Houston Area HIV Services Ryan White Planning Council
Office of Support
Meeting Location: 1440 Harold Street, Houston, Texas 77006
832 927-7926 telephone; http://rwpchouston.org

Memorandum

To:	Members, Quality Improvement Committee	
	Tana Pradia, Co-Chair	Norman Mitchell
	Pete Rodriguez, Co- Chair	Diana Morgan
	Kevin Aloysius	Beatriz E.X. Rivera
	Yvonne Arizpe	Evelio Salinas Escamilla
	Caleb Brown	*Rodrigo Arias*
	Michael Elizabeth	*Lisa Felix*
	Glen Hollis	*Ivy Ortega*
	Denis Kelly	*Gloria Sierra*
		Mike Smith
Copy:	Glenn Urbach	Patrick Martin
	Eric James	Tionna Cobb
	Mauricia Chatman	Jeff Benavides
	Francisco Ruiz	Diane Beck
	James Supak	Rodriga "Rod" Avila
	Tiffany Shepherd	Gary Grier
	Sha'Terra Johnson	
From:	Tori Williams	
Date:	Tuesday, November 19, 2024	
Re:	Meeting Notice	

Thank you for allowing us to postpone your committee meeting last week and reschedule it for November 26th. The time has allowed us to include additional information in this packet that should be helpful to you. Please note the correct meeting details below:

Quality Improvement Committee Meeting
2:00 p.m., Tuesday, November 26, 2024
Sandwiches will be available to those with a medical need

To participate virtually, click on this link:
https://us02web.zoom.us/j/81144509622?pwd=SFNBM1RScVFabHkzakVpaUZoeHhIdz09
Meeting ID: 811 4450 9622 Passcode: 125672
Or, call in by dialing: 346 248 7799

To attend in person: Bering Church, 1440 Harold St, Houston, Texas 77006. Please enter the building from the Hawthorne Street parking lot behind the church.

RSVP to Rod and let her know if you will be in attendance or not. She can be reached by telephone at 832 927-7926 or by email at: Rodriga.Avila@harriscountytx.gov. And, if you have questions for your committee mentor, do not hesitate to contact her at: Tana Pradia, 832 298-4248, tanapradia@gmail.com.

DRAFT

Houston Area HIV Services Ryan White Planning Council
Quality Improvement Committee
2:00 p.m., Tuesday, November 26, 2024

Join the meeting via Zoom at:
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 811 4450 9622 Passcode: 125672
Or, use your cell phone to dial in at: 346 248 7799
In person location: 1440 Harold Street, Houston, Texas 77006

Agenda
^ = REVISED OR NEW DOCUMENT

Please note that the use of artificial intelligence (AI) is prohibited at Ryan White sponsored meetings.

I.	Call to Order	Tana Pradia and
	A. Welcoming Remarks and Moment of Reflection	Pete Rodriguez, Co-Chair
	B. Adoption of Agenda	
	C. Approval of Minutes	
II.	Public Comments and Announcements	
	(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.	
III.	Reports from the Administrative Agents	
	A. Ryan White Part B and State Services	Tionna Cobb
	B. Ryan White Part A	Glenn Urbach
	1. Procurement and SUR**^ Reports	
	2. Update on Spanish Translation at RW funded Clinics^	Mauricia Chatman
	3. Financial Eligibility for 3 new services^	Tori Williams
	4. Updates on Other Services	Eric James
IV.	FY 2025 Standards of Care and Performance Measures	Bob Taylor and
	A. Ryan White Part A and MAI^	Kevin Lara, RWGA***
	B. Ryan White Part B and State Services (SS)^	Tionna Cobb, TRG****
	C. DSHS Standards of Care: Substance Abuse Outpatient & Residential	Sha'Terra Johnson
V.	Old Business	
	A. 2025 Data Reports	
	B. Committee Quarterly Report	
	C. Appreciations	
VI.	Announcements	
VII.	Adjourn	

** SUR = Service Utilization Report
***RWGA = Ryan White Grant Administration
****TRG = The Resource Group

FY 2024 Ryan White Part A and MAI Service Utilization Report

Date Range: 03/01/2024 - 10/31/2024 23:59:00

RW PART A Service Utilization Report																		
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non - Hispanic)	White (non - Hispanic)	Other (non - Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-54	55-64	65+
1	Outpatient/Ambulatory Primary Care (excluding Vision)	9,780	7,487	74%	23%	2%	43%	11%	2%	45%	0%	0%	5%	27%	28%	22%	15%	3%
1.a	Primary Care - Public Clinic (A)	3,113	2,610	69%	30%	1%	41%	7%	2%	50%	0%	0%	3%	17%	26%	27%	22%	5%
1.b	Primary Care - CBO Targeted to AA (A)	2,335	1,947	70%	26%	3%	99%	0%	1%	0%	0%	1%	6%	36%	29%	16%	11%	2%
1.c	Primary Care - CBO Targeted to Hispanic (A)	1,934	1,855	82%	14%	4%	0%	0%	0%	100%	0%	0%	6%	32%	29%	21%	10%	2%
1.d	Primary Care - CBO Targeted to White and/or MSM (A)	774	615	85%	13%	2%	0%	83%	17%	0%	0%	0%	3%	25%	27%	23%	20%	3%
1.e	Primary Care - CBO Targeted to Rural (A)	752	562	72%	27%	1%	40%	19%	2%	40%	0%	0%	4%	25%	30%	23%	15%	3%
1.f	Primary Care - Women at Public Clinic (A)	872	784	1%	99%	1%	51%	5%	1%	42%	0%	1%	3%	14%	27%	29%	20%	6%
1.g	Primary Care - Pediatric (A)																	
1.h	Vision	2,663	1,806	72%	26%	2%	45%	11%	3%	41%	0%	0%	3%	21%	25%	25%	20%	6%
2	Medical Case Management	5,719	2,804	69%	28%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
2.a	Clinical Case Management	967	560	74%	24%	2%	56%	14%	2%	28%	0%	1%	3%	27%	23%	20%	20%	7%
2.b	Med CM - Targeted to Public Clinic (A)	578	381	90%	7%	2%	50%	12%	1%	37%	0%	1%	2%	28%	25%	19%	20%	6%
2.c	Med CM - Targeted to AA (A)	1,479	643	67%	29%	3%	98%	0%	1%	0%	0%	0%	3%	30%	29%	20%	14%	4%
2.d	Med CM - Targeted to H/L (A)	728	355	81%	15%	4%	0%	0%	0%	100%	0%	0%	6%	28%	30%	22%	11%	3%
2.e	Med CM - Targeted to White and/or MSM (A)	460	148	82%	16%	1%	0%	85%	14%	1%	0%	0%	2%	16%	23%	28%	22%	9%
2.f	Med CM - Targeted to Rural (A)	554	428	69%	31%	0%	51%	24%	2%	23%	0%	0%	2%	21%	23%	22%	23%	10%
2.g	Med CM - Targeted to Women at Public Clinic (A)	259	214	1%	99%	0%	66%	7%	1%	25%	0%	0%	0%	26%	30%	24%	15%	4%
2.h	Med CM - Targeted to Geriatrics	532	50	58%	38%	5%	70%	9%	2%	20%	0%	0%	0%	0%	0%	0%	59%	41%
2.i	Med CM - Targeted to Veterans	148																
2.j	Med CM - Targeted to Youth	14	9	89%	11%	0%	67%	0%	0%	33%	0%	22%	78%	0%	0%	0%	0%	0%
3	Local Drug Reimbursement Program (A)	5,781	4,583	75%	22%	3%	40%	11%	2%	46%	0%	0%	4%	24%	27%	25%	17%	3%
4	Oral Health	348	279	67%	32%	1%	39%	27%	2%	32%	0%	0%	1%	18%	27%	28%	18%	9%
4.a	Oral Health - Untargeted (D)	NA	NA															
4.b	Oral Health - Rural Target	348	279	67%	32%	1%	39%	27%	2%	32%	0%	0%	1%	18%	27%	28%	18%	9%
5	Health Insurance (D)	2,034	1,910	78%	20%	2%	45%	21%	3%	31%	0%	0%	2%	14%	22%	20%	28%	14%
6	Mental Health Services (D)	NA	NA															
7	Medical Nutritional Therapy/Nutritional Supplements	515	393	77%	22%	2%	40%	17%	5%	38%	0%	0%	1%	6%	10%	28%	35%	20%
8	Substance Abuse Treatment - Outpatient	19	9	100%	0%	0%	22%	22%	0%	56%	0%	0%	0%	44%	44%	0%	11%	0%
9	Hospice Services	NA	NA															
10	Emergency Financial Assistance	3,218	985	75%	22%	3%	44%	8%	2%	45%	0%	0%	6%	25%	28%	23%	15%	3%
10.a	Emergency Financial Assistance-Pharmacy Assistance	3,105	891	75%	22%	3%	42%	8%	2%	47%	0%	0%	6%	25%	30%	23%	13%	2%
10.b	Emergency Financial Assistance - Other (MCC only)	113	95	71%	27%	2%	61%	13%	1%	25%	0%	0%	3%	20%	17%	19%	31%	11%
11	Referral for Health Care - Non Core Service (D)	NA	NA															
12	Non-Medical Case Management	8,568	5,672															
12.a	Service Linkage Targeted to Youth	179	154	64%	31%	6%	55%	3%	2%	41%	0%	11%	89%	0%	0%	0%	0%	0%
12.b	Service Linkage at Testing Sites	132	98	73%	23%	3%	51%	5%	8%	36%	0%	0%	0%	54%	26%	10%	7%	3%

12.c	Service Linkage at Public Clinic Primary Care Program (A)	3,621	2,555	65%	34%	1%	49%	8%	2%	41%	0%	0%	0%	17%	25%	26%	24%	7%
12.d	Service Linkage at CBO Primary Care Programs (A)	4,636	2,865	73%	25%	2%	48%	10%	3%	40%	0%	0%	4%	27%	29%	21%	14%	5%
13	Transportation	2,358	1,174	69%	28%	2%	60%	9%	2%	29%	0%	0%	1%	15%	21%	25%	29%	8%
13.a	Transportation Services - Urban	687	280	64%	34%	2%	54%	8%	5%	34%	0%	0%	1%	20%	25%	22%	20%	10%
13.b	Transportation Services - Rural	195	94	65%	34%	1%	33%	33%	2%	32%	0%	0%	1%	16%	16%	30%	26%	12%
13.c	Transportation vouchering	1,476	902	70%	28%	2%	66%	6%	1%	27%	0%	0%	1%	13%	20%	26%	32%	8%
14	Linguistic Services (D)	NA	NA															
15	Outreach Services	955	417	73%	24%	4%	59%	10%	2%	29%	0%	1%	6%	32%	26%	18%	14%	3%
	Net unduplicated clients served - all categories	15,378	13,050	73%	24%	2%	47%	12%	2%	39%	0%	0%	4%	23%	26%	22%	18%	6%
	Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (B)	NA	30,198	75%	25%	0%	48%	17%	5%	30%	0%		4%	21%	23%	25%	20%	0%

Harris County
Public Health
Building a Healthy Community

RWA Case Management Translation Assessment
RWPC Quality Improvement Committee
11/19/2024

Mauricia Chatman, MPH
QMD Coordinator
Ryan White Grant Administration

HCPHTX.ORG

Accredited Health Department · PHAB · Public Health Accreditation Board

The Assessment

Quality Improvement Committee: Public Comment August 13, 2024	Data was collected on 9/11/24	RWA QMD
Virtual Collection	#of participants N=6	Tool consist of 9 questions

Reminders

- Ryan White A does not fund Linguistic Services

- Client Satisfaction Survey (CSS) captures indirect indicators for language barriers (i.e., Cultural humility questions)

The Tool

Ryan White Grant Administration
Quality Management Assessment
Bilingual/Monolingual Translation Services

Agency Name:

Date:

1. What linguistic (translation) services or apps do CM/frontline use at your organization for bilingual clients?	
2. What process does CM/frontline follow at your organization when assisting Spanish speaking clients? How is this process different or the same for monolingual Spanish speakers?	
3. What barriers have you identified, or observed, at your organization for bilingual speaking clients accessing quality services efficiently?	
4. If your organization has a Community Advisory Board/Group, what percentage of the group identifies at Hispanic and/or Spanish speaking?	

RWA Quality Management 1 September 2024

Ryan White Grant Administration
Quality Management Assessment
Bilingual/Monolingual Translation Services

5. What percentage of frontline staff, at your organization, are bilingual?	
6. Have you ever experienced turning a client away due to lack of translation services?	
7. What best practices does your organization do well when servicing monolingual clients? What could improve?	
8. How can the Administrative Agent support your organization with identified barriers for monolingual Spanish speaking clients?	
9. Please share any addition comments for the Administrative Agent to consider in the improvement of the overall quality and satisfaction for bilingual and monolingual clients.	

Thank you for your feedback!

RWA Quality Management 2 September 2024

Question #1 *What linguistic (translation) services or apps do CM/frontline use at your organization for bilingual clients?*

Agency A	MasterWord and Globo services are ordered for English/non-Spanish Bilingual patients.
Agency B	We schedule interpreters for all languages except Spanish from MasterWord and Crabtree GLOBO agencies. We have the state services grant that allows us to order interpreters for all RW agencies. A 3-day advance notice is required to request interpretation services along with submission of eligibility documentation. One of our case manager receives the requests and places the order to MasterWord or GLOBO depending on the language of the client.
Agency C	Frontline staff utilizes multiple robust linguistic services to ensure that bilingual clients receive the care they need without language barriers. The services include over-the-phone on-demand interpretation available 24/7 in over 250 languages, Video Remote Interpreting (VRI) for critical languages like Spanish, Vietnamese, and Mandarin, and In-person Spanish interpreters available at all locations. These services ensure that language does not hinder effective communication between staff and clients.
Agency D	Translation Line, we also have a bilingual MCM who provides mental health services.
Agency E	Boostlingo's interpreting services expand language access and improve communication with innovative technology. The solutions include on-demand Video Remote Interpretation (VRI) and Over-the-Phone Interpretation (OPI), interpreter management, simultaneous interpretation, remote simultaneous interpretation, and AI captioning and translations.
Agency F	A language line for phone appts and use a virtual interpreter for in clinic appointments.

Question #2 *What process does CM/frontline follow at your organization when assisting Spanish speaking clients? How is this process different or the same for monolingual Spanish speakers?*

Agency A	Spanish-speaking medical staff are used for medical and Spanish-speaking CM Team staff are utilized for case management appointments. Process is the same but utilizes in-house staff instead of translator agencies.
Agency B	All of our front desk staff are bilingual and assist all clients equally with our eligibility documentation. Our eligibility forms are in both English and Spanish. Half of our Clinical Case Managers are bilingual as well as our Lead Case Manager who assists with assignment of clients.
Agency C	For Spanish-speaking clients, frontline staff utilizes the over-the-phone on-demand interpretation service line or in-person interpreters as needed. Additionally, Video Remote Interpreting (VRI) is employed for a more immediate and visual interaction. A dedicated team of qualified bilingual staff members who can directly communicate with Spanish-speaking clients, ensuring that monolingual Spanish speakers receive the same level of care and service as other clients. The process remains consistent across the board, whether the client is monolingual or bilingual, to ensure that all communications are clear and effective.
Agency D	Process is the same, we have bilingual staff. Specifically for mental health side, patients referred for services that are Spanish speaking are sent to the Spanish speaking clinician.
Agency E	A diverse staff with at least 90% of the front-end staffing being bilingual in English and Spanish. For those staff members who do not speak Spanish or clients who speak an alternative language, we are using Boostlingo for any translation needs.
Agency F	Utilizing cultural competent forms, reading out loud so the if the client can't read successfully, utilizing

Question #3 *What barriers have you identified, or observed, at your organization for bilingual speaking clients accessing quality services efficiently?*

Agency A	In-house, we do not have enough Spanish-speaking Medical Case Managers. External agencies, we rely on interpreter translation but have found medical information can often be misinterpreted as interpreters may not have full medical understanding. We have also seen difficulty securing interpreters for several languages.
Agency B	Documentation in Spanish can be a barrier as flyers describing outside services or referral forms to outside agencies are not frequently in Spanish. Bilingual staff often have full caseloads so clients may have to wait a short time for on-going case management. Our Lead Case manager will call clients to assess for immediate needs and offer resources as needed while clients wait to for assignment to a clinical case manager.
Agency C	No significant barriers have been identified at this time, we are committed to providing comprehensive language services to all clients. The organization continuously educates and reinforces the importance of utilizing available interpretation services among staff. However, a potential area for improvement could be increasing the availability of iPads for Video Remote Interpreting (VRI) to further streamline access to interpretation services, including American Sign Language (ASL) for hearing-impaired clients.
Agency D	None identified, services are provided if requested by patient.
Agency E	Prior to the usage of Boostlingo barriers that we experienced with translations included either the patient not attending the appointment and more so the patient attending the appointment and the translator not attending. With the implementation of Boostlingo, our team can obtain virtual and phone translation assistance within 60 seconds of the request.
Agency F	No barriers that I have experienced.

Question #4 *If your organization has a Community Advisory Board/Group, what percentage of the group identifies at Hispanic and/or Spanish speaking?*

Agency A	There is a CAB, but statistical information is not available to case management team.
Agency B	We are currently in the process of forming a Community Advisory Board and are accepting applications. The board is set yet so I am unable to provide data at present.
Agency C	Three out of seven members of the Community Advisory Board/Group identify as Hispanic and/or are Spanish speakers, reflecting the organization's commitment to inclusivity and representation in its advisory processes.
Agency D	Unknown
Agency E	We are currently in the process of establishing a community advisor in which the goal would be to have a percentage of Hispanic and Spanish Speaking members to match the percentage of our Hispanic population.
Agency F	N/A

Question #5 *What percentage of frontline staff, at your organization, are bilingual?*

Agency A	For Case Management, 60% of staff are bilingual in Spanish & English. Percentage unknown for our frontline staff.
Agency B	100% font desk staff and 50% of CCMs are bilingual (and one CCM is actually trilingual English/Spanish/French). 75% of case managers from other departments are bilingual. We have one staff who is bilingual in ASL.
Agency C	Approximately 25% of its staff who are Spanish-speaking. At high traffic clinic, about 45% of the staff are Spanish-speaking, ensuring that there is adequate bilingual support available for Spanish-speaking clients.
Agency D	1 MCM staff, 3 CMSL. We also have front desk staff at our sites that are bilingual.
Agency E	About 90% of our frontline staff are bilingual.
Agency F	40%

* QMD inserted language to deidentify agency.

Question #6 *Have you ever experienced turning a client away due to lack of translation services?*

Agency A	Yes, but for non-Spanish speaking patients. Often this is due to Interpreter Agency unable to secure an interpreter, though sometimes due to an interpreter not showing.
Agency B	Monolingual clients who speak Spanish are not turned away as we ask staff (from other departments if needed) who are bilingual to assist the client. Staff who meet with monolingual clients request interpretation services ahead of their scheduled appointment.
Agency C	No client has ever been turned away due to a lack of translation services. The comprehensive language access services ensure that all clients receive the necessary communication support, regardless of the language they speak.
Agency D	No
Agency E	We have never experienced turning a client away due to a lack of translation.
Agency F	No, not at all.

Question #7 *What best practices does your organization do well when servicing monolingual clients? What could improve?*

Agency A	MasterWord and Globo services are ordered through partnered agency for English/non-Spanish Bilingual patients.
Agency B TMC	We operate in an integrative care approach and collaborate with other departments to ensure all of our clients receive services. This team approach is helpful when monolingual clients are receiving services. Staff frequently consult with each other about unique resources for our monolingual clients and for clients who do not have legal documentation/residency. Increasing the number of bilingual staff would allow us to serve monolingual clients quickly for CCM services.
Agency C	Agency excels in identifying and tagging clients in the Epic system who need an interpreter, specifying the language required. This tagging ensures that language needs are immediately recognized and addressed. The system also supports a wide range of translation services, including American Sign Language (ASL) for the hearing impaired. For non-common languages, the Interpreter Services team arranges for in-person interpreters to assist patients directly. Additionally, the organization offers an 8-week Spanish class to all staff members interested in improving their language skills, further strengthening their ability to serve monolingual clients. One area for improvement could be securing more iPads to enhance access to interpretation services, including ASL.
Agency D	We provided services mental health and case management services to our monolingual clients with a bilingual staff. We have also offered in the past Spanish speaking support groups. Marketing materials have provided in Spanish to market services to the clients.
Agency E	Best practices used when serving monolingual clients include through communication with clients and/or representatives prior to the visit to best prepare for the visit.
Agency F	We have staff that speaks a variety of languages including English, Spanish, French, mandarin, ASL and Portuguese.

* QMD inserted language to deidentify agency.

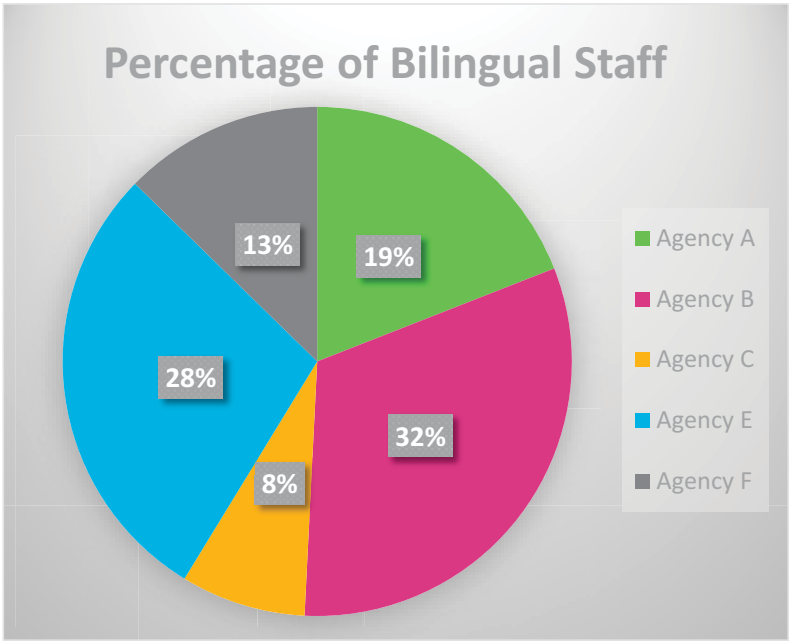
Question #8 *How can the Administrative Agent support your organization with identified barriers for monolingual Spanish speaking clients?*

Agency A	Funding for additional resources and securing longer appointment standards.
Agency B	Recruiting bilingual LMSWs is difficult as the salary we are able to offer is below what a bilingual social worker can earn at other agencies. A unit rate increase for salaries is essential in securing bilingual LMSWs.
Agency C	The Administrative Agent can support us by providing additional funding to secure more iPads, which would enhance access to Video Remote Interpreting (VRI) and American Sign Language (ASL) services. Moreover, the Agent could share barriers identified by other organizations and disseminate this information to all Ryan White-funded organizations, along with educational resources to address these barriers effectively.
Agency D	None identified at this time
Agency E	No support is needed currently.
Agency F	Have more RW funded agencies that have Spanish speaking clients.

Question #9 *Please share any addition comments for the Administrative Agent to consider in the improvement of the overall quality and satisfaction for bilingual and monolingual clients.*

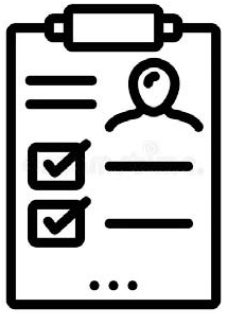
Agency A	**N/A**
Agency B	Ensuring that all Ryan White forms are in Spanish such as the CPCDMS registration and update forms.
Agency C	To improve overall quality and satisfaction for bilingual and monolingual clients, Ryan White could consider including language access as a core component of patient care and confidentiality standards. Additionally, offering a differential incentive for frontline staff members who are bilingual certified, funded by Ryan White, could encourage more staff to become certified, thereby improving language access services across the organization.
Agency D	None at this time
Agency E	Over time and through much review, we have implemented systems and feel we are in a good place to provide services to monolingual clients.
Agency F	No comments at this time.

- **Includes:**
  - Front Desk Staff
  - Medical Case Mangers
  - Non-Medical Case Mangers (SLW)
  - Clinical Case Managers
    - (*include one trilingual)



Themes

1. Every Part A agency has at least one bilingual frontline staff member, and at least one clinician
2. No consistency of 3rd party translation services/organizations
   - Boostlingo
   - MasterWord
   - GLOBO
   - Video Remote Interpreting utilized for 'critical' languages (Vietnamese, and Mandarin)
3. Larger institutions have stronger infrastructure to support language services including, but not limited to RW.
4. 1/6 agencies have turned away a client due to lack of access to translation services



Barriers

- Not enough Spanish speaking MCMs
- Documentation/resources not printed in Spanish
- Two of four agencies does not have a CAB

Table of Contents

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

Service Definition	Approved FY24 Financial Eligibility Based on federal poverty guidelines	Recommended FY25 Financial Eligibility Based on federal poverty guidelines	Page #
Ambulatory/Outpatient Medical Care (includes Medical Case Management[1], Service Linkage[2], Outreach[3], EFA-Pharmacy Assistance[4], Local Pharmacy Assistance[5]) - Part A - CBO - Public Clinic - Rural	**300%** (None[1], None[2], None[3], 500%[4], 500%[5])	**300%** **Rural = 400%** (None[1], None[2], None[3], 500%[4], 500%[5])	**1** **16** **31**
Case Management: - Clinical - Part A - Non-Medical (Service Linkage at Testing Sites) - Part A - Non-Medical (targeting Substance Use Disorders) - State Services	**No Financial Cap**	**No Financial Cap**	**46** **52** **58**
Emergency Financial Assistance (EFA) - Other - Part A	**400%**	**400%**	**63**
Health Insurance Premium and Cost Sharing Assistance: - Part B/State Services - Part A	**0 - 400%** **ACA plans: must have a subsidy** (see Part B service definition for exception)	**0 - 400%** **ACA plans: must have a subsidy** (see Part B service definition for exception)	**66** **69**
Hospice Services - State Services	**300%**	**300%**	**72**
Linguistic Services - State Services	**500%**	**500%**	**76**
Medical Nutritional Therapy and Nutritional Supplements - Part A	**400%**	**400%**	**78**
Mental Health Services - State Services - Untargeted - Targeting Special Populations	**500%**	**500%**	**82** **87**
Oral Health: - Untargeted - Part B - Rural (North) - Part A	**300%**	**300%**	**93** **96**
Referral for Health Care: - ADAP Enrollment Workers - State Services - Incarcerated - State Services	**500%** **No Financial Cap**	**500%** **---**	**99** **101**
Substance Abuse Treatment - Part A	**500%**	**500%**	**104**
Transportation - Part A	**400%**	**500%**	**107**
Vision Care - Part A	**400%**	**400%**	**113**

2025-2026 Houston EMA: RWGA Part A
Standards of Care for HIV Services
Ryan White Grant Administration

DRAFT

Workgroups Feedback

The Ryan White Grant Administration (RWGA) participated with 3 workgroups, inviting feedback and suggestion for the 2025-2026 Standards of Care. This document summarizes the comments and suggestions for revision proposed by participants from the workgroups outlined below:

- October 21, 2024 Ryan White A & B: Affected Community Input Mtg
- November 4, 2024 Ryan White A: (RWA) Provider & Community Input Mtg
- November 13, 2024 Ryan White A: Case Management Supervisors Peer-Led Mtg
- December 4, 2024 Ryan White A: RWGA SOC Review Mtg

I. Ryan White A & B: Affected Community Input

Suggestion 1:	Services should be explained to the client in their preferred language so there are no barriers to understanding the services or procedures that are being covered by RW.
Justification:	Google translate is not appropriate to use when conducting eligibility or communicating with the client. It should be in the clients preferred language so there is no confusion about their services.
Service Definition or Standard of Care:	GS 4.1 Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations.
Suggestion 2:	Complaint and grievance process should be easily available to all clients.
Justification:	Clients that would like to file a complaint or grievance should be able to access information regarding the process and it should be easily available to get that information
Service Definition or Standard of Care:	SVG 3.5 states, agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client.
Suggestion 3:	Staff should be mindful when saying client's name or information.
Justification:	When walking into an agency the client should feel like their name or information is being kept confidential. It is not keeping confidentiality when saying a person's name out loud for people in the waiting room to hear.
Service Definition or Standard of Care:	GS 3.2 - Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local,

	state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.

II. Ryan White A: (RWA) Provider & Community Input

Suggestion 1:	Make "EHE Rapid Start" model as a regular part of Part A services. There was concern expressed that PCARE 1.6 allows for up to 3 weeks before the patient sees a medical care professional. They stated it should be changed to no less than 1 week.
Justification:	Rapid diagnosis, connection to care and access to medications would increase the goal of viral suppression and reduce the risk of transmission.
Service Definition or Standard of Care:	PCARE 1.6 - All people living with HIV receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) ~~within 3 weeks~~ within 1 week of initial contact with the client.
Suggestion 2:	Providers should ensure that sufficient bilingual personnel (English/Spanish) are on staff to serve Spanish speaking consumers. (This is actually the same concern that was presented in the consumer's input meeting.)
Justification:	It was shared that from a personal observation at a subrecipient's site, a clinic staff person was using Google Translate to interact with a Spanish speaking patient (in the lobby) who apparently was newly diagnosed and was brought to the clinic to access services. During the observation, it appeared that the patient was not understanding what was being communicated to him because Google Translate does not accurately translate.
Service Definition or Standard of Care:	GS 4.1 Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations.
Suggestion 3:	For the supervisor's Peer Led meeting, there is no allowance for someone to miss one of the 4 per contract year meeting. If the person is out ill, they cannot attend. It becomes a citation during the Site Visit. All other meetings allow for 1 absence.
Justification:	All other meetings allow for the possibility of someone being out on sick leave.
Service Definition or Standard of Care:	CMALL 1.4: Change it from "supervisors must attend all 4 Peer Lead meetings" to "they must attend 3 out of 4 meetings."

Suggestion 4:	Better integration of mental health services into the primary care model. It was stated: "Clients need the mental health provider to really listen to clients concerning their mental health needs (therapy).
Justification:	Just having a psychiatrist prescribe medications is not sufficient." There were questions asking as to is there a warm handoff by CM service providers to mental health services? Or do they just provide referrals without really making sure they have engaged mental health services?
Service Definition or Standard of Care:	*To be completed.*
Suggestion 5:	All bundled services for primary care must also have Clinical Case Manager (CCM) on staff as part of their care model so as to provide mental health therapy.
Justification:	There appears to be a lack of mental health services for eligible patients. Having a CCP available to provide actual therapy and not just sending them to a psychiatrist to prescribe a medication would better serve the client's need. "Clients want to be heard on their mental health needs."
Service Definition or Standard of Care:	*To be completed.*

III. Ryan White A: Case Management Supervisors Peer-Led Mtg

Suggestion 1:	Medication Education is a required service when there is a change to a patient's HIV Medications. This is looked for in the charts during our Annual Part-A Site Visit. They are looking for the education in either the Provider's Note or Nursing Note in the electronic medical record.
Justification:	Every patient who receives a new medication from the Thomas Street Pharmacy receives Medication Education at the window from a Registered Licensed Pharmacists. I have witnessed this process many times when escorting a patient to the window. The education is extensive and detailed. Would it be possible to count this extensive education for any patient who is picking up that medication at our (HHS -Thomas St. at Quentin Mease) pharmacy?
Service Definition or Standard of Care:	PCARE 1.15 All clients must receive comprehensive documented education regarding their most current prescribed medication regimen.
Suggestion 2:	The Standards require that Clinical Case Managers (CCM) must consult with medical providers every 6 months. TMC would like to remove "clinical setting" from SOC and be allowed to consult with internal licensed medical staff (at TMC).

Justification:	This is a barrier for CMM staff at TMC because TMC is not connected to a clinic. Would like to remove "clinical setting" from SOC and be allowed to consult with internal licensed medical staff.
Service Definition or Standard of Care:	SOC CCM 2.3 - Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs. Clinical Case Management services provided to clients accessing primary medical care from a Ryan White Part A funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every six (6) months or more often if clinically indicated for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi- disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.
Suggestion 3:	Peer-Led Training: We have several required meetings/trainings. We are allowed to miss one Case Manager Supervisor Meeting during the year without being penalized. However, we are not allowed to miss any of the Peer-Led Trainings without being penalized. I realize that this is probably because there are only a few of the Peer-Led Trainings each year.
Justification:	Would it be possible to offer a "make-up" opportunity in the event a Manager/Supervisor has a conflict and must miss a Peer-Led Training. These are recorded meetings…. Maybe we could sit through the recorded meeting and let that count for a missed Peer-Led Training? There could be a stipulation that this option is available only once in a grant year. Folks are going to have conflicts – so offering an alternative option for adherence would seem fair.
Service Definition or Standard of Care:	CM ALL 1.4 - Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in 3 of the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.

IV. Ryan White A: RWGA SOC Review Mtg

THE RESOURCE GROUP

State of Standards

Update for the DSHS SOC Review Process

Houston
Categories Reviewed

Services that have been released for comments.

- Universal Standards
- Health Insurance Assistance
- Mental Health Services
- Non-Medical Case Management
- Oral Health Care
- Referral For Health Care

Houston
Categories Finalized

Services that have been finalized and published to the website.

- Non-Medical Case Management

Non-Medical Case Management

Brief Overview of Changes

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Initial Assessment: Case managers should conduct an initial assessment for all NMCM clients to determine their need for medical and support services, as well as barriers to accessing services, client strengths, and resources. The 30-day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information. The assessment should determine client needs in the following areas: • Access to medical care and medication • Food security and nutritional services • Financial needs and entitlements • Housing security • Transportation • Legal assistance • Linguistic services • Any other applicable medical or support service needs Case managers should also include the following in the initial assessment: • Client strengths and resources • Other agencies that serve client and household	1. Percentage of clients with a completed initial assessment within 30 calendar days of the first appointment to access NMCM services.

Care Planning: The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum: • Problem statement based on client need • One to three current goals • Interventions to achieve goals (such as tasks, referrals, or service deliveries) • Individuals responsible for the activity (such as case management staff, the client, other team members, the client's family, or another support person) • Anticipated time for the completion of each intervention Staff should update the care plan with outcomes and revise or amend the plan in response to changes in access to care and services. Case managers should update tasks, types of assistance in accessing services, and services as they identify or complete them, not at set intervals. Case managers must update care plans at least once every six months, and should document that they reviewed and revised, if appropriate, all required elements (problem statement or need, goals, interventions, responsible party, and timeframe).	2. Percentage of clients with a care plan that contains all of the following: 2a:Problem statement or need; 2b: Goal(s); 2c: Intervention (tasks, referral, service delivery); 2d: Responsible party for the activity; and 2e: Timeframe for completion. 3. Percentage of clients with care plans that have been updated at least once every six months.
Assistance in Accessing Services and Follow-Up: Case management staff should work with the client to overcome barriers to accessing services and complete the interventions identified in the care plan. Case managers should base assistance on the needs identified, collaboratively with the client, during the care planning process. If the client denies any assistance, staff should document this. When clients receive assistance in accessing services outside of the agency providing NMCM, case notes must include documentation of follow-up and outcome.	4. Percentage of clients with documentation of assistance provided, based on the client care plan. 5. Percentage of clients who received assistance in accessing outside services that have documentation of follow-up. **Former Measure 5 Removed**

Case Closure and Graduation: Agencies should close cases and document in the client's chart when clients are no longer engaged in active case management services. This should include brief narrative progress notes, formal case closure, and a graduation summary. The case management supervisor should review and sign all closed cases. Staff must notify clients of plans for case closure and provide written documentation explaining the reason for closure or graduation and the process clients can follow if they elect to appeal the case closure or graduation from service. At the time of case closure, agencies should also provide clients with detailed information on how to reestablish NMCM services. A client is "out of care" if three attempts to contact the client (via phone, e-mail, or written correspondence) are unsuccessful and the agency has given the client 30 days from initial contact to respond. Staff should utilize multiple methods of contact (i.e., phone, text, e-mail, or certified letter), as permitted by client authorization, when trying to re-engage a client. The agency should initiate case closure proceedings 30 days following the third attempt at contact. Common reasons for case closure include: • The client no longer needs non-medical case management services. • The provider refers the client to another case management program. • The client relocates outside of the service area. • The client chooses to terminate services. • The client is no longer eligible for services due to not meeting eligibility requirements. • The client is lost to care or does not engage in service. • The client is or will be incarcerated for more than 6 months in a correctional facility. • The provider-initiated termination due to behavioral violations, per agency's policy and procedures. Graduation criteria:	6. Percentage of closed cases with discharged documentation including: 6a. A formal case closure or graduation summary that documents the reason for case closure; 6b. A supervisor's signature and approval; 6c. Client notification, including the provision of written documentation explaining the reason for case closure or graduation; and 6d. The provider gives the client information on appealing the case closure and the process to re-establish NMCM in the future. **Measures 7-9 were collapsed into Measure 6**

• The client completed case management goals for increased access to services or care needs. • The client no longer needs case management services (e.g., client can resolve needs independent of case management assistance or has needs that RHCS can adequately meet.	

Of Course,

It’s never that simple!

Health Insurance Assistance

Additional 2024 Guidance

Hot Off the Presses: DSHS HIA Guidance

- HRSA has confirmed that this includes all nine classes of FDA-approved antiretroviral medication:
  - Nucleoside reverse transcriptase inhibitors
  - Non-nucleoside reverse transcriptase inhibitors
  - Protease inhibitors
  - Integrase strand transfer inhibitors
  - Fusion inhibitor
  - CCR5 antagonist
  - CD4 post-attachment inhibitor
  - Gp120 attachment inhibitor
  - Capsid inhibitor

Hot Off the Presses: DSHS HIA Guidance

- The last five categories each contain only one medication, which all insurance plans must cover: Fuzeon, Selzentry (or generic maraviroc), Rukobia, Trogarzo, and Sunlenca.
- Not all Marketplace plans cover these required medications. Some of these medications are covered by insurance plans but are not listed in the plan's formulary, either because they require prior authorization or because they are administered in office and are covered under the medical benefit instead of the pharmacy benefit.

Hot Off the Presses: DSHS HIA Guidance

- To assist agencies in identifying plans that meet coverage requirements, Care Services has reviewed current Marketplace plans for 2025. We have determined that ACA Marketplace plans from the following carriers cover all HRSA-required medications:
  - Ambetter
  - Blue Cross Blue Shield (Tier 4 and Tier 6 formularies)
  - Cigna (Tier 4 and Tier 5 formularies)
  - Molina
  - United Healthcare

Hot Off the Presses: DSHS HIA Guidance

Agencies are not required to purchase plans from these carriers. However, if an agency uses Ryan White Part B or State Services funds to pay plan premiums through the Health Insurance Premium and Cost Sharing Assistance service category, it will be the responsibility of the agency to maintain documentation of plan eligibility. This requirement only applies when an agency assists the client with medical insurance premium payments. *Clients are eligible for cost-sharing assistance regardless of what insurance plan they are enrolled in, or if that plan meets HRSA requirements, this includes cost-sharing associated with THMP TIAP+ plans. Health Insurance Assistance is a core service category and must be funded at a level that meets client needs*.