Houston Area HIV Services Ryan White Planning Council

Office of Support
1310 Prairie Street, Suite 800, Houston, Texas 77002
832 927-7926 telephone; http://rwpchouston.org

MEMORANDUM

To: Steering Committee Members:
Josh Mica, he/him/él, Chair
Skeet Boyle, Vice Chair
Ryan Rose, Secretary
Johnny Deal, Co-Chair, Affected Community Committee
Carol Suazo, Co-Chair, Affected Community Committee
Kenia Gallardo, Co-Chair, Comprehensive HIV Planning Committee
Robert Sliepka, Co-Chair, Comprehensive HIV Planning Committee
Cecilia Ligons, Co-Chair, Operations Committee
Crystal R. Starr, Co-Chair, Operations Committee
Peta-gay Ledbetter, Co-Chair, Priority and Allocations Committee
Rodney Mills, Co-Chair, Priority and Allocations Committee
Tana Pradia, Co-Chair, Quality Improvement Committee
Pete Rodriguez, Co-Chair, Quality Improvement Committee

Copy: Glenn Urbach
Eric James
Mauricia Chatman
Francisco Ruiz
Tiffany Shepherd
Patrick Martin
Diane Beck
Jason Black

EMAIL ONLY:
Sha'Terra Johnson
David Williams

From: Tori Williams

Date: Tuesday, November 26, 2024

Re: Meeting Announcement

Please contact Rod to RSVP, even if you cannot attend the following meeting, and let her know if you prefer to participate virtually or in person. Rod can be reached by telephone at: 832 927-7926 or by email at: Rodriga.Avila@harriscountytx.gov. Thank you!

Ryan White Steering Committee Meeting

12 noon, Thursday, December 5, 2024

Join the Zoom meeting by clicking on:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192 Passcode: 885832
Or, use your phone to dial in by calling 346 248-7799

In-Person: Please join us at Bering Church, 1440 Harold St., Houston, Texas 77006
Please park and enter from behind the building on Hawthorne Street.

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
<<>>
STEERING COMMITTEE

AGENDA

12 noon, Thursday, December 5, 2024

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

In Person Meeting Location: 1440 Harold Street, Houston, Texas 77006

Join Zoom Meeting by clicking onto:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192
Passcode: 885832
Or, dial in by calling 346 248-7799

I. Call to Order — Josh Mica, he/him/él, Chair RW* Planning Council
- A. Welcoming Remarks and Moment of Reflection
- B. Select the Committee Co-Chair who will be voting today
- C. Adoption of the Agenda
- D. Adoption of the Minutes

II. Public Comment 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 yourself, 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 Committees

A. Comprehensive HIV Planning Committee — Kenia Gallardo, she/her/hers & Robert Sliepka, he/him/they, Co-Chairs

Item: 2024 HIV Prevention & Care Needs Assessment

Recommended Action: FYI: Beth Allen, the Interim Health Planner, met with the Committee on Tuesday afternoon, December 3rd to review the data from the 2024 HIV Prevention and Care Needs Assessment. It is taking longer than expected to complete the report, hence it will be presented to the Committee in January or February and the the Council will see it well before it is needed for the April How To Best Meet the Need process.

B. Affected Community Committee — Johnny Deal, he/him/his & Carol Suazo, she/her/ella,

Item: 2024 Project LEAP/Proyecto VIDA Graduation

Recommended Action: Please join members of the Affected Community Committee in hosting the 2024 Project LEAP/ Proyecto VIDA Graduation on Thursday, December 12th. See Tori or Rod to sign up.

Item: Quarterly Committee Report
Recommended Action: See the attached Quarterly Committee Report.

C. Quality Improvement Committee

Item: Reports from the Administrative Agent – Part B/SS**** — Tana Pradia, she/her/hers & Pete Rodriguez, he/him/él, Co-chairs
Recommended Action: FYI: See the attached reports from the Part B/State Services (SS) Administrative Agent:

- FY24-25 Procurement Report – Part B, dated 11/04/24
- FY23-24 Procurement Report – SS****, dated 11/04/24
- FY23-24 Service Utilization – Pt. B, dated 11/04/24
- FY23-24 Health Insurance Assist Service Utilization, dated 11/04/24

Item: Reports from the Administrative Agent – Part A/MAI***
Recommended Action: FYI: See the attached reports from the Part A/Minority AIDS Initiative (MAI) Administrative Agent:

- FY24 Procurement Report – Part A/MAI, dated 11/12/24
- FY24 Service Utilization – Part A/MAI, dated 11/12/24

Item: New FY 2025 Service Definitions
Recommended Action: **Motion:** Approve the proposed financial eligibility for:

- Home Delivered Meals
- Housing – Temporary Assisted Living
- Legal Assistance – Expungement of Criminal Record

Item: Update on Spanish Translation at RW funded clinics — Mauricia Chatman, RWGA
Recommended Action: FYI: See the attached power point presentation.

Item: Ryan White Part A/MAI Standards of Care & Perf. Measures — B.Taylor & K. Lara, RWGA
Recommended Action: **Motion:** Endorse the Ryan White Part A/MAI Standards of Care and Performance Measures.

Item: Ryan White Part B/SS Standards of Care & Perf. Measures — Tionna Cobb, The Resource Grp.
Recommended Action: FYI: Updates on the Ryan White Part B/*SS* Standards of Care.

Item: TDSHS** Proposed FY 2025 Standards of Care
Recommended Action: FYI: TDSHS** welcomes input into the FY 2025 proposed changes to Part B funded standards of care. See the attached standards for:

- Substance Abuse Outpatient
- Substance Abuse Residential

Please submit all comments to Sha'Terra Johnson, The Resource Group, at: sjohnson@hivtrg.org

D.	Priority and Allocations Committee Per usual, the Committee did not need to meet in November	Peta-gay Ledbetter, she/her/hers Rodney Mills, Co-Chairs
E.	Operations Committee *Item:* Personnel Subcommittee *Recommended Action:* FYI: Verbal update.	Cecilia Ligons, she/her/hers & Crystal R. Starr, she/her/hers, Co-chairs
	*Item:*Part A Memorandum of Understanding (MOU) and Part B Letter of Agreement *Recommended Action:* **Motion:** Since the Houston Ryan White Part A Memorandum of Understanding was signed by the County Judge in 2024, and since the Part B Letter of Agreement is currently being reviewed by the Texas Department of State Services, it is recommended that no changes be made to either document at this time.	
	Item: Ryan White Planning Council (RWPC) Website *Recommended Action:* **Motion:** List educational meetings (like Project LEAP, Proyecto VIDA and Council Orientation) and Personnel Subcommittee meetings on the RWPC website, but do not include the meeting location, agenda or other meeting details.	
	Item: Election of 2025 Council Officers *Recommended Action:* FYI: See the attached list of nominations for the election of the 2025 Council Officers.	
	Item: Important Dates in 2025 *Recommended Action:* FYI: Please note the following dates in 2025: Mentor Luncheon: Thursday, January 16, 2025 Council Orientation: Thursday, January 23, 2025, III Wolfgang Puck February: First 2025 Steering and Council meetings	
V.	Report from the Office of Support	Tori Williams, she/her/hers, Director
VI.	Report from Ryan White Grant Administration	Glenn Urbach, he/him/his, Manager
VII.	Report from The Resource Group	Sha'Terra Johnson, she/her/hers, Health Planner
VIII.	Announcements	
IX.	Adjournment	

** RW = Ryan White*
***DSHS = Texas Department of State Health Services*
****MAI = Minority AIDS Initiative*
***** = State Services funding*

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
<<>>
STEERING COMMITTEE

MINUTES

12 noon, Thursday, November 7, 2024
Meeting Location: Bering Church 1440 Harold Street; Houston, TX and Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Josh Mica, he/him/él, Chair	Skeet Boyle, Vice Chair	*Ryan White Grant Administration*
Ryan Rose, Secretary	Crystal R. Starr	Glenn Urbach
Johnny Deal	Tana Pradia	James Supak
Carol Suazo		Mauricia Chatman
Kenia Gallardo		Eric James
Robert Sliepka		
Cecilia Ligons		*The Resource Group*
Peta-gay Ledbetter		Sha'Terra Johnson
Rodney Mills		
Pete Rodriguez		*Office of Support*
		Tori Williams
		Diane Beck

Call to Order: Josh Mica, he/him/él, Chair, called the meeting to order at 12:00 p.m. During opening remarks he thanked everyone for being in attendance and for being excellent committee co-chairs. He then called for a Moment of Reflection.

Those selected to represent their committee at the meeting were: Deal for Affected, Gallardo for Comprehensive HIV Planning, Ligons for Operations, Ledbetter for Priority and Allocations, and Rodriguez for Quality Improvement.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Ligons, Deal) to approve the October 3, 2024 minutes.* **Motion carried.** Abstentions: Gallardo.

Public Comment and Announcements: None.

Reports from Committees
Comprehensive HIV Planning Committee: Robert Sliepka, Co-Chair, reported on the following:
2024 Houston Area HIV Epidemiological Supplement: ***Motion:*** *Endorse the attached, 2024 Houston Area HIV Epidemiological Supplement, which will include a few suggested edits.* ***Motion approved.***

2024 Houston Area HIV Epidemiological Supplement: The 2024 Epidemiological Supplement would not have been created without significant collaboration and the hard work of Bingjie Li, Alamou Sanoussi and Imran Shaikh from the Houston Health Department. As well as Nithya Lakshmi Mohan

Dass from Ryan White Grant Administration and Beth Allen, the Interim Health Planner in the Ryan White Office of Support. And, thanks to Sha'Terra Johnson for providing HSDA data. Many thanks to all.

Spanish Translation: ***Motion #4:*** *Translate the 2024 Epidemiological Supplement into Spanish.* (Note: The Committee prefers to make a decision about translation as each document is finalized.) **Motion Carried.**

2024 HIV Prevention & Care Needs Assessment: The Interim Health Planner is working to complete the 2024 HIV Prevention and Care Needs Assessment which is scheduled to be reviewed at the November 14, 2024 Committee meeting.

Updates on the Joint Planning Body: Williams said that the committee and workgroup meetings for November would be cancelled and the Leadership Team will meet in December. The committees and workgroups will start up again in January.

Affected Community Committee: Carol Suazo, Co-Chair, reported on the following:
FY 2025 Standards of Care: Consumer-only members of the Committee and of two EHE/Integrated Planning workgroups met jointly to discuss and provide input into the FY 2025 Standards of Care. Staff from Ryan White Grant Administration and The Resource Group took notes and will report back to the group.

Ryan White Information Table at City/County Joint Training: Members of the Committee hosted a table at the bi-annual, case management and disease intervention specialist joint training. Materials provided included information on Planning Council and Affiliate Committee membership, Project LEAP, Proyecto VIDA and more.

Quality Improvement Committee: Pete Rodriguez, Co-Chair, reported on the following:
Texas Department of State Health Services (TDSHS) Proposed FY 2025 Standards of Care: TDSHS welcomes input into the FY 2025 proposed changes to Part B funded standards of care. See the attached standards for Mental Health and Oral Health. Please submit all comments to Sha'Terra Johnson, The Resource Group, at: sjohnson@hivtrg.org.

New FY 2025 Service Definitions: ***Motion #5:*** *Approve the attached FY 2025 service definitions for Home Delivered Meals, Housing – Temporary Assisted Living, and Legal Assistance – Expungement of Criminal Record.* **Motion Carried.**

Updates on the Distribution of Bus Passes and Translation Services: When invited to provide updates related to the distribution of bus passes at Ryan White funded agencies, Urbach said that agencies have been notified that clients are able to get a bus pass at any RW agency. They are in the process of making changes to the CPCDMS in order for this to work. One agency is currently having issues with their social services staffing but they say it should not be a problem for clients seeking bus passes. Chatman is collecting information from agencies about the translation issue and should have information for the Quality Improvement Committee later this month.

Priority and Allocations Committee: Rodney Mills, Co-Chair, reported on the following:
See the attached reports from the Part A/Minority AIDS Initiative (MAI) Administrative Agent:

- FY24 Procurement Report – Part A/MAI, dated 10/09/24
- FY24 Service Utilization – Part A/MAI, dated 10/08/24

See the attached reports from the Part B/State Services Administrative Agent:

- FY24-25 Procurement Report – Part B, dated 10/03/24
- FY23-24 Procurement Report – State Services, dated 10/03/24
- FY23-24 Service Utilization – State Services, dated 1o/10/24

- FY23-24 Health Insurance Assistance Service Utilization, dated 09/23/24

FY 2024 Ryan White Part A Allocation Increases: ***Motion #6:*** *Approve the recommendations for Ryan White Part A funding increases outlined on the attached chart.* **Motion Carried.**

FY 2024 Ryan White Minority AIDS Initiative (MAI) Allocation Increases: ***Motion #7:*** *Divide $60,000 in unspent MAI dollars by allocating $20,000 to each of the 3 MAI funded subrecipients who do not have unspent primary care or case management funds.* **Motion Carried.**

FY 2024 Unspent Ryan White Part A Funds: ***Motion #8:*** *In the final quarter of the FY 2024 Ryan White Part A, Part B and State Services grant years, after implementing the year end Council-approved reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, Ryan White Grant Administration (RWGA) may reallocate any remaining unspent funds as necessary to ensure the Houston EMA has less than 5% unspent Formula funds and no unspent Supplemental funds. The Resource Group (TRG) may reallocate any remaining unspent funds as necessary to ensure no funds are returned to the Texas Department of State Health Services. RWGA and TRG must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council meeting.* **Motion Carried.**

FY 2024 Ryan White Part A Carryover Funds: ***Motion #9:*** *If there are FY 2024 Ryan White Part A carryover funds, it is the intent of the committee to recommend allocating the full amount to Outpatient/Ambulatory Primary Medical Care.* **Motion Carried.**

Quarterly Committee Report: See the attached Quarterly Committee Report

Operations Committee: Cecilia Ligons, Co-Chair, reported on the following:
Alternative Policy for Members Speaking at Meetings: ***Motion #10:*** *Approve the revised, proposed procedure for members speaking at meetings, see attached.* **Motion Carried.**

Inflation: ***Amendment to Motion #12:*** *it was moved and seconded (Suazo, Rodriguez) to set the minimum increase of 50%.* **Motion Carried**. ***Motion #12:*** *In view of inflation, ask the Chair of the Planning Council to send a letter to the appropriate person in Harris County requesting them to increase the amount allowed for volunteers to be reimbursed for meals.* **Motion Carried.**

Council and Committee Input: ***Motion #13:*** *Allow current Planning Council and Affiliate Committee members to be included in committee discussions at meetings where they are not members. Allow these individuals to add their comments, with the exception of Steering Committee and Council meetings (affiliate members can add their comments at Council meetings.) But, these individuals will have no voting privileges at meetings where they are not an appointed member.* ***Justification****: Per public comment from a Council member, this will allow Ryan White volunteers to have more input into committee meeting decisions.* **Motion Failed.** ***Motion #14:*** *it was moved and seconded (Ligons, Deal) to send the policy back to Operations for revision.* **Motion Carried**.

Election of 2025 Council Officers: ***Motion #15:*** *Accept the attached list of nominations for the election of the 2025 Council Officers. See the attached list of eligible nominees.* **Motion Carried.**

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

Report from Ryan White Grant Administration: Glenn Urbach, Manager, summarized the attached report.

Report from The Resource Group: Sha'Terra Johnson, Health Planner, summarized the attached report.

Announcements: None.

Adjournment: ***Motion:*** *it was moved and seconded (Sliepka, Rodriguez) to adjourn the meeting at 1:59 p.m.* **Motion Carried.**

Submitted by:

Approved by:

_____ _____

Tori Williams, Director Date

Committee Chair Date

2024 Steering Committee Voting Record for Meeting Date 11/07/24

C = Chaired the meeting, ja = Just arrived, lm = Left the meeting

Aff-Affected Community Committee, Comp-Comprehensive HIV Planning Committee, Op-Operations Committee,
PA-Priority and Allocations Committee, QI-Quality Improvement Committee

MEMBERS	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** 2024 Epi Supplement **Carried**				**Motion #4** Translate the 2024 Epi Supplement **Carried**				**Motion #5** New Service Definitions **Carried**				**Motion #6** FY24 Part A Allocation Increases **Carried**				**Motion #7** FY24 MAI Allocation Increases **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Josh Mica, he/him/él, Chair				**C**				**C**				**C**				**C**				**C**				**C**				**C**
Ryan Rose, Secretary		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Johnny Deal, Aff		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Kenia Gallardo, Comp		**X**						**X**		**X**				**X**				**X**				**X**				**X**		
Cecilia Ligons, Op		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Peta-gay Ledbetter, PA		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Pete Rodriguez, QI		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Non-voting members at the meeting:																												
Carol Suazo, Aff ja 12:15																												
Robert Sliepka, Comp																												
Rodney Mills, PA																												
Absent members:																												
Skeet Boyle, Vice Chair																												
Crystal Starr, Op																												
Tana Pradia, QI																												

MEMBERS	**Motion #8** FY24 Part A Unspent Funds **Carried**				**Motion #9** FY24 Part A Carryover Funds **Carried**				**Motion #10** Alt policy for members at meetings **Carried**				**Motion #11** Inflation amendment increase to 50% **Carried**				**Motion #12** Inflation **Carried**				**Motion #13** Council & Committee input **Carried**				**Motion #14** Send back Council & Committee input **Carried**				**Motion #15** Slate of Nominees **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Josh Mica, he/him/él, Chair				**C**				**C**				**C**				**C**				**C**				**C**				**C**				**C**
Ryan Rose, Secretary		**X**				**X**				**X**				**X**				**X**					**X**			**X**				**X**		
Johnny Deal, Aff		**X**				**X**				**X**				**X**				**X**					**X**			**X**				**X**		
Kenia Gallardo, Comp		**X**				**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Cecilia Ligons, Op		**X**				**X**				**X**				**X**				**X**					**X**			**X**				**X**		
Peta-gay Ledbetter, PA		**X**				**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Pete Rodriguez, QI		**X**				**X**				**X**				**X**				**X**					**X**			**X**				**X**		
Non-voting members at the meeting:																																
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Affected Community Committee

2024 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE
(November 2024)

Status of Committee Goals and Responsibilities (* indicates a HRSA mandate):

1. Educate consumers so they understand how to access HIV/AIDS treatment and medication. Provide information that can be understood by consumers of diverse educational backgrounds on client-centered issues.
   Status: Glenn Road to Success event in 2024

2. Continue to get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more.
   ongoing

3. Assure participation by people living with HIV in all Council work products.
   Status: Done

4. *Work with other committees to coordinate Public Hearings regarding the FY 2025 How to Best Meet the Need Results & Priorities and Allocations for Ryan White Parts A and B and State Services.
   Status: Done

5. Recruit Project LEAP, Proyecto VIDA and Council applicants throughout the year.
   Status: Done

6. Annually, review the status of committee activities identified in the current Integrated HIV Prevention and Care Plan.
   Status: Done Now many committees are part of the joint Planning body.

Committee Chairperson

12-25-2024
Date

Quality Improvement Committee Report

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2425 Ryan White Part B

Procurement Report

April 1, 2024 - March 31, 2025

Reflects spending through September 2024

Spending Target: 50%

Revised 11/4/24

Priority	Service Category	Original Allocation per	% of Grant	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
4	Oral Health Service-General	$2,101,048	59%		$2,101,048		$2,101,048	4/1/2023	$727,873	35%
4	Oral Health Service -Prosthodontics	$631,145	18%		$631,145		$631,145	4/1/2023	$340,627	54%
5	Health Insurance Premiums and Cost Sharing (1)	$805,845	23%		$805,845		$805,845	4/1/2023	$773,159	96%
				$0	$0		$0			
		$0	0%	$0	$0					
	Total Houston HSDA	3,538,038	100%	0	3,538,038	$0	$3,538,038		1,841,659	52%

Note: Spending variances of 10% of target will be addressed:

(1) Increase due to costs in spending

2024-2025 Ryan White Part B Service Utilization
4/1/2024- 3/31/2025 Houston HSDA (4816)
2nd Quarter 4-1-24 to 9-30-24

Revised 11/4/2024

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums	***759***	640	81.74%	17.65%	0.15%	0.46%	34.06%	27.65%	33.90%	4.39%	0.00%	0.15%	0.93%	15.46%	18.78%	23.12%	30.78%	10.78%
Oral Health Care	***3,465***	1,839	70.27%	27.67%	0.00%	2.06%	50.51%	10.27%	36.59%	2.63%	0.00%	0.19%	2.01%	16.74%	22.07%	23.49%	25.01%	10.49%
Unduplicated Clients Served By State Services Funds:	*NA*	2,479	76.00%	22.66%	0.08%	1.26%	42.28%	18.96%	35.25%	3.51%	0.00%	0.17%	1.47%	16.10%	20.42%	23.30%	27.90%	10.64%

Completed By: C.Aguries

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2324 DSHS State Services

Procurement Report

September 1, 2023 - August 31, 2024

Chart reflects spending through August (final) 2024

Spending Target: 100%

Revised 11/4/2024

Priority	Service Category	Original Allocation per	% of Grant	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$892,101	29%	$808,566	$1,700,667	$0	$1,700,667	9/1/2023	$1,700,666	100%
6	**Mental Health Services**	$300,000	10%	-$102,307	$197,693	$0	$197,693	9/1/2023	$197,372	100%
11	**Hospice**	$293,832	10%	-$20,612	$273,220	$0	$273,220	9/1/2023	$272,800	100%
13	**Non Medical Case Management (2)**	$350,000	12%	-$170,746	$179,254	$0	$179,254	9/1/2023	$179,253	100%
16	**Linguistic Services**	$68,000	2%	-$50,000	$18,000	$0	$18,000	9/1/2023	$9,649	54%
	Referral for Healthcare-Incarcerated (5)	$141,000	5%	-$141,000	$0	$0	$0	9/1/2023	$0	0%
	ADAP/Referral for Healthcare	$525,000	17%	-$37,017	$487,983	$0	$487,983	9/1/2023	$436,347	89%
	Food Bank	$5,400	0.2%	$0	$5,400	$0	$5,400	9/1/2023	$4,225	78%
	Medical Transportation	$84,600	3%	$0	$84,600	$0	$84,600	9/1/2023	$68,651	81%
	Emergency Financial Assistance (Compassionate Care)	$368,123	12%	-$140,000	$228,123	$0	$228,123	9/1/2023	$228,123	100%
		3,028,056	**100%**	**$146,884**	$3,174,940	$0	$3,174,940		3,097,087	98%

Note

(1) HIP- Funded by Part A, B and State Services/. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31.

(2) Reallocation approved due to a change in provider.

(5) Service was eliminated; reallocation approved by RWPC

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2024-09/30/2024

Revised: 10/28/2024

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	87	$11,341.20	64	*0*	*$0.00*	*0*
Medical Deductible	39	$23,290.00	25	*0*	*$0.00*	*0*
Medical Premium	643	$252,643.30	515	*0*	*$0.00*	*0*
Pharmacy Co-Payment	1559	$78,219.94	579	*0*	*$0.00*	*0*
APTC Tax Liability	0	$0.00	0	*0*	*$0.00*	*0*
Out of Network Out of Pocket	0	$0.00	0	*0*	*$0.00*	*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	2328	$365,494.44	1183	0	$0.00	

Comments: This report represents services provided under all grants.

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2024 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**11,169,413**	**370,766**	**134,765**	**0**	**0**	**0**	**11,674,944**	**46.32%**	**11,674,944**	**0**		**$6,069,729**	**52%**	**67%**
1.a	Primary Care - Public Clinic (a)	4,109,697	144,599					4,254,296	16.88%	4,254,296	0	3/1/2024	$2,500,344	59%	67%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,114,019	37,077	45,820				1,196,916	4.75%	1,196,916	0	3/1/2024	$818,384	68%	67%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	952,840	33,369	39,082				1,025,291	4.07%	1,025,291	0	3/1/2024	$881,675	86%	67%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,201,238	40,784	49,863				1,291,885	5.13%	1,291,885	0	3/1/2024	$357,127	28%	67%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,151,088	40,784					1,191,872	4.73%	1,191,872	0	3/1/2024	$507,954	43%	67%
1.f	Primary Care - Women at Public Clinic (a)	2,090,531	74,153					2,164,684	8.59%	2,164,684	0	3/1/2024	$695,235	32%	67%
1.g	Primary Care - Pediatric (a.1)														
1.h	Vision	500,000						500,000	1.98%	500,000	0	3/1/2024	$309,010	62%	67%
1.x	Primary Care Health Outcome Pilot	50,000	0					50,000	0.20%	50,000	0	3/1/2024	$0	0%	67%
2	**Medical Case Management**	**2,183,040**	**0**	**0**	**0**	**0**	**0**	**2,183,040**	**8.66%**	**2,183,040**	**0**		**803,205**	**37%**	**67%**
2.a	Clinical Case Management	531,025	0					531,025	2.11%	531,025	0	3/1/2024	$340,844	64%	67%
2.b	Med CM - Public Clinic (a)	301,129	0					301,129	1.19%	301,129	0	3/1/2024	$118,871	39%	67%
2.c	Med CM - Targeted to AA (a) (e)	183,663	0					183,663	0.73%	183,663	0	3/1/2024	$85,378	46%	67%
2.d	Med CM - Targeted to H/L (a) (e)	183,665	0					183,665	0.73%	183,665	0	3/1/2024	$47,562	26%	67%
2.e	Med CM - Targeted to W/MSM (a) (e)	66,491	0					66,491	0.26%	66,491	0	3/1/2024	$22,678	34%	67%
2.f	Med CM - Targeted to Rural (a)	297,496	0					297,496	1.18%	297,496	0	3/1/2024	$82,469	28%	67%
2.g	Med CM - Women at Public Clinic (a)	81,841	0					81,841	0.32%	81,841	0	3/1/2024	$82,762	101%	67%
2.h	Med CM - Targeted Geriatrics	400,899	0					400,899	1.59%	400,899	0	3/1/2024	$0	0%	0%
2.i	Med CM - Targeted to Veterans	86,964	0					86,964	0.35%	86,964	0	3/1/2024	$0	0%	67%
2.j	Med CM - Targeted to Youth	49,867	0					49,867	0.20%	49,867	0	3/1/2024	$22,642	45%	67%
3	**Local Pharmacy Assistance Program**	**2,067,104**	**0**	**33,513**	**0**	**0**	**0**	**2,100,617**	**8.33%**	**2,100,617**	**0**	3/1/2024	**$1,151,143**	**55%**	**67%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	367,104	0					367,104	1.46%	367,104	0	3/1/2024	$152,324	41%	67%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,700,000	0	33,513				1,733,513	6.88%	1,733,513	0	3/1/2024	$998,819	58%	67%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**0**	**166,404**	**0.66%**	**166,404**	**0**	3/1/2024	**111,150**	**67%**	**67%**
4.b	Oral Health - Targeted to Rural	166,404	0					166,404	0.66%	166,404	0	3/1/2024	$111,150	67%	67%
5	**Health Insurance (c)**	**1,583,137**		**311,204**	**0**	**0**	**0**	**1,894,341**	**7.52%**	**1,894,341**	**0**	3/1/2024	**$921,390**	**49%**	**67%**
7	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**					**341,395**	**1.35%**	**341,395**	**0**	3/1/2024	**$165,717**	**49%**	**67%**
8	**Substance Abuse Services - Outpatient (c)**	**25,000**	**0**	**0**	**0**	**0**	**0**	**25,000**	**0.10%**	**25,000**	**0**	3/1/2024	**$10,920**	**44%**	**67%**
10	**Emergency Financial Assistance**	**2,139,136**	**0**	**11,722**	**0**	**0**	**0**	**2,150,858**	**8.53%**	**2,150,858**	**0**		**$924,206**	**43%**	**67%**
10.a	EFA - Pharmacy Assistance	2,039,136	0	11,722				2,050,858	8.14%	2,050,858	0	3/1/2022	$883,052	43%	67%
10.b	EFA - Other	100,000	0					100,000	0.40%	100,000	0	3/1/2024	$41,154	41%	67%
12	**Non-Medical Case Management**	**1,267,002**	**0**	**0**	**0**	**0**	**0**	**1,267,002**	**5.03%**	**1,267,002**	**0**	3/1/2024	**$703,434**	**56%**	**67%**
12.a	Service Linkage targeted to Youth	110,793	0					110,793	**0.44%**	110,793	0	3/1/2024	$46,634	42%	67%
12.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0					100,000	**0.40%**	100,000	0	3/1/2024	$39,051	39%	67%
12.c	Service Linkage at Public Clinic (a)	370,000	0					370,000	**1.47%**	370,000	0	3/1/2024	$206,506	56%	67%
12.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	0					686,209	**2.72%**	686,209	0	3/1/2024	$411,243	60%	67%
13	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**0**	**424,911**	**1.69%**	**424,911**	**0**		**$200,920**	**47%**	**67%**
13.a	Medical Transportation services targeted to Urban	252,680	0					252,680	1.00%	252,680	0	3/1/2024	$132,344	52%	67%
13.b	Medical Transportation services targeted to Rural	97,185	0					97,185	0.39%	97,185	0	3/1/2024	$68,576	71%	67%
13.c	Transportation vouchering (bus passes & gas cards)	75,046	0					75,046	0.30%	75,046	0	3/1/2024	$0	0%	67%
15	**Outreach**	**320,000**	0					**320,000**	**1.27%**	320,000	**0**	3/1/2024	**$84,434**	**26%**	**67%**
FY23_RW_DIR	**Total Service Dollars**	**21,686,542**	**370,766**	**491,204**	**0**	**0**	**0**	**22,548,512**	**89.46%**	**22,548,512**	**0**		**$11,146,249**	**49%**	**67%**
									Unallocated	Unobligated					67%
	Part A Grant Award:	**25,204,121**	***Carryover:***	**491,204**			***Total Part A:***	**25,204,121**	1	**0**					67%

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2024 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
		Original Allocation	Award Reconcilation	July Adjusments (carryover)	August 10% Rule Adjustments	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	Award Category	Award Amount	Amount Spent	Balance
	Core (must not be less than 75% of total service dollars)	**17,535,493**	**370,766**	**479,482**	**0**	**0**	**0**	**18,385,741**	**81.54%**	**8,311,865**	**81.97%**	Formula			0
	Non-Core (may not exceed 25% of total service dollars)	**4,151,049**	**0**	**11,722**	**0**	**0**	**0**	**4,162,771**	**18.46%**	**1,828,560**	**18.03%**	Supplement			0
	Total Service Dollars (does not include Admin and QM)	**21,686,542**	**370,766**	**491,204**	**0**	**0**	**0**	**22,548,512**		**10,140,424**		Carry Over	0		0
												Totals	0	0	0
	Total Admin (must be ≤ 10% of total Part A + MAI)	**2,133,394**	**0**	**0**	**0**	**0**	**0**	**2,133,394**	**7.71%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**522,214**	**0**	**0**	**0**	**0**	**0**	**522,214**	**1.89%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**2,068,055**	**30,356**	**47,459**	**0**	**0**	**0**	**2,145,870**	**87.07%**	**2,145,870**	**0**		**$1,287,775**	**60%**	**67%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,045,669	15,482	24,204	0			1,085,355	44.04%	1,085,355	0	3/1/2024	$718,740	66%	67%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	1,022,386	14,874	23,255	0			1,060,515	43.03%	1,060,515	0	3/1/2024	$569,035	54%	67%
2	**Medical Case Management**	**314,060**	**4,536**	**0**	**0**	**0**	**0**	**318,596**	**12.93%**	**318,596**	**0**		**$102,570**	**32%**	67%
2.c (MAI)	MCM - Targeted to African American	157,030	2,268					159,298	6.46%	159,298	0	3/1/2024	$72,400	45%	67%
2.d (MAI)	MCM - Targeted to Hispanic	157,030	2,268					159,298	6.46%	159,298	0	3/1/2024	$30,170	19%	67%
	Total MAI Service Funds	**2,382,115**	**34,892**	**47,459**	**0**	**0**	**0**	**2,464,466**	**100.00%**	**2,464,466**	**0**		**$1,390,345**	**56%**	**67%**
	Grant Administration	0	0	0	0	0	0	0	0.00%	0	0		$0	0%	0%
	Quality Management	0	0	0	0	0	0	0	0.00%	0	0		$0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**$0**	**0%**	**0%**
	Total MAI Funds	**2,382,115**	**34,892**	**47,459**	**0**	**0**	**0**	**2,464,466**	**100.00%**	**2,464,466**	**0**		**$1,390,345**	**56%**	**67%**
	MAI Grant Award	**2,464,466**	***Carry Over:***	**47,459**			***Total MAI:***	**2,464,466**							67%
	Combined Part A and MAI Orginial Allocation Total	**26,724,265**							Unallocated	Unobligated					
									0	**0**		***MAI Award***	**2,464,466**		
Footnotes:												**Total Part A & MAI Award**	**27,668,587**		
All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.														
(a)	Single local service definition is multiple HRSA service categories. (1) does not include LPAP. Expenditures must be evaluated both by individual service category and by combined service categories.														
(c)	Funded under Part B and/or SS														
(e)	10% rule reallocations														

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

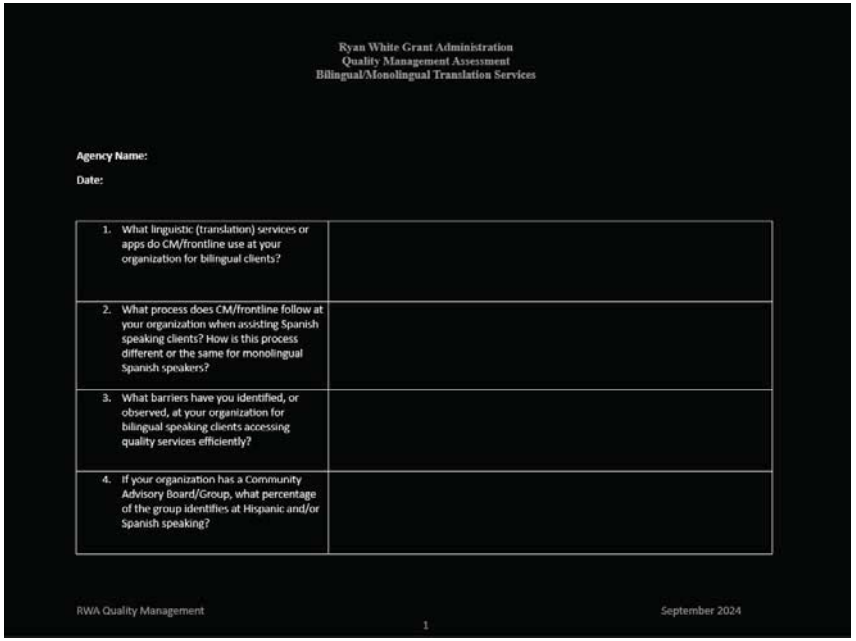
The Assessment

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.

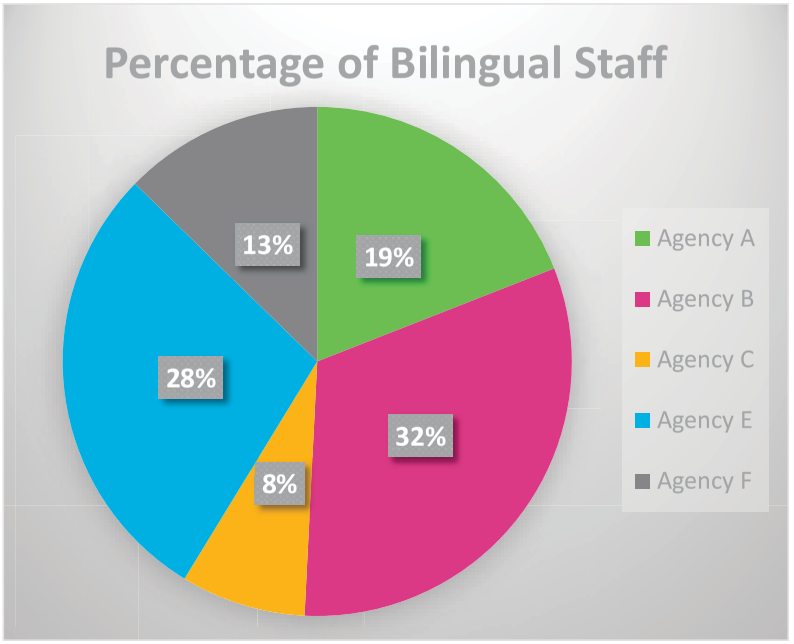
Question #8 *How can the Administrative Agent support your organization with identified barriers for monolingual Spanish speaking clients?*

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.*

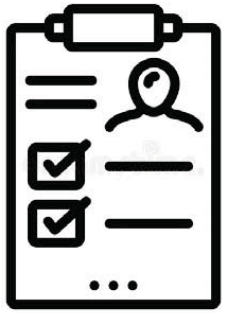
Agency A	**N/A**
Agency B	Ensuring that all Ryan White forms are in Spanish such as the CPCDMS registration and update forms.
Agency C	To improve overall quality and satisfaction for bilingual and monolingual clients, Ryan White could consider including language access as a core component of patient 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

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

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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."

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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).

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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

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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*.

Substance Abuse Outpatient Care Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Group Counseling	Per visit
Individual Counseling	Per visit
Intake	Per visit
Medication Treatment Maintenance	Per visit
Medication-Assisted Detoxification	Per visit
Substance Abuse Services—Outpatient	Per visit

Health Resources & Services Administration (HRSA) Description:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders.

Program Guidance:

Agencies may fund acupuncture therapy under this service category only when it is part of the documented substance use disorder treatment plan.

Limitations:

Agencies may not use Ryan White Part-B and State Services program funds to carry out the distribution or exchange of sterile needles or syringes for the use of injection of illegal substances, or for programs or materials designed to promote or directly encourage intravenous drug use.

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Services:

Activities under the Substance Abuse Outpatient Care service category include:

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

Universal Standards:

Services providers for Substance Abuse Outpatient Care must follow HRSA and DSHS Universal Standards 1-## and ###-###.

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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
Provision of Services: A physician or other qualified and licensed professional must supervise Substance Abuse Outpatient Services. Professionals must have a license, be in good standing in the State of Texas, and have at least 1,000 hours of documented experience treating substance-related disorders. Qualified and licensed professionals include: • Licensed Chemical Dependency Counselor (LCDC) • Licensed Professional Counselor (LPC) • Licensed Master Social Worker (LMSW) • Licensed Marriage and Family Therapist (LMFT) • Licensed psychologist • Licensed physician • Licensed physician assistant • Certified Addictions Registered Nurse (CARN) • Advanced Practice Registered Nurse recognized by the Board of Nurse Examiners as a Clinical Nurse Specialist (APRN-CNS) or a Psychiatric-Mental Health Advanced Practice Nurse (APN-P/MH) Services include and are limited to: • Pre-treatment and recovery readiness programs • Harm reduction • Mental health counseling associated with substance use disorder • Medication-assisted therapy	1. Percentage of clients with documentation a physician or qualified licensed professional provided or supervised services. (Pilot Measure) 2. Percentage of clients with documentation that HRSA and DSHS allow all services provided under the Ryan White Part-B and State Services program. (Pilot Measure)

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• Neuropsychiatric pharmaceuticals • Relapse prevention • Acupuncture A licensed acupuncture provider must provide acupuncture services. Agencies providing acupuncture services must have a referral from the client's HIV medical provider and cannot use acupuncture as the primary treatment modality.	
Comprehensive Assessment: An LCDC or other qualified professional must complete a comprehensive psychosocial assessment for all clients. Professional staff must complete the comprehensive assessment no later than the third counseling session and ensure that the assessment includes the following, as applicable: • Presenting problems • Alcohol and other substance use • Psychiatric and chemical dependency treatment • Medical history and current health status • Client strengths and challenges, coping mechanisms, and self-help strategies • Psychosocial history, which may include: o Living situation o Social support and family relationships o Education and employment history, including military service o Sexual and relationship history and status o Physical, emotional, or sexual abuse history o Domestic violence assessment o Trauma assessment o Legal history o Leisure and recreational activities	3. Percentage of clients with documentation of an initial comprehensive assessment completed by the third counseling session.

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Staff may use approved assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) for substance use and sexual history, and the Mini-Mental State Examination (MMSE) for cognitive assessment. Staff may use other industry-recognized assessment tools if approved by the provider agency.	
Treatment Plan: Staff must complete a treatment plan specific to individual client needs within 30 calendar days of completing a comprehensive psychosocial assessment. Treatment planning is a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies and modalities for achieving them. The treatment plan must include documentation of the following: • Goals and objectives of treatment • Treatment start date and projected end date • Quantity, frequency, and modality of treatment • Regular monitoring and assessment of client progress • Any recommendations for follow-up • Signature of staff providing services or the staff's supervisor Staff will offer appropriate referrals to clients for support services as applicable to meet goals.	4. Percentage of clients with documentation of a treatment plan completed within 30 calendar days of the completed comprehensive assessment. 5. Percentage of clients with documentation that staff reviewed or modified treatment plans at least once, midway through the number of determined sessions agreed upon.

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Progress Notes: Staff must provide services according to the individual's treatment plan and document services in the client's primary record. For each professional counseling session, the counselor should document a progress note that includes: • Client name • Session date • Clinical observations • Focus of the session • Interventions • Assessment • Duration of session • Newly identified issues or goals • Client's responses to interventions and referrals • HIV medication adherence • Substance use treatment adherence • Documentation of missed visits with attempts to reschedule as applicable	6. Percentage of clients with documented progress notes for each counseling session that the client attended, or documentation of missed visits and attempts to reschedule, as applicable.

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Discharge Summary: Agencies may discontinue services when the client: • Reaches goals and objectives • Demonstrates ongoing non-adherence to the treatment plan • Has missed three consecutive appointments in a six-month period • Self-terminates services • Demonstrates unacceptable behavior • Is deceased When an agency discharges a client, staff will document a discharge summary in the client chart that includes: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral to a case manager or primary care provider, as appropriate • Signature of provider Staff will complete discharge planning in collaboration with the client when possible. Providers will attempt to link clients who leave care with appropriate services to meet their needs.	7. Percentage of clients with documentation of discharge summary, as applicable.

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References:

Substance Use Care. Clinical Guidelines Program. New York State Department of Health AIDS Institute, 2024.

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Food, Drugs, Alcohol, and Hazardous Substances, Subtitle B. Alcohol and Substance Programs, Chapter 464 Facilities Treating Persons with a Chemical Dependency. Subchapter A. Regulation of Chemical Dependency Treatment Facilities. *http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.464.htm*

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.

Texas Administrative Code, Title 22, Part 30, Chapter 681 - Texas Board of Examiners of Professional Counselors. Located at: *https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=22&pt=30&ch=681*

Texas Administrative Code. Title 26, Health and Human Services. Part 1, Health and Human Services Commission. Chapter 564. Chemical Dependency Treatment Facilities, Subchapter H, Screening and Assessment. https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=26&pt=1&ch=564&rl=804

Texas Administrative Code. Title 26, Health and Human Services. Part 1, Health and Human Services Commission. Chapter 306, Behavioral Health Delivery System. Subchapter D, Mental Health Services – Admission, Continuity, and Discharge. https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=26&pt=1&ch=306

Texas Administrative Code. Title 25, Health Services. Part 1, Department of State Health Services. Chapter 140, Health Professions Regulation. Subchapter I, Licensed Chemical Dependency Counselors. https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=140&sch=I&rl=Y

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Location of Change	Prior Version	New Version	Notes
Comprehensive Psychosocial Assessment section	A Licensed substance use counselor or other qualified professional will complete a comprehensive psychosocial assessment for all clients. Staff must complete the comprehensive psychosocial assessment prior to the third counseling session and the assessment must include the following: • Presenting problems • Alcohol and other substance use • Psychiatric and chemical dependency treatment • Medical history and current health status • Relationships with family including domestic or intimate partner violence • History of trauma • Experience with HIV or substance use-related stigma • Housing stability, expelled from home • HIV treatment adherence • Social and leisure activities • Education and vocational training • Employment status and history • Legal issues • Mental and emotional functioning • Strengths and challenges Approved assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) may be used for substance use and sexual history, and the Mini-Mental State Examination (MMSE) may be used for cognitive assessment. Other industry-recognized assessment tools may be used if approved by the provider agency. Measures: 3. Percentage of clients with documentation of initial comprehensive psychosocial assessments completed by the third counseling session. 4. Percent of clients with documentation of a comprehensive psychosocial assessment completed with a licensed professional using industry-recognized assessment tools. A Licensed substance use counselor or other qualified professional will complete a comprehensive psychosocial assessment for all clients.	An LCDC or other qualified professional must complete a comprehensive psychosocial assessment for all clients. Professional staff must complete the comprehensive assessment no later than the third counseling session and ensure that the assessment includes the following , as applicable: •Presenting problems •Alcohol and other substance use •Psychiatric and chemical dependency treatment •Medical history and current health status •Client strengths and challenges, coping mechanisms, and self-help strategies •Psychosocial history, which may include: bliving situation bsocial support and family relationships beducation and employment history, including military service bsexual and relationship history and status bphysical, emotional, or sexual abuse history bdomestic violence assessment btrauma assessment blegal history bleisure and recreational activities Staff may use approved assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) for substance use and sexual history, and the Mini-Mental State Examination (MMSE) for cognitive assessment. Staff may use other industry-recognized assessment tools if approved by the provider agency. Measure 3. Percentage of clients with documentation of an initial comprehensive assessment completed by the third counseling session.	The name of this standard was changed to "Comprehensive Assessment" to reflect that the assessment covers a broader range of topics beyond psychosocial. Language was changed where appropriate to align with the Mental Health Services (MH) SOC. "As applicable" language was added to acknowledge that not all items in the assessment are relevant to all clients and to mirror the MH standard. Measure 4 was removed. Reason: Different assessment tools may be useful in different situations, depending on the client's presenting problems, the type of program, and the practitioner delivering care, and there is not a good rationale for requiring every client to have one of these.
Treatment Plan section	Staff must complete a treatment plan specific to individual client needs within 30 calendar days of completing a comprehensive psychosocial assessment. Treatment planning is a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies and modalities for achieving them. The treatment plan will include documentation of the following: • Identification of the identified substance use disorder • Goals and objectives and progress toward meeting them • Treatment modality • Start date for substance use counseling • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up The licensed substance use counselor who is providing or supervising the service must sign the treatment plan.	Staff must complete a treatment plan specific to individual client needs within 30 calendar days of completing a comprehensive psychosocial assessment. Treatment planning is a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies and modalities for achieving them. The treatment plan must include documentation of the following: •Goals and objectives of treatment •Treatment start date and projected end date •Quantity, frequency, and modality of treatment •Regular monitoring and assessment of client progress •Any recommendations for follow-up •Signature of staff providing services or the staff's supervisor Staff will offer appropriate referrals to clients for support services as applicable to meet goals.	Language in this standard was reorganized and edited to align with the MH SOC where appropriate. Language regarding referrals was added to incorporate elements from the (now removed) Referrals section.
Referrals section	The agency will offer appropriate referrals to clients for support services as applicable to meet goals. Measure: 8. Percentage of clients with documentation of referrals offered as applicable.	Removed	This measure was removed and language relevant to referrals was moved to the Treatment Planning section. Reason: Subrecipient monitoring shows that this measure is either met or NA, and does not indicate that no referral is made in cases where a need for a referral is documented.

Discharge Planning section	Staff will complete discharge planning when treatment goals are met. Discharge planning will include: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral after completing substance use treatment to a case manager or primary care provider, as appropriate • Discharge plan • Counselor authentication, in accordance with TAC Standards and the counselor licensure requirements. In all cases, providers and case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. Measure: 9. Percentage of clients with documentation of discharge planning in collaboration with the client prior to case closure as applicable.	Removed	This standard and measure 9 were removed. Language from the standard was combined with the Discharge Summary standard below.
Discharge Summary section	Agencies may discontinue services when the client: • Reaches goals and objectives • Demonstrates ongoing non-adherence to the treatment plan • Has missed three consecutive appointments in a six-month period • Self-terminates services • Demonstrates unacceptable behavior • Is deceased When a client is discharged, staff should document a discharge summary in the client chart that includes the reason for discharge.	Agencies may discontinue services when the client: •Reaches goals and objectives •Demonstrates ongoing non-adherence to the treatment plan •Has missed three consecutive appointments in a six-month period •Self-terminates services •Demonstrates unacceptable behavior •Is deceased When an agency discharges a client, staff will document a discharge summary in the client chart that includes: •Circumstances of discharge •Summary of needs at admission •Summary of services provided •Goals and objectives completed during counseling •Referral to a case manager or primary care provider, as appropriate •Signature of provider Staff will complete discharge planning in collaboration with the client when possible. Providers will attempt to link clients who leave care with appropriate services to meet their needs.	This standard was changed to incorporate the (now removed) Discharge Planning standard. The consolidated measure addresses both planned discharges and those discharged from services due to issues such as self-termination, client death, etc., which do not lend themselves to advanced planning.

Substance Abuse Services (Residential) Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Detoxification	Per day
Residential Services	Per day
Substance Abuse Services (Residential)	Per day

Health Resources and Services Administration (HRSA) Description:

Substance Abuse Services (residential) (SA-R) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder.

Program Guidance:

A clinical provider must provide a written referral as part of a substance use disorder treatment program funded under the HRSA Ryan White HIV/AIDS Program (RWHAP) for SA-R. Agencies may only provide acupuncture therapy under this service category when a provider has included acupuncture therapy in a documented treatment plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Limitations:

Agencies may not use HRSA RWHAP funds for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license.

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Services:

Activities provided under the SA-R service category include:

- Pretreatment and recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication-assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Agencies must provide services in accordance with the Texas Health and Safety Code, Title 6, Subtitle B, Chapter 464.

Universal Standards:

Service providers for Substance Abuse Services - Residential must follow HRSA and DSHS Universal Standards 1-## and ###-###.

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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
Eligibility: A clinical provider must place a written referral for SA-R as part of a substance use disorder treatment program funded under the RWHAP. To be eligible for admission to a treatment program, an individual must meet the current Diagnostic and Statistical Manual (DSM) criteria for substance use or dependence (or substance withdrawal or intoxication in the case of a detoxification program).	1. Percentage of client charts with documentation of a written referral from a clinical provider for residential substance use disorder treatment or detoxification.
Comprehensive Assessment: A Licensed Chemical Dependency Counselor (LCDC) or other qualified professional must complete a comprehensive psychosocial assessment for all clients. Professional staff must complete the comprehensive assessment within three days of admission and offer to provide the client with a copy of the completed assessment. If emergent needs prevent the completion of the assessment within three days, staff must document this in the client's record. The assessment must include the following, as applicable: • Presenting problems • Alcohol and other substance use • Psychiatric and chemical dependency treatment • Medical history and current health status • Client strengths and challenges, coping mechanisms, and self-help strategies	2. Percentage of clients with an initial comprehensive assessment completed within 96 hours of admission. 3. Percentage of clients with a health assessment completed within 96 hours of admission.

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• Psychosocial history, which may include:
  ▸ Living situation
  ▸ Social support and family relationships
  ▸ Education and employment history, including military service
  ▸ Sexual and relationship history and status
  ▸ Physical, emotional, or sexual abuse history
  ▸ Domestic violence assessment
  ▸ Trauma assessment
  ▸ Legal history
  ▸ Leisure and recreational activities
 	
During the initial assessment, providers should assess clients for care coordination needs and make referrals to case management or other support programs as appropriate.
 	
Staff may use approved assessment tools, such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) for substance use and sexual history and the Mini-Mental State Examination (MMSE) for cognitive assessment. Staff may also use other industry-recognized assessment tools if approved by the provider agency.
 	
A licensed health professional must conduct a health assessment for all residential clients within 96 hours of admission per 26 TAC § 564.803.	

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Treatment Plan: Staff must complete a treatment plan and file it in the client record within five days of admission. Treatment planning is a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them. Providers should discuss all available treatment options with the client and incorporate the client's wishes regarding the treatment course and modality. The treatment plan must include documentation of the following: • Goals and objectives of treatment • Treatment start date and projected end date • Quantity, frequency, and modality of treatment • Regular monitoring and assessment of client progress • Any recommendations for follow-up • Signature of staff providing services or the staff's supervisor Staff will offer appropriate referrals to clients for support services as applicable to meet goals. For clients accessing detox programs, staff should make referrals to outpatient or residential substance use programs for continuity of care. Staff must evaluate the treatment plan regularly and revise it as needed to reflect the ongoing reassessment of the client's issues, needs, and response to treatment. At a minimum, agencies must review and update treatment plans midway through the projected duration of treatment and no less frequently than monthly.	4. Percentage of clients with treatment plans completed within five days of admission. 5. Percentage of clients with treatment plans updated midway through the projected duration of the treatment at a minimum and no less frequently than monthly.

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Progress Notes: Staff must provide services according to the individual's treatment plan and document services in the client's primary record. For each professional counseling session, the counselor should document a progress note that includes: • Client name • Session date • Clinical observations • Focus of the session • Interventions • Assessment • Duration of session • Newly identified issues or goals • Client's responses to interventions and referrals • HIV medication adherence • Substance use treatment adherence • Signature of the counselor conducting the session For detox program clients, notes should include: • Client name • Evaluation date • Vitals assessed • Medications provided to the client during a detox program • Medical evaluation(s) • Discussion regarding the transition plan after the completion of the detox program	6. Percentage of clients in counseling programs with progress notes for each counseling session. 7. Percentage of clients accessing detox programs with progress notes.

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Discharge Planning: Providers must conduct discharge planning collaboratively with clients and complete planning before the client's scheduled discharge. A written discharge plan must address ongoing client needs and continuity of services and must include: • Individual goals or activities to sustain recovery • Referrals to case management and primary care providers, as appropriate • Outpatient substance abuse services and other recovery maintenance services, as applicable • Date and signatures of the counselor and client Providers and case managers should ensure that they link clients who leave care with appropriate services to meet their needs to the greatest extent possible. When a client voluntarily leaves services before completing discharge planning, staff should document the circumstances of discharge in the discharge summary.	8. Percentage of clients with a completed discharge plan before discharge from the residential program.
Discharge Summary: Staff must complete a discharge summary for each client within 30 days of discharge and must include: • Dates of admission and discharge • Needs and issues identified at the time of admission, during treatment, and at discharge • Services provided • Assessment of the client's progress toward goals • Reason for discharge • Referrals and recommendations, including arrangements for recovery maintenance • Signature of the counselor	9. Percentage of clients with a discharge summary completed within 30 days of discharge. 10. Percentage of clients with documentation of attempts to contact the client 60-90 days after discharge with the client's current status or the reason contact was unsuccessful.

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The facility must contact each client no sooner than 60 days and no later than 90 days after discharge from the residential program and document the client's current status or the reason contact was unsuccessful.	

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References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.

Texas Administrative Code, Title 22, Part 30, Chapter 681 - Texas Board of Examiners of Professional Counselors. Located at: https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=22&pt=30&ch=681

Texas Health and Safety Code, Title 6. Food, Drugs, Alcohol, and Hazardous Substances, Subtitle B. Alcohol and Substance Abuse Programs, Chapter 464. Located at: http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.464.htm

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Location of Change	Prior Version	New Version	Notes
Initial Screening section (now "Eligibility")	**Initial Screening:** Staff must screen each client for SA-R services using the Texas Department of Insurance criteria per the TAC standards for substance abuse services. The screening process should collect all information necessary to determine the type of services required to meet the client's needs. To be eligible for admission to a treatment program, an individual must meet the current Diagnostic and Statistical Manual (DSM) criteria for substance use or dependence (or substance withdrawal or intoxication in the case of a detoxification program). **Measure:** 1. Percentage of client charts with documentation of a completed initial screening.	**Eligibility:** A clinical provider must place a written referral for SA-R as part of a substance use disorder treatment program funded under the RWHAP. To be eligible for admission to a treatment program, an individual must meet the current Diagnostic and Statistical Manual (DSM) criteria for substance use or dependence (or substance withdrawal or intoxication in the case of a detoxification program).	This standard was renamed and edited to address eligibility and a corresponding measure was added to align with the NMS. The HRSA NMS requires the following: "A written referral was made by a clinical provider as part of a substance use disorder treatment program funded under the RWHAP." The previous initial screening standard referred to an outdated process. Also, an initial comprehensive assessment is already covered in the next section (Comprehensive Assessment). Language stating that staff must screen clients using Texas Dept. of Insurance criteria was removed, as this requirement does not currently appear in TAC rules on substance abuse.
Comprehensive Psychosocial Assessment section	A licensed substance use disorder counselor must conduct a comprehensive psychosocial assessment for all clients. Staff should complete and sign a comprehensive assessment within 3 days of admission, and should offer and provide a copy of the completed assessment to the client. If emergent needs prevent the assessment from being completed within 3 days, staff must document this in the client's record. The comprehensive assessment should include: • Presenting problem(s) • Alcohol and other substance use • Previous psychiatric and chemical dependency treatment • Medical history, including current HIV treatment and level of adherence • Relationships with family, including domestic or intimate partner violence • History of trauma • Housing status • Social and leisure activities • Education and vocational training • Employment history • Legal issues • Cognitive status	**Comprehensive Assessment:** A Licensed Chemical Dependency Counselor (LCDC) or other qualified professional must complete a comprehensive psychosocial assessment for all clients. Professional staff must complete the comprehensive assessment within three days of admission and offer to provide the client with a copy of the completed assessment. If emergent needs prevent the completion of the assessment within three days, staff must document this in the client's record. The assessment must include the following, as applicable: • ☐ Presenting problems • ☐ Alcohol and other substance use • ☐ Psychiatric and chemical dependency treatment • ☐ Medical history and current health status • ☐ Client strengths and challenges, coping mechanisms, and self-help strategies • ☐ Psychosocial history, which may include: ☐ Living situation ☐ Social support and family relationships ☐ Education and employment history, including military service ☐ Sexual and relationship history and status	This standard was edited for clarity and to align with the Comprehensive Assessment standard in the Substance Abuse - Outpatient draft service standards. Measure 2 timeframe was changed from "3 days" to 96 hours for simplicity and consistency with measure 5 (health assessment). Measures 3 and 4 (requiring specific assessment tools) were removed, but language referring to assessment tools was retained in the standard. Reason: There is no professional guideline, statute, or HRSA policy guiding the inclusion of the tools specified in these measures, nor is there a good rationale for requiring every client to get one of the tools specified. Different tools may be useful in different situations, depending on the client's presenting problems, the type of program, and the practitioner delivering care.

	• Cognitive status • Strengths and challenges During the initial assessment, providers should assess clients for care coordination needs and make referrals to case management or other support programs as appropriate. Staff should use a valid and reliable assessment tool such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) or Addiction Severity Index (ASI) to evaluate substance use. For cognitive assessment, providers may use the Mini-Mental State Examination (MMSE) or other validated tool. A licensed health professional must conduct a health assessment for all residential clients within 96 hours of admission per 25 TAC Section 488.803. Measure 2. Percentage of clients with an initial comprehensive psychosocial assessment completed within 3 days of admission. Measure 3. Percentage of clients evaluated using a valid and reliable assessment tool for substance use. 4. Percentage of clients evaluated using a valid and reliable assessment tool for cognitive assessment. 5. Percentage of clients with a health assessment completed within 96 hours of admission.	☐Sexual and relationship history and status ☐Physical, emotional, or sexual abuse history ☐Domestic violence assessment ☐Trauma assessment ☐Legal history ☐Leisure and recreational activities During the initial assessment, providers should assess clients for care coordination needs and make referrals to case management or other support programs as appropriate. Staff may use approved assessment tools, such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) for substance use and sexual history and the Mini-Mental State Examination (MMSE) for cognitive assessment. Staff may also use other industry-recognized assessment tools if approved by the provider agency. A licensed health professional must conduct a health assessment for all residential clients within 96 hours of admission per 26 TAC § 564.803. 2. Percentage of clients with an initial comprehensive assessment completed within 96 hours of admission. 3. Percentage of clients with a health assessment completed within 96 hours of admission.	
Referrals section	Agencies must make appropriate referrals for clients with medical or support needs. For clients accessing detox programs, staff should make referrals to outpatient or residential substance use programs for continuity of care. **Measure:** 10. Percentage of clients with referrals based on need demonstrated in the assessment and progress notes, as applicable.	Removed	This standard and corresponding measure was removed and language was moved to the Treatment Planning section. Reason: This standard/measure would only capture the very rare situation where a referral need is documented but no referral is documented, and does not provide much useful monitoring data.
Discharge Planning section	Providers should conduct discharge planning collaboratively with all clients and complete planning before the client's scheduled discharge. A written discharge plan must address ongoing client needs and continuity of services, and should include: • Individual goals or activities to sustain recovery • Referrals to case management and primary care providers, as appropriate • Outpatient substance abuse services and other recovery maintenance services, as applicable • Date and signatures of the counselor and client Providers and case managers should ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs.	Providers must conduct discharge planning collaboratively with clients and complete planning before the client's scheduled discharge. A written discharge plan must address ongoing client needs and continuity of services and must include: • Individual goals or activities to sustain recovery • Referrals to case management and primary care providers, as appropriate • Outpatient substance abuse services and other recovery maintenance services, as applicable • Date and signatures of the counselor and client Providers and case managers should ensure that they link clients who leave care with appropriate services to meet their needs to the greatest extent possible. When a client voluntarily leaves services before completing discharge planning, staff should document the circumstances of discharge in the discharge summary.	This standard was changed to address the voluntary departure of clients before discharge planning can be completed.

Operations Committee Report

Memorandum of Understanding

Parties to the Memorandum of Understanding:

1. Harris County Judge – The "Chief Elected Official" (CEO)
2. Houston Eligible Metropolitan Area (EMA) Ryan White CARE Act (as amended) Part A Planning Council – The "Planning Council" (RWPC)
3. Houston EMA Ryan White CARE Act Part A Planning Council Office of Support – The "Office of Support" (RWPC/OS)
4. Harris County Public Health , Ryan White Grant Administration – The "Recipient" (HCPH/RWGA)

PURPOSE

This Memorandum of Understanding is created to facilitate cooperative and collaborative working relationships between and among the Houston Ryan White Planning Council, the Council's Office of Support and the Houston Administrative Agency. The Health Resources and Services Administration (HRSA), the federal agency that administers the Ryan White program, encourages stakeholders to draft a Memorandum of Understanding (MOU) to better define responsibilities. This document is not intended to restate all HRSA rules but to clarify entity roles and outline procedures that will foster productive interaction and efficient communication between and among the three stakeholders.

This MOU is a dynamic tool to help the aforementioned stakeholders avert misunderstanding. The underlying foundation of the memorandum is the principle of mutual respect. Mutual respect is created through open communication, active listening, seeking understanding, and acknowledging our mutual goals. This document is built upon the understanding that the three entities are equal stakeholders in the Ryan White process with the mutual goal of helping eligible individuals and families living with HIV/AIDS obtain the highest quality and most appropriate Ryan White Program services.

HRSA DEFINED ROLES AND DUTIES

The following is taken from the 2013 HRSA Part A manual and the Part A Planning Council Primer and describes the role and duties of the:

Chief Elected Official (CEO or G): Harris County Judge

The CEO is the person who officially receives the Ryan White Part A funds. In Houston the CEO is the County Judge, making the Judge ultimately responsible for administering all aspects of the Part A program funds (Part A includes Minority AIDS Initiative, or "MAI" funds). Duties include: ensuring that all legal requirements are met, appointing all members of the Planning Council and selecting the Harris County Public Health and Environmental Services Department to be the Administrative Agency for the Part A grant.

Planning Council: Houston Area HIV Services Ryan White Planning Council

The Houston Ryan White Planning Council is a group of volunteers appointed by the CEO whose purpose is to plan for and oversee the delivery of services to persons living with HIV in the Houston EMA. Duties include: setting up planning body operations; setting service priorities; allocating resources to those priorities; and assessing the administrative mechanism, which means reviewing how long the Recipient takes to pay providers, reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether all the funds are spent". The Council also works in partnership with the Administrative Agency to assess need, develop a comprehensive plan, coordinate with other Ryan White programs and services, and reallocate funds. The Council reports to the CEO.

Planning Council Support: Office of Support
This entity provides administrative support to the Council. Duties include: coordinating and staffing all Council processes; interfacing with HRSA, the CEO's Office and other County Offices regarding Council business; and assisting Council members to stay in compliance with federal and county rules and regulations as well as Council bylaws, policies & procedures. The Manager of the Office of Support reports to the Planning Council and the CEO.

Administrative Agency (the CEO 's Agent, also called the Recipient): Harris County PH/Ryan White Grant Administration
This entity carries out the day-to-day administrative activities required to implement and administer services in the Houston EMA according to the plan set forth by the Planning Council. Duties include: procuring services for PLWH consistent with Planning Council priorities and allocations, including all aspects of the RFP, review, award and contracting process with service providers; establishing intergovernmental agreements; ensuring services to women, infants, children and youth living with HIV ; ensuring that Ryan White Part A funds are used to fill gaps; ensuring delivery of quality services; preparing and submitting Part A applications; assuring all services are in compliance with the HRSA Ryan White National Part A and Universal Monitoring Standards; limiting Recipient administrative costs; limiting contractor administrative costs; monitoring contracts; implementing Quality Management activities, advising the Council on HRSA mandates; and working with the Council to assess need, develop a Comprehensive Plan, coordinate with other Ryan White programs and services, and reallocate funds. According to HRSA, an employee of the Recipient may serve as a co-chair to the Planning Council, provided the bylaws of the planning council permit or specify that arrangement. At the current time, Council bylaws do not permit such an arrangement. The Manager of RWGA reports to the Executive Director of the Harris County Public Health Services Department (HCPHS) or his/her designee.

LOCALLY DEFINED RESPONSIBILITIES

HRSA clearly assigns responsibility for certain work products to specific entities. For example: the Planning Council is the only entity allowed to set service priorities and determine annual allocations. Similarly, the Administrative Agency is the only entity allowed to monitor contracts and collect agency-specific information. In areas where there is shared responsibility, it is agreed that, in the Houston EMA, the entity named below will have primary responsibility for initiating and completing the following:

Planning Council:

- Through the Needs Assessment process, determine the size and demographics of the population of individuals with HIV disease (Section VI, page 2).
- Determine the needs of such population.
- Adapt the HRSA defined service definitions to meet the local needs.
- Indicate to the Recipient, through the service definitions and standards of care, how the services are to be purchased.
- Determine the annual Part A service priorities.
- Determine the annual Part A allocations.
- Collaborate with the Administrative Agency in determining the Part A Standards of Care.
- Collaborate with the Administrative Agency in determining the Part A Performance Measures.
- Reallocate unspent or carryover funds in a timely manner (see below under Administrative Agency for an explanation of the 10% rule).

- Through Council membership and joint activities, such as the Needs Assessment process, coordinate with other Ryan White programs and services.
- According to HRSA mandates, produce the Comprehensive Needs Assessment that is currently required at least every three (3) years.
- According to HRSA mandates, produce and update the Integrated HIV Prevention and Care Services Plan that is currently required at least every five (5) years.
- Produce the Blue Book so long as it is a Council-approved priority. Work with the Harris County Purchasing Department to procure a printer for the final product.
- Procure vendors for specific work products where the contract is under $25,000 and no formal RFP process is needed. Provide system-wide guidance regarding the Continuum of Care, client eligibility and preferred treatment strategies, at a minimum meeting HHS treatment guidelines, in order that HCPHS/RWGA can implement the Centralized Patient Care Data Management System (CPCDMS) in a manner supportive of the Council's annual implementation plan and approved Integrated Plan. Examples of such guidance include the Council's approved stance on de-identified client-level data collection (i.e., no names or other identifying information stored in the CPCDMS) and applicable goals and objectives listed in the Integrated Plan.

RWPC Office of Support Staff:

- Provide guidance to the Council on HRSA and County policy that relates to Council processes and work products.
- Provide guidance and leadership to the Council in order to ensure the Council accomplishes all required and necessary goals and objectives.
- At the beginning of each grant year (i.e., January and February) meet with all stakeholders in the Ryan White Part A process to provide guidance and leadership in the Council's development and implementation of a timeline for all required Council work products that is consistent with published deadlines. Inform and advise the Council on multi-year and/or recurring processes such as needs assessment and integrated planning in order that the Council is appropriately informed of its deadlines and expected work products.
- Coordinate and staff all Council processes except the workgroups for Standards of Care and Performance Measures.
- If an outside vendor is utilized, supervise the vendor contract for the Comprehensive Needs Assessment.
- If an outside vendor is utilized, supervise the vendor contract for the Integrated Plan.
- Work with the Council to develop the Blue Book. The Office of Support will work with the Purchasing Department to secure and supervise the printer and other vendors needed to produce the document.
- Provide RWPC-related information required for the submission of the annual HRSA grant application in a timely manner in order that HCPH/RWGA can prepare the grant application and non-competing renewable funding request for review and submission by the CEO.

Administrative Agency:

- Provide the Council with accurate, timely, aggregate service category and other information needed for the different Council processes such as the *How to Best Meet the Need*, priority setting, annual allocations and other processes.
- Collaborate with the Planning Council in determining the Part A Standards of Care.
- Collaborate with the Planning Council in determining the Part A Performance Measures.
- Coordinate and staff the Part A Standard of Care and Outcome Measures workgroups in order to ensure appropriate interface with the Quality Management Program and because Standards of Care must also

reflect the HRSA Ryan White Part A National Programmatic, Fiscal and Universal Monitoring Standards, the current Part A grant guidance, conditions of award and more.

- Reallocate funds per Council-approved decisions. Inform the Council no later than the next scheduled Planning Council Steering Committee meeting of any allocation changes made under the Houston RWPC-approved "10% rule". The 10% rule allows the administrative agency to shift funds between Service Categories without prior Council approval so long as the funds shifted are no more than 10% of the current approved Council allocation for either service category affected by the change.
- Prepare the Houston EMA HRSA grant application and non-competing renewal funding request for review and submission to HRSA by the CEO.
- Implement and maintain the de-identified client-level data system used in the Houston EMA. The data system used by HCPH/RWGA is the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is the property of HCPH/RWGA and is used to securely collect and store HRSA- and RWPC- required data on client utilization, client demographics, medical and co-morbidity information, health outcomes and to enable the Recipient to implement the HRSA-mandated Quality Management program.
- Inform the Council in an ongoing and timely manner of issues surrounding automated client-level data collection, changing data requirements from HRSA and other stakeholders, future technology changes and potential future issues of concern to Houston EMA stakeholders (e.g. interface with the State's Take Charge Texas data system for RW Part B data collection by TDSHS).

PROCEDURES

Meetings: Please refer to Council bylaws, policies and procedures for details regarding protocol for Council members. This section is devoted to outlining staff functions in relationship to Council protocol. Regarding the Administrative Agent and Office of Support:

- Staff representation from the Office of Support will be provided at all regular Council meetings including standing committees, ad-hoc and workgroup meetings. Staff representation from RWGA will be provided as appropriate.
- In an effort to help chairs and other attendees delineate between members of the voting body, staff and the general public, neither staff nor members of the general public will sit at the table with Council or committee members while business is being conducted. Because of the more informal nature of the Affected Community Committee and most workgroups, the chair of the committee or workgroup may choose to make an exception to this rule by allowing the general public to sit at the table and participate in discussion throughout the meeting. Only members of the committee may vote at a committee meeting See the Council policy regarding voting at workgroup meetings.
- Staff will provide data and give periodic reports to the Planning Council during time allotted on the meeting agenda.
- Additional insights and suggestions from staff will be given to the Planning Council during meetings in the following manner:
    - Staff and Planning Council members will request permission from the Chairperson before providing input or requesting information from other members of the group.

Requesting Information: Council committees and workgroups will follow Council-approved policy and procedures to request information from the Office of Support or RWGA. This may be done via a standardized form or, in more informal situations, by request of the Council Chair or Vice Chair, Committee Chair or Co-Chair, or workgroup Chair as applicable. Individual Council members should make requests for

information through the Committee or workgroup chair as described above.

Distributing Information to the Council, its Committees and Work Groups: Information will be delivered to the Manager of the Office of Support for distribution to the Council, its Committees and workgroups. The Manager will determine the appropriate process to be used to disseminate the information. When providing information, please keep the following in mind:

1) Requests requiring Council or committee approval must be submitted in writing eight days before the date of the meeting.
2) If the information does not require approval, submission of the information eight days before the date of the meeting is preferred.
3) Once a workgroup or committee has created a recommendation in response to the request, the chair of the Committee, workgroup or designee will be responsible for moving the request forward and speaking on behalf of the request.

Verifying Information. Any member of this MOU can question accuracy and request sources to support or verify reports and other information. When accuracy is questioned within the context of a Council or Committee meeting, the chair can ask the entity that submitted the document or report to verify the information at the next meeting. It is incumbent on the one who submitted the document or report to verify the source and attest to its accuracy. While the information is being verified, it is important that decision-making continue and that the information be treated as valid to the extent possible.

However, it is the responsibility of HCPH/RWGA and RWPC Office of Support staff to provide guidance to the Council regarding HRSA policy, County rules and procedures and other relevant information necessary for the Council to perform its responsibilities in an appropriate and timely manner. Therefore, information provided to the Council or its committees by staff is expected to be accurate and relevant to the issue or question being discussed and Stakeholders should respect such information. When necessary, more detail regarding the accuracy or applicability of such information may be requested, however such requests must not infringe upon established roles and responsibilities under the Ryan White Program (e.g., Council members may not, in their role as Council members, request agency or contract-specific information). Office of Support and HCPH/RWGA staff are responsible for ensuring the overall Ryan White Part A grant process complies with all applicable HRSA guidelines and other Federal, State and local laws, rules and guidelines.

Proof Reading the Ryan White Part A Grant Application: The Administrative Agency will provide the Office of Support with a draft copy of the application for review by the Council. Notwithstanding HRSA giving Recipients less than the customary 60 days to prepare and submit the annual Part A grant application, the Council will nominally have one week (7 calendar days) to review the application and suggest corrections, edits or improvements. The Office of Support will be responsible for collecting and collating the comments and sending these to the Administrative Agency in a timely manner.

Contracting with outside vendors: Any contracting process that requires issuing an RFP or Interlocal Agreement shall be the responsibility of the Administrative Agency.

Reviewing and Updating the MOU: Annually in October of each year the Operations Committee of the Ryan White Planning Council will contact the principal Stakeholders (i.e., RWPC, RWPC Office of Support, CEO and Administrative Agency) in this MOU to see if any of the Stakeholders wish to review and/or revise the document. This annual process will provide an opportunity for Stakeholders to ensure the MOU will continue to be responsive to the needs and responsibilities of all concerned.

services funded by Ryan White Part A are meeting community needs.	
✔ **Do review and discuss aggregate data about service categories.**	✔ **Don't get directly involved in the administration of the grant or be involved in the selection of particular entities as recipients of Part A funds.**

Signed By:

County Judge Lina Hidalgo	April 18, 2024 Date
Crystal Renee Starr, Chair Houston Ryan White Planning Council	December 14, 2023 Date
Glenn Urbach, Manager HCPH/Ryan White Grant Administration	12/14/2023 Date
Victoria "Tori" Williams, Director, Office of Support, Houston Ryan White Planning Council	December 14, 2023 Date

Ryan White Planning Council Committee
INFORMATION REQUEST FORM

Signature of Committee Chair: _____ Date: _____

Name of Committee Chair: _____ Telephone: _____

Email Address: _____ Due date: _____ (Min. of 30 Days From Date of Request)

Question you want answered. (ex. How many youth are in primary care?)

In what form/s would you like the information (please check all that apply):

___Word Table ___Word Chart ___Word Text ___PowerPoint presentation

___Excel Table ___Excel Chart ___SPSS Table ___SPSS Chart

___Other: (Please describe):

_____

In order that we might present the information in the most useful format for you, please indicate how you plan to use the data

Thank you. Email this form to: Victoria.williams@harriscountytx.gov

Date request filled: _____

Received by _____ Date Received: _____

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
http://rwpchouston.org

LETTER OF AGREEMENT

Parties to the Letter of Agreement:

1. Harris County Judge – The "Chief Elected Official" (CEO)
2. Houston Eligible Metropolitan Area (EMA) Ryan White Part A Planning Council – The "Planning Council" (RWPC)
3. Houston EMA Office of Support for the Ryan White Part A Planning Council
4. Texas Department of State Health Services (TDSHS) - Part B Grantee
5. Houston Regional HIV/AIDS Resource Group, Inc. - Houston HIV Service Delivery Area (HSDA) Part B Administrative Agency
6. Harris County Public Health, Ryan White Grant Administration Section (HCPH/RWGA) - Houston EMA Part A Administrative Agency

PURPOSE

This Letter of Agreement is created to facilitate cooperative and collaborative working relationships between and among the Ryan White Part B Administrative Agency (AA) and the Ryan White Part A Planning Council. The Health Resources and Services Administration (HRSA), a division of the United States Department of Health and Human Services, encourages stakeholders to document via a Letter of Agreement (LOA) to better define responsibilities for the Houston Eligible Metropolitan Area (EMA) and the Houston Health Services Delivery Area (HSDA) designated by the Texas Department of State Health Services (TDSHS). The Houston EMA is designated by HRSA to receive Ryan White Program Part A funds to provide services to People Living with HIV/AIDS (PLWH/A). The Houston EMA is a six-county area in southeast Texas that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller counties. The Houston HSDA consists of these same six counties and four others – Austin, Colorado, Walker and Wharton.

This document is not intended to restate all HRSA and TDSHS rules, but rather to clarify entity roles and outline procedures that will foster productive interaction and efficient communication between and among the six stakeholders.

This LOA is a dynamic tool to help the principal stakeholders avert conflict and foster collaborative relationships and decision-making processes. The underlying foundation of the agreement is the principle of mutual respect. Mutual respect is created through open communication, active listening, seeking understanding, and acknowledging our mutual goals. This document is built upon the understanding that the six entities, parties to the LOA, are equal stakeholders in the Ryan White process with the shared goal of helping individuals and families living with HIV/AIDS obtain the highest quality and most appropriate Ryan White Program eligible services.

HRSA DEFINED ROLES AND DUTIES

The following is taken from the 2002 HRSA Title I (Part A) manual and the Title I (Part A) Planning Council Primer and describes the role and duties of the:

Chief Elected Official (CEO):
The CEO is the person who officially receives the Part A Ryan White Program funds, also referred to as the Grantee for Part A. In the Houston EMA, the CEO is the County Judge., The County Judge is ultimately responsible for administering all aspects of the Part A funds. Duties include: ensuring that all legal requirements are met; appointing all members of the Planning Council; and selecting the HCPH to be the AA (or recipient) for the Part A funding.

Houston Ryan White Part A Planning Council (Planning Council)
This entity is a group of volunteers appointed by the CEO whose purpose is to plan for and oversee the delivery of services to persons with HIV in the defined EMA/HSDA. Duties include: setting up planning body operations; setting priorities; allocating resources to those priorities; assessing the administrative mechanism which means reviewing how long the grantee takes to pay providers, reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council; and whether all the funds are spent. The Council also works with the AAs to assess need, develop a comprehensive plan, coordinate with other Ryan White programs and services, and reallocate funds as necessary. The Planning Council reports to the CEO.

Planning Council Office of Support:
This entity provides administrative support to the Council. Duties include, but not limited to: coordinating and staffing all Council processes; interfacing with HRSA, the CEO's Office and other County Offices regarding Council business; and assisting Council members stay in compliance with federal and county rules and regulations, as well as Council bylaws, policies and procedures. The Manager of the Office of Support reports to the Planning Council and the CEO.

Ryan White Part A Administrative Agency (CEO's Agent, also called the Part A recipient):
This entity carries out the day-to-day administrative activities required to implement and administer services in the defined EMA according to the plan set forth by the Planning Council. Duties include: procuring services for PLWH/A consistent with Planning Council priorities and allocations, including all aspects of the Request for Proposals (RFP), review, award and contracting process with service providers: establishing intergovernmental agreements; ensuring services to women, infants, children, and youth with HIV/AIDS; ensuring that Ryan White Program Part A funds address funding gaps; ensuring delivery of quality services; preparing and submitting Part A applications; assuring all services are in compliance with HRSA rules and regulations; limiting recipient administrative costs; limiting contractor administrative costs; monitoring contracts; advising the Council on HRSA mandates; and working with the Council to assess need, develop a comprehensive plan, coordinate with other Ryan White Program recipients and service providers programs, and reallocate funds.

Texas Department of State Health Services (TDSHS)

This entity is the Ryan White Program Part B and State Services (SS) Recipient for the state of Texas. The Part B recipient is the entity that officially receives the Part B funds. Locally, TDSHS is ultimately responsible for administering all aspects of Part B and SS funds. Duties include: ensuring that all legal requirements are met; selecting and contracting with Part B/SS AAs; and

providing oversight, monitoring and technical assistance to AAs in the planning and implementation of Part B/SS funds.

Houston Regional HIV/AIDS Resource Group, Inc.

This entity is contracted by TDSHS to carry out the day-to-day administrative activities required to implement and administer services in the Part B and SS HIV/AIDS Administrative Service Area (HASA) according to the comprehensive plan. Duties include: procuring services for PLWH/A consistent with the local priorities and allocation as approved by TDSHS; including all aspects of the RFP, review, award and contracting process with service providers; establishing intergovernmental agreements; ensuring services to women, infants, children, and youth living with HIV/AIDS; **(ADD): ensuring service deliver to rural residents living with HIV/AIDS residing in the HSDA**; ensuring that Ryan White Program funds are used to address gaps; ensuring delivery of quality services; preparing and submitting Part B applications to the State; assuring all services are in compliance with HRSA rules and regulations; limiting recipient administrative costs; limiting contractor administrative costs; monitoring contracts; and assessing need, developing a comprehensive plan, coordinating with other Ryan White Program recipients and services; and reallocating funds.

DEFINED RESPONSIBILITIES IN THE HOUSTON EMA/HSDA

In areas where there is shared responsibility between the Part A Planning Council, Part A & B/SS AAs, and the Office of Support, it is agreed that, in the Houston EMA/HSDA, the entities named above will have primary responsibility for initiating and completing the following:

Houston Ryan White Planning Council and Part A and B/SS Administrative Agents agree to:

- Collaborate in developing the Part A and B/SS Standards of Care;
- Collaborate in determining the Part A/Part B/SS Outcome Measures; and
- The Part B/SS AA, TDSHS, and Part A AA will develop procedures to ensure that Part A, Part B & State Services client level data is entered into the ARIES system whether through direct input or import.

Houston Ryan White Planning Council and Part B/SS Administrative Agency (The Resource Group) agree to:

- Collaborate to provide guidance and leadership in the development and implementation of a timeline for all required Part B/SS AA and Council work products that is consistent with published deadlines;
- Collaborate on planning and completion of multi-year and/or recurring processes, such as needs assessment and comprehensive planning in order that the Council is appropriately informed of its deadlines and expected work products;
- Collaborate on a Needs Assessment process to determine the size and demographics of the population of individuals living with or affected by HIV/AIDS in the Houston EMA/HSDA, and through this process jointly determine the needs of such populations in the defined geographic area;
- Collaborate on the production of, and updates to, the Comprehensive Needs Assessment for the defined EMA/HSDA; and
- The Part B/SS AA and the Planning Council will collaborate to develop a single list of service priorities for the Houston HSDA.

Houston Ryan White Planning Council agrees to:

- Indicate to the Part A and Part B/SS AAs, through the service definitions and the standards of care, how the services are to be configured;
- Develop recommendations for Part B and State Services allocations for the EMA/HSDA; (Recommended priorities and allocations and reallocations for the EMA/HSDA may not be changed by the Part B/SS Administrative Agency and must be presented to TDSHS for approval.)
- Develop recommendations for the reallocation of Part B and SS funds;
- Assess the Part B/SS AA administrative mechanism, which could include reviewing how long the AA takes to pay providers, reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether all the funds are spent. (Per the County Judge's Office: Distribute copies of the final assessment to DSHS, the Part B/SS AA and the Chair of the Board of Directors for the Houston AA for RW Part B and State Services.) This will be done annually in January; and
- Solicit input from the Part B/SS AA in the development of the Houston EMA/HSDA HIV/AIDS Resource Guide, commonly known as The Blue Book.

Part B/State Services Administrative Agency agrees to:

- Provide accurate, timely, aggregate service category and other information needed or requested for the different Council processes such as the *How to Best Meet the Need*, priority setting, annual allocations, reallocations and other processes;
- Coordinate and staff the Part B/SS Standard of Care and Outcome Measures Work Groups to ensure appropriate interface with the Quality Management Program and because Standards of Care must also reflect all HRSA Ryan White and TDSHS programmatic and fiscal guidelines and more;
- Within thirty-days of receiving a notice of grant award for Part B or State Services funding, inform the Office of Support in writing of the award amount and date of notice;
- Inform the Office of Support after the initial grant awards are distributed and within 45-days after the end of the second quarter of any unobligated funds available for reallocation;
- Notify all Part B/SS agencies when the Planning Council's Priority and Allocations Committee is preparing to allocate or reallocate funds;
- Within 30-days of announcing the availability of funds, provide the Council with de-identified service category funding requests increase so that the Council can review and make recommendations for reallocating these funds;
- Inform the Office of Support within thirty-days of any allocation changes made under the Houston RWPC-approved "10% rule". The 10% rule allows the AA to shift funds between Service Categories without prior Council recommendation as long as funds shift no more than 10% of the current approved TDSHS allocation for either service category affected by the change;
- In the final quarter of the Ryan White Part B and SS grant years, after implementing the year end Planning Council-approved reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, the Part B/SS AA may reallocate any remaining unspent funds as necessary to ensure no funds are returned to the TDSHS. If funds are to be moved from the Houston HSDA, the Part B/SS AA will notify the Office of Support when the information is submitted to the TDSHS. The Office of Support will notify the members of the Priority and Allocations Committee upon receipt and the Steering Committee and Council at their next scheduled meetings; and
- Annually in November of each year, contact the principal Stakeholders, listed at the beginning of this document, to determine if any wish to review and/or revise the LOA.

This annual process will provide an opportunity for Stakeholders to ensure the LOA will continue to be responsive to the needs and responsibilities of all concerned.

Distributing Information to the Council, its Committees and Work Groups

Information will be delivered to the Office of Support for distribution to the Council, its Committees and workgroups. The Office of Support will determine the appropriate process to be used to disseminate the information. When providing information, please keep the following in mind:

1.) Requests requiring Council or committee approval must be submitted in writing eight-days prior to the date of the meeting;
2.) When information does not require approval, submission of the information eight-days before the date of the meeting is preferred; and
3.) Once a workgroup or committee has created a recommendation in response to the request, the chair of the Committee, workgroup or designee will be responsible for moving the request forward and speaking on behalf of the request.

Signed By:

_____	_____
Harris County Judge	Date
_____	_____
Chair, Houston Ryan White Planning Council	Date
_____	_____
Office of Support for the Houston Ryan White Planning Council	Date
_____	_____
TDSHS, Texas Part B and State Services Grantee	Date
_____	_____
Houston Regional HIV/AIDS Resource Group, Inc.	Date
_____	_____
Harris County Public Health, RWGA Section	Date

Members Eligible to Run for Chair of the 2025 Ryan White Planning Council

(as of 10-14-24)

According to Council Policy 500.01 regarding election of officers: "Ryan White Part A, B and State Services funded providers/employees/subcontractors/Board Members and/or employees/subcontractors of the Grantees for these entities shall not be eligible to run for office of Chair of the Ryan White Planning Council. Candidates will have served as an appointed member of the RWPC for the preceding twelve (12) months and, if needed, have been reappointed by the CEO. One of the three officers must be a self-identified HIV positive person. "Nominations for all three positions: Council Chair, Vice Chair and Secretary, must be submitted to the Director of the Office of Support before the end of the November Steering Committee or at the December Council meeting, which is the day of the election.

Eligible To Run for Chair (* must be reappointed):	Not Eligible To Run for Chair
Servando Arellano*	Kevin Aloysius (Legacy Community Health)
Jay Bhowmick	Laura Alvarez (appointed mid-year 2024)
Skeet Boyle*	Yvonne Arizpe (Legacy Community Health)
Caleb Brown*	Kenneth Jones (Legacy Community Health)
Titan Capri	Norman Mitchell (Bee Busy, subcontractor RW agency)
Johanna Castillo*	Shital Patel - conflicted (Harris Health System)
Johnny Deal	Beatriz E.X. Rivera (Legacy Community Health)
Kathryn Fergus*	Megan Rowe* (City Housing & Community Develop)
Kenia Gallardo*	Yolanda Ross (may be employed by an agency that would make her ineligible to run)
Glen Hollis	Jose Serpa-Alvarez (Harris Health System)
Denis Kelly	Carol Suazo* (City Housing & Community Develop)
Peta-gay Ledbetter*	
Cecilia Ligons	
Roxane May*	
Josh Mica	
Rodney Mills	
Diana Morgan*	
Bill Patterson	
Oscar Perez	
Tana Pradia	
Ryan Rose*	
Evelio Salinas Escamilla	
Robert Sliepka*	
Steven Vargas	
Mike Webb	
Priscilla Willridge	