 and no contraindications to starting ART. Contra-indications for this groups include: complicated or unknown ART history with possibility of acquired resistance; medical contraindication such as a suspected intracranial opportunistic infection.

Individuals at the Health and Wellness Center will likely have an initial test positive with use of the INSTI HIV Antibody 1/2 rapid test and we recent or chronic infection.

Procedure for Rapid ART at the Health and Wellness Center

Several basic steps will occur following a positive test and initiation of rapid ART at the Health and Wellness Center. These steps are the following:

- Verification of rapid HIV test
- Confirmation of new HIV diagnosis by Disease Intervention Specialists
- Post-test provider counseling including potential benefits of immediate ART and assessment of patient's interest in immediate ART
- Linkage to care, including assessment of where the client will engage in HIV primary care
- Mental health assessment and wrap-around counseling

Verification of Rapid HIV Test

A positive INSTi® test generated by the Health Tech will be communicated to the clinician ordering the test. This test will be repeated and verified by the health tech. The client will be roomed into an examination room.

Confirmation of new HIV positive diagnosis

The clinician will verify information with the DIS who will look up the patient in eHARS and DCPHIS. The DIS will document the last negative HIV test (if available), and prior HIV tests (if available).

Notification of Linkage to Care and Mental Health Counselor

The clinician will inform the linkage to care specialist regarding the new positive diagnosis. The Linkage to Care specialist will prepare the HIV Counselor regarding the new positive diagnosis. The Linkage to Care specialist will review the chart from the clinician prior to seeing the patient.

Medical Evaluation

The clinician will ***merge*** the Rapid ART template **(STD Rapid ART)** into the existing note and review the following topics in the medical history:

HIV History: Date of last negative HIV test, prior HIV test
PrEP use: Current, or periods within the past
PEP use: Current, or periods within the past
Sexual practices: As outlined within the SOGI, serostatus of partners if known

Medical history: Co-morbidities including renal and hepatic issues
Medications

The Linkage to Care specialist will offer the patient options of HIV primary care including Whitman Walker Health Center and AIDS Healthcare Foundation. After the patient chooses a HIV primary care site, the Linkage to Care Specialist will call the contact person at the site and set up an appointment for within 3 days.

The patient will visit the HIV counselor and undergo a brief assessment and be offered additional counseling services.

Follow-Up Care:
One day following ART initiation: The Linkage to Care Specialist calls the patient on the day after ART initiation to provide psychosocial support, assess for any clinical symptoms, or medication side effects, and provide any support for the patient to fill his/her long-term ART prescription. This may involve contacting the patient's pharmacy to work out any potential problem with access to medications. Any medical symptoms or questions are conveyed to the provider for the appropriate follow-up.

Five days following ART initiation: The patient has a follow-up appointment with the long-term provider who provides follow-up on clinical care and laboratory tests drawn by the Health and Wellness Center. At that visit, CD4, HIV RNA and HLAB5701 results are reviewed with the patient. Assessment is made for HIV or medication side effects. Treatment may be adjusted as appropriate. Care resumes with the provider as per routine primary HIV care.

Ten days following ART initiation: The Linkage to Care Specialist ensures the patient completes follow-up with the HIV primary care site. The Linkage to Care specialist will re-engage the patient for an appointment for additional medication if the patient has not followed up with the HIV Primary Care site.

Thirty days following ART initiation: The Linkage to Care Specialist contacts the patient to monitor follow-up with the HIV primary care site. The patient is offered additional mental health counseling services at the Health and Wellness Center. The patient is searched in eHARS regarding changes in regimen, and follow-up viral load levels.

Ninety days following ART initiation: The Linkage to Care Specialist contacts the patient to monitor follow-up with the HIV primary care site. The patient is offered additional mental health counseling services at the Health and Wellness Center. The patient is searched in eHARS regarding changes in regimen, and follow-up viral load levels.

One-hundred and eighty days following ASRT initiation: The patient is searched within eHARS and viral load levels, medication changes, and appointments are documented.

Report through September 2018

Jurisdiction	Current Distribution - Finalized	Expenditures	Variance	Percent
District of Columbia - Part A	3,726,146	1,739,865	1,986,281	46.7%
District of Columbia - MAI	1,146,033	637,571	508,462	55.6%
District of Columbia - UBC	5,484,500	4,190,046	1,294,454	76.4%
District of Columbia Subtotal	**10,356,679**	**6,567,482**	**3,789,197**	**63.4%**
Northern Virginia - Part A	1,877,674	743,539	1,134,135	39.6%
Northern Virginia -- MAI	423,004	299,143	123,861	70.7%
Northern Virginia Subtotal	**2,300,678**	**1,042,682**	**1,257,996**	**45.3%**
Suburban Maryland - Part A	4,098,897	1,960,110	2,138,787	47.8%
Suburban Maryland -- MAI	901,071	500,612	400,459	55.6%
Suburban Maryland Subtotal	**4,999,968**	**2,460,722**	**2,539,246**	**49.2%**
West Virginia - Part A	347,050	188,730	158,320	54.4%
West Virginia Subtotal	**347,050**	**188,730**	**158,320**	**54.4%**
TOTAL -- Part A	10,049,767	4,632,244	5,417,523	46.1%
TOTAL -- MAI	2,470,108	1,437,326	1,032,782	58.2%
TOTAL -- UBC	5,484,500	4,190,046	1,294,454	76.4%
TOTAL Subtotal	**18,004,375**	**10,259,616**	**7,744,759**	**57.0%**

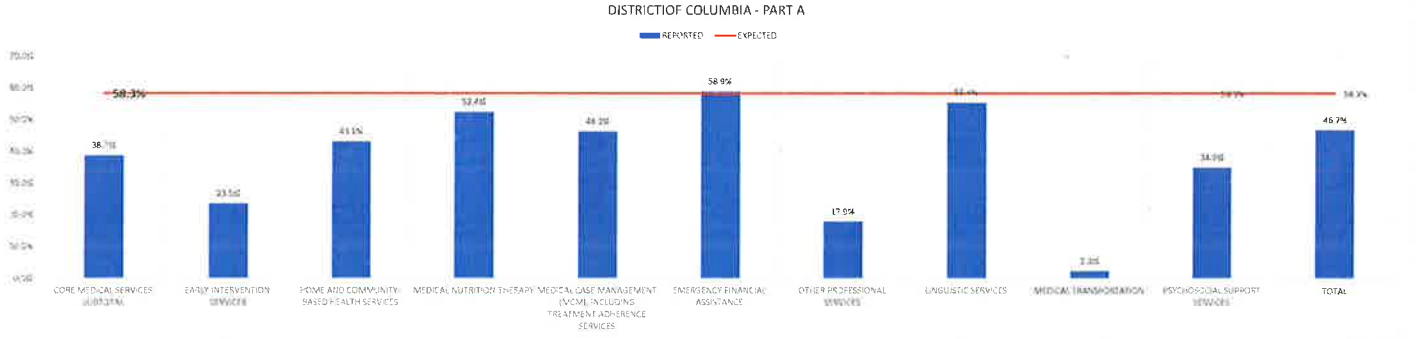
District of Columbia - Part A

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	2,869,178	39,040	2,908,219	1,680,736	523,258	2,203,994	59.1%	853,818	38.7%	1,288,663	58.3%	1,350,176	61.3%	(431,845)	(33.6%)
Early Intervention Services	196,519	522,258	718,777	196,519	522,258	718,777	19.3%	168,842	23.5%	419,287	58.3%	549,935	76.5%	(250,444)	(59.7%)
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSALI)	275,127	-	275,127	-	-	-	0.0%	-	0.0%	-		-	0.0%	-	0.0%
Home and Community-Based Health Services	275,127	16,782	291,909	190,909	101,000	291,909	7.8%	125,845	43.1%	170,260	58.3%	166,064	56.9%	(44,436)	(26.1%)
Medical Nutrition Therapy	157,215	-	157,215	118,182	-	118,182	3.2%	61,940	52.4%	68,940	58.3%	56,242	47.6%	(7,000)	(10.2%)
Medical Case Management (MCM), including Treatment Adherence Services	1,965,191	(500,000)	1,465,191	1,075,126	-	1,075,126	28.9%	497,191	46.2%	627,157	58.3%	577,935	53.8%	(129,966)	(20.7%)
Support Services Subtotal	**786,076**	**766,341**	**1,552,417**	**624,504**	**897,648**	**1,522,152**	**40.9%**	**755,294**	**49.6%**	**887,922**	**58.3%**	**636,105**	**41.8%**	**(1,675)**	**(0.2%)**
Emergency Financial Assistance	432,342	631,326	1,063,668	432,342	631,326	1,063,668	28.5%	626,205	58.9%	620,473	58.3%	437,463	41.1%	5,732	0.9%
Other Professional Services	117,911	6,097	124,008	11,818	112,190	124,008	3.3%	22,203	17.9%	72,338	58.3%	101,805	82.1%	(50,135)	(69.3%)
Linguistic Services	78,608	-	78,608	48,343	-	48,343	1.3%	26,767	55.4%	28,200	58.3%	21,576	44.6%	(1,433)	(5.1%)
Medical Transportation	39,304	20,910	60,214	14,090	46,124	60,214	1.6%	1,361	2.3%	35,125	58.3%	58,853	97.7%	(33,764)	(96.1%)
Outreach Services	-	-	-	-	-	-	0.0%	-	0.0%			-	0.0%	-	0.0%
Psychosocial Support Services	117,911	108,008	225,919	117,911	108,008	225,919	6.1%	78,759	34.9%	131,786	58.3%	147,160	65.1%	(53,028)	(40.2%)
TOTAL	**3,655,256**	**805,381**	**4,460,637**	**2,305,240**	**1,420,906**	**3,726,146**	**100.0%**	**1,739,865**	**46.7%**	**2,173,585**	**58.3%**	**1,855,529**	**49.8%**	**(302,988)**	**(13.9%)**

Underspent over 30%
Overspent over 30%

Note: For Housing Case Management and Referral Allocation please refer to DC - UBC Housing Case Management and Referral Allocation entrie



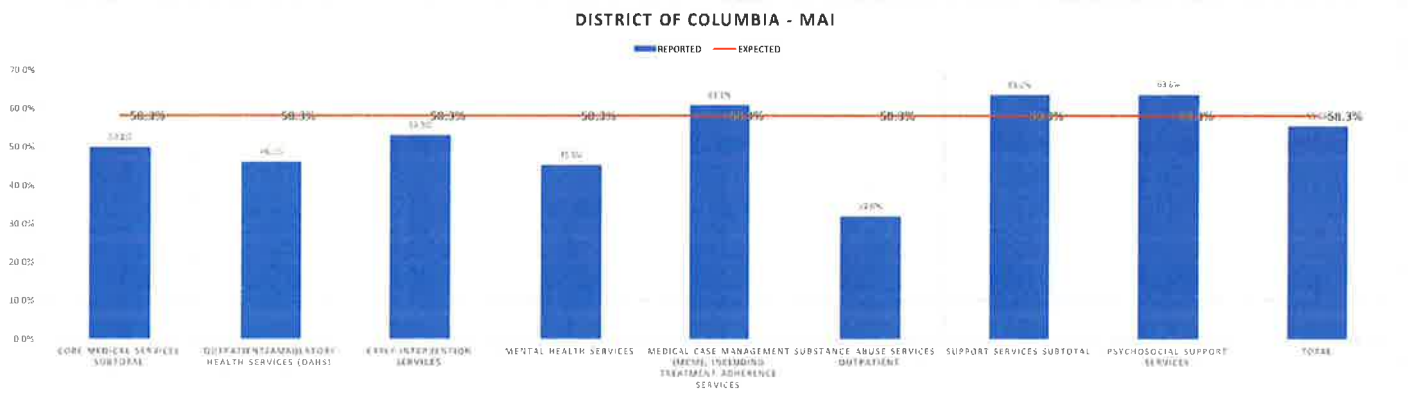
District of Columbia - MAI

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	992,380	25,349	1,017,729	1,010,391	-	1,010,391	88.2%	506,037	50.1%	589,395	58.3%	504,354	49.9%	(83,357)	(14.1%)
Outpatient/Ambulatory Health Services (OAHS)	404,881	(35,128)	369,753	369,753	-	369,753	32.3%	170,738	46.2%	215,689	58.3%	199,015	53.8%	(44,951)	(20.8%)
Early Intervention Services	185,020	44,839	229,859	229,859	-	229,859	20.1%	122,268	53.2%	134,084	58.3%	107,591	46.8%	(11,817)	(8.8%)
Mental Health Services	108,129	(9,475)	98,654	98,654	-	98,654	8.6%	44,849	45.5%	57,548	58.3%	53,805	54.5%	(12,699)	(22.1%)
Medical Case Management (MCM), including Treatment Adherence Services	248,696	(6,715)	241,981	234,643	-	234,643	20.5%	143,353	61.1%	136,875	58.3%	91,290	38.9%	6,478	4.7%
Substance Abuse Services - Outpatient	45,654	31,828	77,482	77,482	-	77,482	6.8%	24,830	32.0%	45,198	58.3%	52,652	68.0%	(20,368)	(45.1%)
Support Services Subtotal	160,991	(25,349)	135,642	135,642	-	135,642	11.8%	86,487	63.8%	79,125	58.3%	49,155	36.2%	7,363	9.3%
Psychosocial Support Services	160,991	(25,349)	135,642	135,642	-	135,642	11.8%	86,487	63.8%	79,125	58.3%	49,155	36.2%	7,363	9.3%
TOTAL	1,153,371	-	1,153,371	1,146,033	-	1,146,033	100.0%	637,571	55.6%	668,519	58.3%	508,462	44.4%	(30,948)	(4.6%)

Underspent over 30%

Overspent over 30%



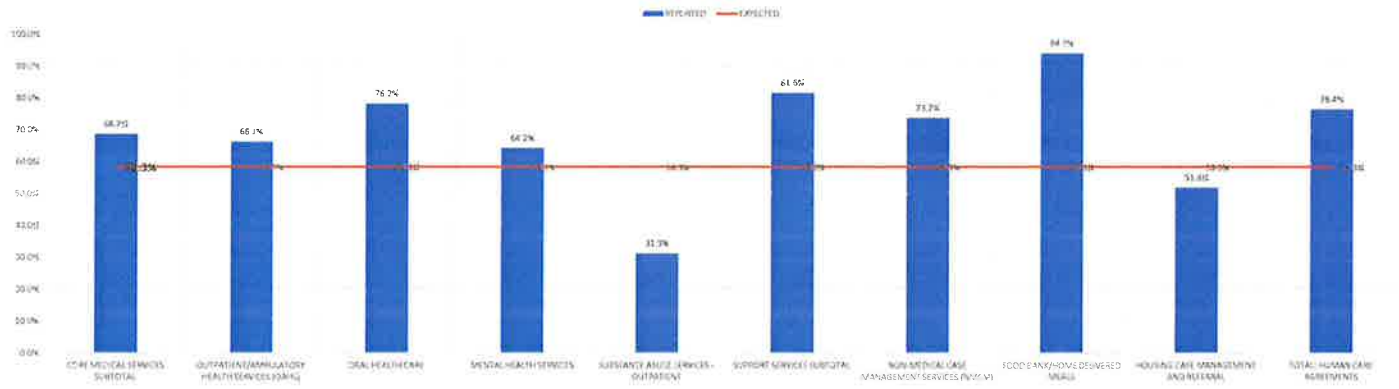
District of Columbia - Unit Based Costs (UBC) **Report through September 2018**

Service Area	Allocations				Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current		Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**10,892,239**	**(3,400,000)**	**7,492,239**	**53.6%**	**2,199,000**	**-**	**2,199,000**	**40.1%**	**1,610,209**	**68.7%**	**1,282,750**	**58.3%**	**888,791**	**31.3%**	**227,459**	**17.7%**
Outpatient/Ambulatory Health Services (OAHS)	3,713,264	(1,500,000)	2,213,264	40.4%	1,155,000	-	1,155,000	21.1%	763,915	66.1%	673,750	58.3%	391,085	33.9%	90,165	13.4%
Oral Health Care	3,465,713	(900,000)	2,565,713	46.8%	745,000	-	745,000	13.6%	582,261	78.2%	434,583	58.3%	162,739	21.8%	147,678	34.0%
Mental Health Services	2,475,508	(700,000)	1,775,508	32.4%	214,300	-	214,300	3.9%	137,565	64.2%	125,008	58.3%	76,735	35.8%	12,556	10.0%
Substance Abuse Services - Outpatient	1,237,754	(300,000)	937,754	17.1%	84,700	-	84,700	1.5%	26,469	31.3%	49,408	58.3%	58,231	68.7%	(22,939)	(46.4%)
Support Services Subtotal	**4,978,596**	**1,500,000**	**6,478,596**	**46.4%**	**3,285,500**	**-**	**3,285,500**	**59.9%**	**2,679,837**	**81.6%**	**1,916,542**	**58.3%**	**605,664**	**18.4%**	**763,295**	**39.8%**
Non-Medical Case Management Services (NMCM)	3,713,264	-	3,713,264	67.7%	1,778,500	-	1,778,500	32.4%	1,310,938	73.7%	1,037,458	58.3%	467,563	26.3%	273,479	26.4%
Food Bank/Home Delivered Meals	990,205	1,500,000	2,490,205	45.4%	1,395,000	-	1,395,000	25.4%	1,310,844	94.0%	813,750	58.3%	84,156	6.0%	497,094	61.1%
Housing Case Management and Referral	275,127	-	275,127	5.0%	112,000	-	112,000	2.0%	58,055	51.8%	65,333	58.3%	53,945	48.2%	(7,278)	(11.1%)
TOTAL: Human Care Agreements	**15,870,835**	**(1,900,000)**	**13,970,835**	**100.0%**	**5,484,500**	**-**	**5,484,500**	**100.0%**	**4,190,046**	**76.4%**	**3,199,292**	**58.3%**	**1,294,454**	**23.6%**	**990,754**	**31.0%**

Underspent over 30%
Overspent over 30%

Note: UBC Housing Case Management and Referral Allocation entries - DC Only

DISTRICT OF COLUMBIA - UBC

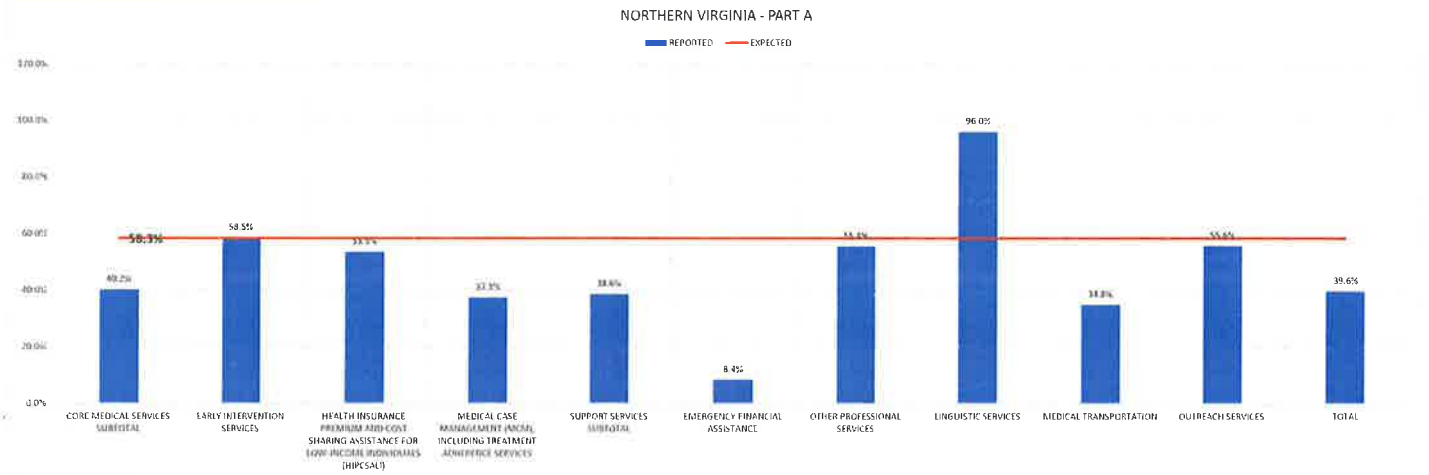


Northern Virginia - Part A

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**1,267,430**	**(97,125)**	**1,170,305**	**1,170,305**	**-**	**1,170,305**	**62.3%**	**470,149**	**40.2%**	**682,678**	**58.3%**	**700,156**	**59.8%**	**(212,529)**	**(31.1%)**
Early Intervention Services	122,049	(21,565)	100,484	100,484	-	100,484	5.4%	58,763	58.5%	58,616	58.3%	41,721	41.5%	147	0.3%
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSALI)	75,107	(1,791)	73,316	73,316	-	73,316	3.9%	39,215	53.5%	42,768	58.3%	34,101	46.5%	(3,553)	(8.3%)
Medical Case Management (MCM), including Treatment Adherence Services	1,070,274	(73,769)	996,505	996,505	-	996,505	53.1%	372,171	37.3%	581,295	58.3%	624,334	62.7%	(209,124)	(36.0%)
Support Services Subtotal	**610,244**	**97,125**	**707,369**	**707,369**	**-**	**707,369**	**37.7%**	**273,390**	**38.6%**	**412,632**	**58.3%**	**433,979**	**61.4%**	**(139,242)**	**(33.7%)**
Emergency Financial Assistance	206,544	30,569	237,113	237,113	-	237,113	12.6%	19,819	8.4%	138,316	58.3%	217,294	91.6%	(118,497)	(85.7%)
Other Professional Services	150,214		150,214	150,214	-	150,214	8.0%	83,186	55.4%	87,625	58.3%	67,028	44.6%	(4,439)	(5.1%)
Linguistic Services	-	52,721	52,721	52,721	-	52,721	2.8%	50,604	96.0%	30,754	58.3%	2,117	4.0%	19,850	64.5%
Medical Transportation	131,437	7,408	138,845	138,845	-	138,845	7.4%	48,318	34.8%	80,993	58.3%	90,527	65.2%	(32,675)	(40.3%)
Outreach Services	122,049	6,427	128,476	128,476	-	128,476	6.8%	71,463	55.6%	74,944	58.3%	57,013	44.4%	(3,481)	(4.6%)
TOTAL	**1,877,674**	**-**	**1,877,674**	**1,877,674**	**-**	**1,877,674**	**100%**	**743,539**	**39.6%**	**1,095,310**	**58.3%**	**1,134,135**	**60.4%**	**(351,771)**	**(32.1%)**

Underspent over 30%
Overspent over 30%



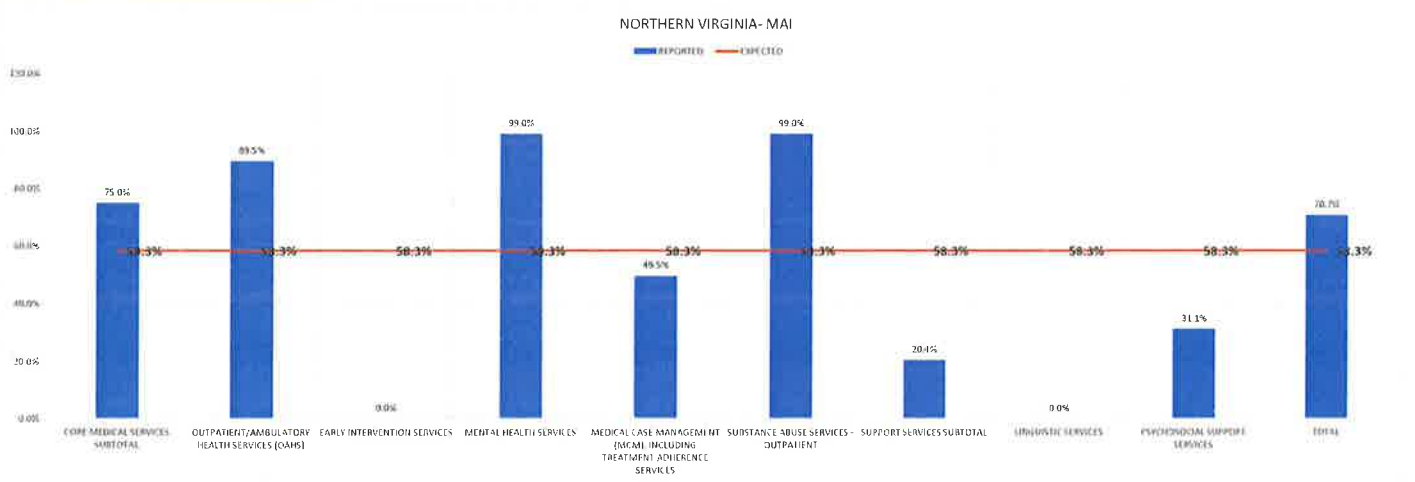
Northern Virginia - MAI

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**390,526**		**389,732**	**390,526**		**389,732**	**92.1%**	**292,357**	**75.0%**	**227,344**	**58.3%**	**97,375**	**25.0%**	**65,013**	**28.6%**
Outpatient/Ambulatory Health Services (OAHS)	211,772	-	211,772	211,772	-	211,772	50.1%	189,535	89.5%	123,534	58.3%	22,237	10.5%	66,001	53.4%
Early Intervention Services	19,086	(794)	18,292	19,086	(794)	18,292	4.3%	-	0.0%	10,670	58.3%	18,292	100.0%	(10,670)	(100.0%)
Mental Health Services	30,000	-	30,000	30,000	-	30,000	7.1%	29,699	99.0%	17,500	58.3%	301	1.0%	12,199	69.7%
Medical Case Management (MCM), including Treatment Adherence Services	111,718	-	111,718	111,718	-	111,718	26.4%	55,353	49.5%	65,169	58.3%	56,365	50.5%	(9,816)	(15.1%)
Substance Abuse Services - Outpatient	17,950	-	17,950	17,950	-	17,950	4.2%	17,770	99.0%	10,471	58.3%	180	1.0%	7,299	69.7%
Support Services Subtotal	**32,478**		**33,272**	**32,478**		**33,272**	**7.9%**	**6,786**	**20.4%**	**19,409**	**58.3%**	**26,486**	**79.6%**	**(12,623)**	**(65.0%)**
Linguistic Services	11,477	-	11,477	11,477	-	11,477	2.7%	-	0.0%	6,695	58.3%	11,477	100.0%	(6,695)	(100.0%)
Psychosocial Support Services	21,001	794	21,795	21,001	794	21,795	5.2%	6,786	31.1%	12,714	58.3%	15,009	68.9%	(5,928)	(46.6%)
TOTAL	**423,004**	**-**	**423,004**	**423,004**	**-**	**423,004**	**100.0%**	**299,143**	**70.7%**	**246,752**	**58.3%**	**123,861**	**29.3%**	**52,391**	**21.2%**

Underspent over 30%

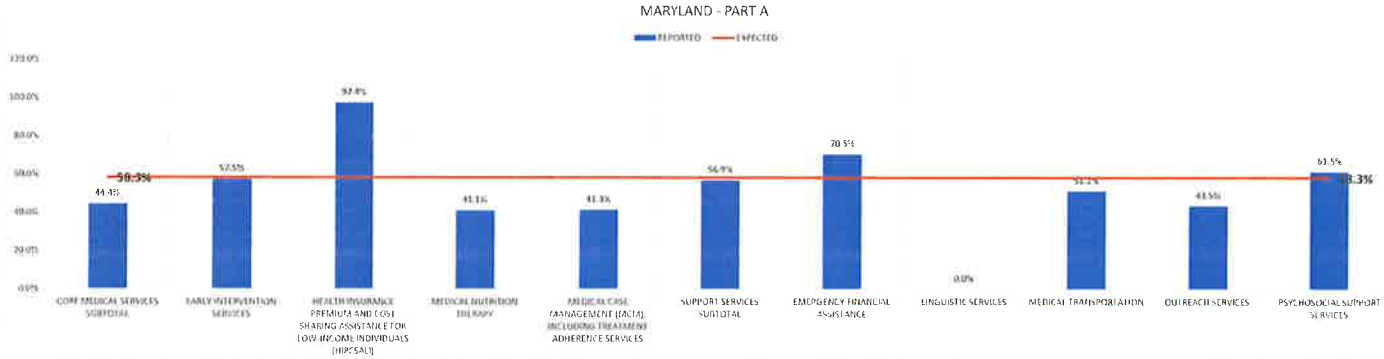
Overspent over 30%



Suburban Maryland - Part A **Report through September 2018**

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**1,892,695**	**1,094,619**	**2,987,314**	**2,987,314**	**-**	**2,987,314**	**72.9%**	**1,327,636**	**44.4%**	**1,742,600**	**58.3%**	**1,659,678**	**55.6%**	**(414,964)**	**(23.8%)**
Early Intervention Services	480,684	-	480,684	480,684	-	480,684	11.7%	276,185	57.5%	280,399	58.3%	204,499	42.5%	(4,214)	(1.5%)
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSALI)	30,043	-	30,043	30,043	-	30,043	0.7%	29,259	97.4%	17,525	58.3%	784	2.6%	11,734	67.0%
Medical Nutrition Therapy	330,471	-	330,471	330,471	-	330,471	8.1%	135,834	41.1%	192,775	58.3%	194,637	58.9%	(56,941)	(29.5%)
Medical Case Management (MCM), including Treatment Adherence Services	1,051,497	1,094,619	2,146,116	2,146,116	-	2,146,116	52.4%	886,358	41.3%	1,251,901	58.3%	1,259,758	58.7%	(365,543)	(29.2%)
Support Services Subtotal	**1,111,583**	**-**	**1,111,583**	**1,111,583**	**-**	**1,111,583**	**27.1%**	**632,474**	**56.9%**	**648,423**	**58.3%**	**479,109**	**43.1%**	**(15,949)**	**(2.5%)**
Emergency Financial Assistance	270,385	-	270,385	270,385	-	270,385	6.6%	160,495	70.5%	157,725	58.3%	79,890	29.5%	32,770	20.8%
Linguistic Services	30,043	(15,043)	15,000	15,000	-	15,000	0.4%	-	0.0%	8,750	58.3%	15,000	100.0%	(8,750)	(100.0%)
Medical Transportation	90,128	-	90,128	90,128	-	90,128	2.2%	46,168	51.2%	52,575	58.3%	43,940	48.8%	(6,387)	(12.1%)
Outreach Services	300,428	15,043	315,471	315,471	-	315,471	7.7%	137,276	43.5%	184,025	58.3%	178,195	56.5%	(46,749)	(25.4%)
Psychosocial Support Services	420,599	-	420,599	420,599	-	420,599	10.3%	258,515	61.5%	245,349	58.3%	162,084	38.5%	13,166	5.4%
TOTAL	**3,004,278**	**1,094,619**	**4,098,897**	**4,098,897**	**-**	**4,098,897**	**100%**	**1,960,110**	**47.8%**	**2,391,023**	**58.3%**	**2,138,787**	**52.2%**	**(430,913)**	**(18.0%)**

Underspent over 30%
Overspent over 30%

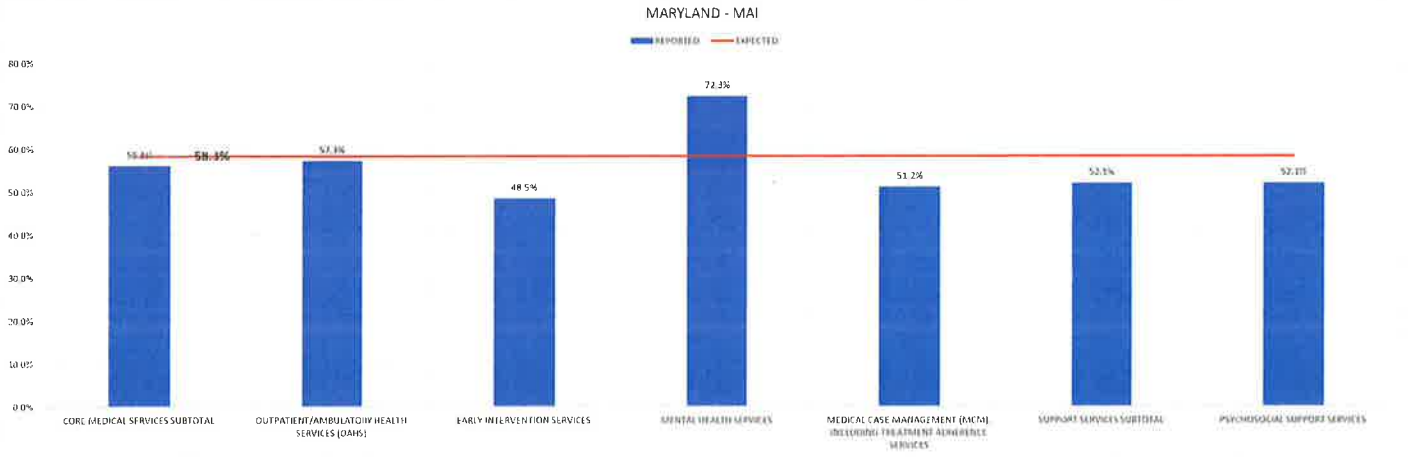


Suburban Maryland - MAI

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**775,209**	**-**	**775,209**	**775,209**	**-**	**775,209**	**86.0%**	**435,076**	**56.1%**	**452,205**	**58.3%**	**340,133**	**43.9%**	**(17,129)**	**(3.8%)**
Outpatient/Ambulatory Health Services (OAHS)	200,589	-	200,589	200,589	-	200,589	22.3%	114,935	57.3%	117,010	58.3%	85,654	42.7%	(2,075)	(1.8%)
Early Intervention Services	182,643	-	182,643	182,643	-	182,643	20.3%	88,566	48.5%	106,542	58.3%	94,077	51.5%	(17,976)	(16.9%)
Mental Health Services	146,374	-	146,374	146,374	-	146,374	16.2%	105,876	72.3%	85,385	58.3%	40,498	27.7%	20,491	24.0%
Medical Case Management (MCM), including Treatment Adherence Services	245,603	-	245,603	245,603	-	245,603	27.3%	125,699	51.2%	143,268	58.3%	119,904	48.8%	(17,569)	(12.3%)
Support Services Subtotal	**125,862**	**-**	**125,862**	**125,862**	**-**	**125,862**	**14.0%**	**65,535**	**52.1%**	**73,420**	**58.3%**	**60,326**	**47.9%**	**(7,884)**	**(10.7%)**
Psychosocial Support Services	125,862	-	125,862	125,862	-	125,862	14.0%	65,535	52.1%	73,420	58.3%	60,326	47.9%	(7,884)	(10.7%)
TOTAL	**901,071**	**-**	**901,071**	**901,071**	**-**	**901,071**	**100.0%**	**500,612**	**55.6%**	**525,625**	**58.3%**	**400,459**	**44.4%**	**(25,013)**	**(4.8%)**

Underspent over 30%
Overspent over 30%



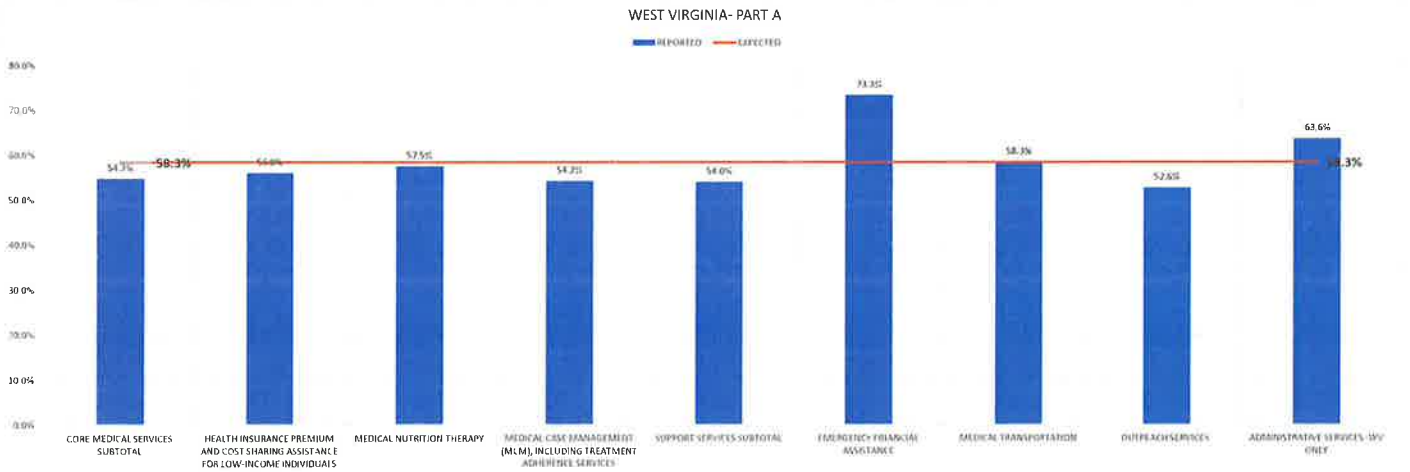
West Virginia - Part A

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**185,400**	**-**	**185,400**	**185,400**	**-**	**185,400**	**53.4%**	**101,482**	**54.7%**	**108,150**	**58.3%**	**83,918**	**45.3%**	**(6,668)**	**(6.2%)**
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSALI)	40,000	-	40,000	40,000	-	40,000	11.5%	22,387	56.0%	23,333	58.3%	17,613	44.0%	(946)	(4.1%)
Medical Nutrition Therapy	10,400	-	10,400	10,400	-	10,400	3.0%	5,977	57.5%	6,067	58.3%	4,423	42.5%	(90)	(1.5%)
Medical Case Management (MCM), including Treatment Adherence Services	135,000	-	135,000	135,000	-	135,000	38.9%	73,118	54.2%	78,750	58.3%	61,882	45.8%	(5,632)	(7.2%)
Support Services Subtotal	**161,650**	**-**	**161,650**	**161,650**	**-**	**161,650**	**46.6%**	**87,248**	**54.0%**	**94,296**	**58.3%**	**54,342**	**33.6%**	**13,012**	**13.8%**
Emergency Financial Assistance	80,000	-	80,000	80,000	-	80,000	23.1%	58,621	73.3%	46,667	58.3%	21,379	26.7%	11,954	25.6%
Medical Transportation	39,600	-	39,600	39,600	-	39,600	11.4%	23,100	58.3%	23,100	58.3%	16,500	41.7%	-	0.0%
Outreach Services	10,500	-	10,500	10,500	-	10,500	3.0%	5,527	52.6%	6,125	58.3%	4,973	47.4%	(598)	(9.8%)
Administrative Services -WV Only	31,550	-	31,550	31,550	-	31,550	9.1%	20,060	63.6%	18,404	58.3%	11,490	36.4%	1,656	9.0%
TOTAL	**347,050**	**-**	**347,050**	**347,050**	**-**	**347,050**	**100.0%**	**188,730**	**54.4%**	**202,446**	**58.3%**	**138,260**	**39.8%**	**6,344**	**3.1%**

Underspent over 30%

Overspent over 30%



Part A - Subtotal (12 month Reporting Period) **Report through September 2018**

Service Area	Allocations			Awards				Expenditures to Date		Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**6,214,704**	**1,036,534**	**7,251,238**	**5,923,755**	**623,258**	**6,547,013**	**65.1%**	**2,753,085**	**42.1%**	**3,793,928**	**57.9%**	**(1,065,006)**	**(27.9%)**
Early Intervention Services	799,252	500,693	1,299,945	777,687	522,258	1,299,945	12.9%	503,790	38.8%	796,155	61.2%	(254,511)	(33.6%)
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSALI)	420,277	(1,791)	418,486	143,359	-	143,359	1.4%	90,861	63.4%	52,498	36.6%	7,235	8.7%
Home and Community-Based Health Services	275,127	16,782	291,909	190,909	101,000	291,909	2.9%	125,845	43.1%	166,064	56.9%	(44,436)	(26.1%)
Medical Nutrition Therapy	498,086	-	498,086	459,053	-	459,053	4.6%	203,751	44.4%	255,302	55.6%	(64,030)	(23.9%)
Medical Case Management (MCM), including Treatment Adherence Services	4,221,962	520,850	4,742,812	4,352,747	-	4,352,747	43.3%	1,828,838	42.0%	2,523,909	58.0%	(710,264)	(28.0%)
Support Services Subtotal	**2,669,553**	**863,466**	**3,533,019**	**2,605,106**	**897,648**	**3,502,754**	**34.9%**	**1,899,219**	**54.2%**	**1,603,535**	**45.8%**	**(144,055)**	**(7.1%)**
Emergency Financial Assistance	989,271	661,895	1,651,166	1,019,840	631,326	1,651,166	16.4%	895,140	54.2%	756,026	45.8%	(68,040)	(7.1%)
Other Professional Services	268,125	6,097	274,222	162,032	112,190	274,222	2.7%	105,389	38.4%	168,833	61.6%	(54,574)	(34.1%)
Linguistic Services	108,651	37,678	146,329	116,064	-	116,064	1.2%	77,371	66.7%	38,693	33.3%	9,667	14.3%
Medical Transportation	300,469	28,318	328,787	282,663	46,124	328,787	3.3%	118,967	36.2%	209,820	63.8%	(72,825)	(38.0%)
Outreach Services	432,977	21,470	454,447	454,447	-	454,447	4.5%	214,266	47.1%	240,181	52.9%	(50,828)	(19.2%)
Psychosocial Support Services	538,510	108,008	646,518	538,510	108,008	646,518	6.4%	337,274	52.2%	309,244	47.8%	(39,862)	(10.6%)
TOTAL	**8,884,258**	**1,900,000**	**10,784,258**	**8,528,861**	**1,520,906**	**10,049,767**	**100.0%**	**4,652,304**	**46.3%**	**5,397,463**	**53.7%**	**(1,210,061)**	**(20.6%)**

MAI - Subtotal **Report through September 2018**

Service Area	Allocations			Awards				Expenditures to Date		Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**2,158,115**	**24,555**	**2,182,670**	**2,176,126**	**(794)**	**2,175,332**	**88.1%**	**1,233,470**	**56.7%**	**941,862**	**43.3%**	**(35,473)**	**(2.8%)**
Outpatient/Ambulatory Health Services (OAHS)	817,242	(35,128)	782,114	782,114	-	782,114	31.7%	475,208	60.8%	306,906	39.2%	18,975	4.2%
Early Intervention Services	386,749	44,045	430,794	431,588	(794)	430,794	17.4%	210,834	48.9%	219,960	51.1%	(40,463)	(16.1%)
Mental Health Services	284,503	(9,475)	275,028	275,028	-	275,028	11.1%	180,424	65.6%	94,604	34.4%	19,991	12.5%
Medical Case Management (MCM), including Treatment Adherence Services	606,017	(6,715)	599,302	591,964	-	591,964	24.0%	324,405	54.8%	267,559	45.2%	(20,907)	(6.1%)
Substance Abuse Services - Outpatient	63,604	31,828	95,432	95,432	-	95,432	3.9%	42,600	44.6%	52,832	55.4%	(13,069)	(23.5%)
Support Services Subtotal	**319,331**	**(24,555)**	**294,776**	**293,982**	**794**	**294,776**	**11.9%**	**158,809**	**53.9%**	**135,967**	**46.1%**	**(13,144)**	**(7.6%)**
Linguistic Services	11,477	-	11,477	11,477	-	11,477	0.5%	-	0.0%	11,477	100.0%	(6,695)	(100.0%)
Psychosocial Support Services	307,854	(24,555)	283,299	282,505	794	283,299	11.5%	158,809	56.1%	124,490	43.9%	(6,449)	(3.9%)
TOTAL	**2,477,446**	**-**	**2,477,446**	**2,470,108**	**-**	**2,470,108**	**100.0%**	**1,437,326**	**58.2%**	**1,032,782**	**41.8%**	**(3,670)**	**(0.2%)**

UBC- Subtotal **Report through September 2018**

Service Area	Allocations			Awards				Expenditures to Date				Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Expected		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**10,892,239**	**(3,400,000)**	**7,492,239**	**2,199,000**	**-**	**2,199,000**	**40.1%**	**1,510,209**	**68.7%**	**1,282,750**	**58.3%**	**688,791**	**31.3%**	**227,459**	**17.7%**
Outpatient/Ambulatory Health Services (OAHS)	3,713,264	(1,500,000)	2,213,264	1,155,000	-	1,155,000	21.1%	763,915	66.1%	673,750	58.3%	391,085	33.9%	90,165	13.4%
Oral Health Care	3,465,713	(900,000)	2,565,713	745,000	-	745,000	13.6%	582,261	78.2%	434,583	58.3%	162,739	21.8%	147,678	34.0%
Mental Health Services	2,475,508	(700,000)	1,775,508	214,300	-	214,300	3.9%	137,565	64.2%	125,008	58.3%	76,735	35.8%	12,556	10.0%
Substance Abuse Services - Outpatient	1,237,754	(300,000)	937,754	84,700	-	84,700	1.5%	26,469	31.3%	49,408	58.3%	58,231	68.7%	(22,939)	(46.4%)
Support Services Subtotal	**4,978,596**	**1,500,000**	**6,478,596**	**3,285,500**	**-**	**3,285,500**	**59.9%**	**2,679,837**	**81.6%**	**1,916,542**	**58.3%**	**605,664**	**18.4%**	**763,295**	**39.8%**
Non-Medical Case Management Services (NMCM)	3,713,264	-	3,713,264	1,778,500	-	1,778,500	32.4%	1,310,938	73.7%	1,037,458	58.3%	467,563	26.3%	273,479	26.4%
Food Bank/Home Delivered Meals	990,205	1,500,000	2,490,205	1,395,000	-	1,395,000	25.4%	1,310,844	94.0%	813,750	58.3%	84,156	6.0%	497,094	61.1%
Housing Case Management and Referral	275,127	-	275,127	112,000	-	112,000	2.0%	58,055	51.8%	65,333	58.3%	53,945	48.2%	(7,278)	(11.1%)
TOTAL: Human Care Agreements	**15,870,835**	**(1,900,000)**	**13,970,835**	**5,484,500**	**-**	**5,484,500**	**100.0%**	**4,190,046**	**76.4%**	**3,199,292**	**58.3%**	**1,294,454**	**23.6%**	**990,754**	**31.0%**

Part A, MAI and UBC Totals

Report through September 2018

Service Area	Allocations			Awards				Expenditures to Date		Unspent		Variance	
	Initial	Adjust	Current	Initial	Adjust	Current		Reported		Amount	Percent	Amount	Percent
Core Medical Services Subtotal	**19,265,058**	**(2,338,911)**	**16,926,147**	**10,298,881**	**622,464**	**10,921,345**	**60.7%**	**5,496,765**	**50.3%**	**5,424,580**	**49.7%**	**(874,020)**	**(13.7%)**
Outpatient/Ambulatory Health Services (OAHS)	4,530,506	(1,535,128)	2,995,378	1,937,114	-	1,937,114	10.8%	1,239,123	64.0%	697,991	36.0%	109,139	9.7%
Oral Health Care	3,465,713	(900,000)	2,565,713	745,000	-	745,000	4.1%	582,261	78.2%	162,739	21.8%	147,678	34.0%
Early Intervention Services	1,186,001	544,738	1,730,739	1,209,275	521,464	1,730,739	9.6%	714,624	41.3%	1,016,115	58.7%	(294,974)	(29.2%)
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSALI)	420,277	(1,791)	418,486	143,359	-	143,359	0.8%	90,861	63.4%	52,498	36.6%	7,235	8.7%
Home and Community-Based Health Services	275,127	16,782	291,909	190,909	101,000	291,909	1.6%	125,845	43.1%	166,064	56.9%	(44,436)	(26.1%)
Mental Health Services	2,760,011	(709,475)	2,050,536	489,328	-	489,328	2.7%	317,988	65.0%	171,340	35.0%	32,547	11.4%
Medical Nutrition Therapy	498,086	-	498,086	459,053	-	459,053	2.5%	203,751	44.4%	255,302	55.6%	(64,030)	(23.9%)
Medical Case Management (MCM), including Treatment Adherence Services	4,827,979	514,135	5,342,114	4,944,711	-	4,944,711	27.5%	2,153,244	43.5%	2,791,467	56.5%	(731,171)	(25.3%)
Substance Abuse Services - Outpatient	1,301,358	(268,172)	1,033,186	180,132	-	180,132	1.0%	69,069	38.3%	111,063	61.7%	(36,008)	(34.3%)
Support Services Subtotal	**7,967,481**	**2,338,911**	**10,306,392**	**6,184,588**	**898,442**	**7,083,030**	**39.3%**	**4,607,112**	**65.0%**	**2,300,119**	**32.5%**	**475,344**	**11.6%**
Non-Medical Case Management Services (NMCM)	3,713,264	-	3,713,264	1,778,500	-	1,778,500	9.9%	1,310,938	73.7%	467,563	26.3%	273,479	26.4%
Emergency Financial Assistance	989,271	661,895	1,651,166	1,019,840	631,326	1,651,166	9.2%	895,140	54.2%	756,026	45.8%	(68,040)	(7.1%)
Food Bank/Home Delivered Meals	990,205	1,500,000	2,490,205	1,395,000	-	1,395,000	7.7%	1,310,844	94.0%	84,156	6.0%	497,094	61.1%
Other Professional Services	268,125	6,097	274,222	162,032	112,190	274,222	1.5%	105,389	38.4%	168,833	61.6%	(54,574)	(34.1%)
Linguistic Services	120,128	37,678	157,806	127,541	-	127,541	0.7%	77,371	60.7%	50,170	39.3%	2,972	4.0%
Medical Transportation	300,469	28,318	328,787	282,663	46,124	328,787	1.8%	118,967	36.2%	209,820	63.8%	(72,825)	(38.0%)
Outreach Services	432,977	21,470	454,447	454,447	-	454,447	2.5%	214,266	47.1%	240,181	52.9%	(50,828)	(19.2%)
Psychosocial Support Services	846,365	83,453	929,818	821,015	108,802	929,817	5.2%	496,083	53.4%	433,734	46.6%	(46,311)	(8.5%)
Housing Case Management and Referral	275,127	-	275,127	112,000	-	112,000	0.6%	58,055	51.8%	53,945	48.2%	(7,278)	(11.1%)
Administrative Services -WV Only	31,550	-	31,550	31,550	-	31,550	0.2%	20,060	63.6%	(164,310)	-520.8%	1,656	9.0%
TOTAL	**27,232,539**	**-**	**27,232,539**	**16,483,469**	**1,520,906**	**18,004,375**	**100.0%**	**10,103,676**	**56.1%**	**7,724,699**	**42.9%**	**(398,676)**	**(3.8%)**

PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

PLANNING COMMISSION (COHAH) GENERAL BODY MEETING AGENDA

THURSDAY, NOVEMBER 29, 2018 – 6:00PM TO 8:00PM

JUDICIARY SQUARE – CITYWIDE CONFERENCE CENTER
441 4TH STREET, NW; 11TH FLOOR; WASHINGTON, DC 20001

Note: all times are approximate

6:00 pm	1. Call To Order and Moment of Silence 2. Welcome and Introductions/Roll Call
6:10 pm	3. Adoption of the Meeting Agenda for November 29, 2018 4. Review and Approval of the Meeting Minutes from October 25, 2018
6:15 pm	5. Ryan White HIV/AIDS Program (RWHAP) Updates • *Suburban Maryland Administrative Agent Report* • *Northern Virginia Administrative Agent Report* • *DC and West Virginia Administrative Agent Report* • *RWHAP Recipent Report*
6:30 pm	6. **COHAH Chat: Data to Care** • *Patrice Ward, MA; DC Health – Strategic Information Division*
7:30 pm	***PUBLIC COMMENT PERIOD***(SEE NEW RULES)*** *-Anyone interested, please complete the form with a COHAH staff member.*
7:40 pm	7. Standing Committee Updates • *Research & Evaluation Committee (REC) {Next mtg.: Tue. Dec. 18th at 3pm}* • *Integrated Strategies Committee (ISC) {Next mtg.: Wed. Dec. 19th at 4pm}* ○ ***ACTION ITEM:** Vote on the Psychosocial Support Service Standard* • *Community Engagement & Education Committee (CEEC) {Next mtg.: Thu. Dec. 18th at 5pm}* • *Comprehensive Planning Committee (CPC) {Next mtg.: Wed. Dec. 19th at 3pm}*
7:50 pm	8. Commission Administrative Business – "Things to Do" • **ACTION ITEM:** *Election of two (2) Commisioners to the Executive Operations Committee (EOC)* • **ACTION ITEM:** *Review and Vote on Bylaws* • *Discussion around extending the COHAH Meetings (5pm to 8pm)*
7:50 pm	9. New Business
7:55 pm	10. Announcements • IMPORTANT DATES FOR DECEMBER (back of the agenda)
8:00 pm	11. Adjournment

NEXT PLANNING COMMISSION (COHAH) MEETING:	**THURSDAY DECEMBER 20, 2018** **6PM-8PM** **JUDICIARY SQUARE – CITYWIDE CONFERENCE CENTER**

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
899 N. CAPITOL ST., NE; 4TH FL.
WASHINGTON, DC 20002-4263
WWW.DCHEALTH.DC.GOV/COHAH

	441 4TH ST. NW; 11TH FLOOR WASHINGTON, DC 20001

IMPORTANT DATES – NOVEMBER AND DECEMBER

DATE	TOPIC	TIME
October 16th	Research and Evaluation Committee (REC) Meeting	3p to 5p
October 17th	Integrated Strategies Committee (ISC) Meeting	4p to 6p
October 18th	Community Engagement & Education Committee (CEEC) Meeting	5p to 7p
October 24th	Comprehensive Planning Committee (CPC) Meeting	3p to 5p
October 25th	Executive Operations Committee (EOC) Meeting @ 441 4th St. NW	5p to 6p
October 25th	COHAH General Body Meeting @ 441 4th Street, NW on the 11th Floor	6p to 8p
November 7th	OPTION 1 for MANDATORY PREVENTION ORIENTATION:	3p to 6p
November 13th	Research and Evaluation Committee (REC) Meeting NEW DATE	3p to 5p
November 14th	Integrated Strategies Committee (ISC) Meeting	4p to 6p
November 15th	Community Engagement & Education Committee (CEEC) Meeting	5p to 7p
November 16th	STIGMA CONFERENCE AT HOWARD UNIVERSITY	
November 27th	OPTION 2 for MANDATORY PREVENTION ORIENTATION:	3p to 6p
November 28th	Comprehensive Planning Committee (CPC) Meeting	3p to 5p
November 29th	Executive Operations Committee (EOC) Meeting @ 441 4th St. NW	5p to 6p
November 29th	COHAH General Body Meeting @ 441 4th Street, NW on the 11th Floor	6p to 8p
Due to the 2018 National Ryan White Conference on HIV Care and Treatment being held from December 10th to the 14th, we needed to reschedule the REC, ISC, and CEEC Meetings. TENTATIVE SCHEDULE BELOW		
December 18th	Research and Evaluation Committee (REC) Meeting	3p to 5p
December 19th	Integrated Strategies Committee (ISC) Meeting	4p to 6p
December 19th	Comprehensive Planning Committee (CPC) Meeting	3p to 5p
December 20th	Executive Operations Committee (EOC) Meeting @ 441 4th St. NW	5p to 6p
December 20th	COHAH General Body Meeting @ 441 4th Street, NW on the 11th Floor	6p to 8p
TBD	Community Engagement & Education Committee (CEEC) Meeting	5p to 7p

PLANNING COMMISSION on HEALTH and HIV

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MOTION FORM

Instructions: *The Committee Chair or another Commissioner making a motion for consideration by the Planning Commission shall complete this form and submit it to Planning Commission staff.*

Standing Committee of Origin:	n/a	**Date Moved:**	**September 27, 2018**
Motion Made By:	Kaleef Morse, Government Co-Chair and Cyndee Clay, Community Co-Chair		
Subject:	***Revisions to Bylaws***		

MOTION STATUS			AYES	NAYES	ABST.	DATE OF VOTE:	CHAIR SIGNATURE:
Committee:	☐ Passed	☐ Failed					
EOC Action:	☐ Passed	☐ Failed					
COHAH Action:	☐ Passed	☐ Failed					
Documents Attached:	Pages 14,15, and 29 of the Draft Bylaws – September 25, 2018						

1. Text of the motion:

To approve the Draft Bylaws dated September 25, 2018 with the following changes:

A. To change the term of office for the Community Co-Chair and the Community Vice Chair from one year to two years. (Draft Bylaws page 14)
B. To change the Community Vice-Chairs rise to Community Co-Chair from "the following year" to "in two years". (Draft Bylaws page 15)
C. To remove the Executive Operations Committee's review of Long Distance Travel expenses after the Government Co-Chair reviews them. (Draft Bylaws page 29)

2. Purpose of the motion / Need for the action

A. For stability and continuity in leadership
B. For stability and continuity in leadership
C. The Government Co-Chair (GCC), not the EOC, creates and monitors the budget in compliance with all District and Federal Government rules and regulations with the Recipient.

3. Research completed prior to formulating recommended action

n/a

4. Alternative strategies explored and reasons why the recommended action is preferable.

n/a

Article 4: Commission Co-Chairs

4.1 Co-Chairs.

A. There shall be two Chairs of the Commission: a Government Co-Chair and a Community Co-Chair.

i. The Government Co-Chair shall be appointed by the Mayor, in accordance with District of Columbia law and Ryan White legislative requirements. The Government Co-Chair shall serve at the pleasure of the Mayor and in compliance with District of Columbia Law.

ii. The Community Co-Chair shall be elected in accordance with the procedures described in Section 4.3. The term of office of the Community Co-Chair shall be ~~one year~~ two years.

Commented [MK(1]: Changed to two years.

B. A Community Vice Chair, elected in accordance with the procedures described in Section 4.3, will serve under the Community Co-Chair for one year. When the Community Co-Chair's ~~one~~ two year term is over, the Community Vice Chair will replace the Community Co-Chair and begin a ~~one~~ two year term, at which point a new Community Vice Chair will be elected.

Commented [MK(2]: Changed to two years.

Commented [MK(3]: Changed to two years.

4.2 Roles and Responsibilities.

A. The Government Co-Chair, in conjunction with the Community Co-Chair and Executive Operations Committee, shall call meetings of the Commission and assist in the preparation of Commission meeting agendas. The Government Co-Chair shall chair Commission and Executive Operations Committee meetings.

In consultation with the Community Co-Chair, the Government Co-Chair shall appoint and discharge all committee chairpersons, and appoint Commission members to committees. In making such appointments, the Government Co-Chair and Community Co-Chair shall ask Commission members to indicate their committee preferences.

The Government Co-Chair shall serve as an ex officio voting member of all committees, but shall not be counted for determining the quorum required for committee action.

B. Community Co-Chair. The Community Co-Chair shall co-facilitate meetings of the Commission with the Government Co-Chair. The Community Co-Chair shall serve as the principal liaison to community-based organizations and the affected community. In the absence or disability of the Government Co-Chair, the Community Co-Chair shall perform those duties that otherwise would be performed by the Government Co-Chair. The Community Co-Chair shall work with

the Government Co-Chair on committee appointments.

The Community Co-Chair shall serve as an ex officio voting member of all committees, but shall not be counted for determining the quorum required for committee action.

C. Community Vice Chair. The Community Vice Chair shall serve under the Community Co-Chair in preparation for the Community Vice Chair's rise to Community Co-Chair ~~the following year~~in two years. The Community Vice Chair shall serve on the Executive Operations Committee and, in accordance with Section 4.6, will serve as Acting Chair in the event of a temporary, planned or unplanned absence (Short-Term) of the Government Co-Chair and the Community Co-Chair.

Commented [MK(4]: Changed to "in two years" or "at the end of the two year term".

4.3 Nominations and Elections of Community Co-Chair and Community Vice Chair.

A. Schedule.

i. The nominations process will open at the Commission meeting one month prior to the scheduled election meeting and will close at the start of the election meeting.
ii. Candidates should notify the Commission at the meeting one month prior to the election meeting that they intend to run and should submit a half-page narrative stating their qualifications for the office and Commission-related experience. This statement will be circulated with the meeting agenda and other meeting materials. If a candidate is not present, the Commission Government Co-Chair should read the statement.
iii. For the initial elections, the Commission will elect a Community Co-Chair and a Community Vice Chair. The process for Community Co-Chair will occur first, followed by a repeat of the process to elect a Community Vice Chair. Nominees for the election should indicate if they are willing to be considered for Community Co-Chair, Community Vice Chair, or either.

B. Process.

i. Any Commission member may nominate another Commission member.
ii. A Commission member may self-nominate
iii. Each nomination will require a second.
iv. The person who is making the nomination and the person seconding the nomination will be allowed time to make a statement supporting the nominee.
v. Time allowed:
    a) Person making the nomination - 2 minute maximum;
    b) Person seconding the nomination - 1 minute maximum.

applicable D.C. regulations. All arrangements must meet both D.C. regulations and federal guidelines.

9.2 Long distance travel expenses. When Commission members travel in the performance of their Commission duties, reasonable travel expenses including transportation, lodging, and per diem for members may be paid from Commission funds and the method of payment shall not require members to advance funds in excess of $100.00. Such travel expenses must be reviewed and recommended by the Government Co-Chair ~~and the Executive Operations Committee~~, and be approved by ~~HRSA and~~\ the recipient~~/grantee~~ in advance to ensure they meet established travel policies and procedures with regard to use of Commission funds.

Commented [MK(6]: Remove EOC. The GCC monitors the budget and regulations with the recipient.

9.3 Expenses of Commission Members. Members of the Commission are eligible for reimbursement of certain expenses incurred in connection with Commission work that are allowable under federal and District guidance and the Commission's Expense Reimbursement Policy (Appendix D).

9.4 Expenses of "Named Members" of Standing Committees. Non-members of the Commission who are accepted as "Named Members" of Standing Committees are eligible for reimbursement of certain expenses incurred in connection with Commission work that are allowable under HRSA guidance and the Commission's Expense Reimbursement Policy.

9.5 Expenses of Other Participants. The Commission may develop policy for the reimbursement of other participants' expenses in a manner allowed under federal and District laws and guidance.

9.6 Allowed Expenses, Requirements and Procedures for Securing Payment. In all cases covered above, the following conditions apply.

A. Specific expenses eligible for reimbursement and the procedures for securing monthly reimbursement are defined in the separate Expense Reimbursement Policy approved by the Commission that may change from time to time based on changes in HRSA policy and Commission decisions.

B. The Commission is not required to reimburse all allowable expense categories. Exercising its best judgment, the Commission may choose not to reimburse some types of allowable expenses based on budget constraints or other factors.

C. Payment of reimbursements will be contingent upon the eligible individual's following established procedure to submit requests and any required documentation in a timely manner.