

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
Ryan Rose, Vice Chair
Bill Patterson, Secretary
Skeet Boyle, Co-Chair, Affected Community Committee
Carol Suazo, Co-Chair, Affected Community Committee
Robert Sliepka, Co-Chair, Comprehensive HIV Planning Committee
Steven Vargas, Co-Chair, Comprehensive HIV Planning Committee
Caleb Brown, Co-Chair, Operations Committee
Cecilia Ligons, Co-Chair, Operations Committee
Jay Bhowmick, Co-Chair, Priority and Allocations Committee
Peta-gay Ledbetter, Co-Chair, Priority and Allocations Committee
Yvonne Arizpe, Co-Chair, Quality Improvement Committee
Tana Pradia, Co-Chair, Quality Improvement Committee

Copy: Glenn Urbach
Eric James
Francisco Ruiz
Tiffany Shepherd

Diane Beck
Jason Black
EMAIL ONLY:
Sha'Terra Johnson
David Williams

From: Tori Williams

Date: Wednesday, February 26, 2025

Re: Meeting Announcement

The Ryan White Steering Committee will have its first meeting in February. Details are as follows:

Ryan White Steering Committee Meeting

12 noon, Thursday, March 6, 2025

Join the Zoom meeting by clicking on:

<https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SIV2RE50ZzYraEErQT09>

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.

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@harriscountytexas.gov. Thank you!

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL



STEERING COMMITTEE

AGENDA

12 noon, Thursday, March 6, 2025

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=YmtrcktWcHY5SIV2RE50ZzYraEErQT09>

Meeting ID: 857 8218 9192 Passcode: 885832

Or, dial in by calling 346 248-7799

- I. Call to Order Josh Mica, He/Him/El, Chair
RW Planning Council
- A. Welcoming Remarks and Moment of Reflection
 - B. Select the Committee Co-Chair who will be voting
 - C. Adoption of the Agenda
 - D. Adoption of the Minutes
- II. Public Comment and Announcements: **SEE ONE WRITTEN COMMENT**
(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 Robert Sliepka and
Steven Vargas, Co-Chairs
Item: 2025 Committee Orientation
Recommended Action: FYI: All Ryan White standing Committees were orientated on their 2025 meeting dates and work products, they approved their 2025 goals and they elected their Committee Vice Chairs.

Item: Committee Vice Chair
Recommended Action: FYI: Georgina "Gina" German was elected to be the 2025 Committee Vice Chair.
 - B. Affected Community Committee Skeet Boyle and
Carol Suazo, Co-Chairs
Item: 2025 Road 2 Success Educational Focus
Recommended Action: FYI: The Committee determined that the focus of 2025 Road 2 Success presentations will be on making consumers aware of how to use the new Blue Book and services that they may be eligible to use.

Item: 2025 Greeters

Recommended Action: FYI: See the attached list of greeters for the 2025 Council meetings.

Item: Committee Vice Chair

Recommended Action: FYI: Ryan Rose was elected to be the 2025 Committee Vice Chair.

C. Quality Improvement Committee

Item: Committee Training on How to Read Reports

Recommended Action: FYI: Please see the two attached presentations on *How to Read Reports* from the Administrative Agents.

Yvonne Arizpe and
Tana Pradia, Co-Chairs

Item: Administrative Agent Reports – Part A/MAI*

Recommended Action: FYI: See the attached reports:

- FY24 Part A/MAI Procurement, dated 02-18-25
- FY24 Part A/MAI Service Utilization, dated 02-13-25
- Clinical Quality Management Presentation, dated 02-18-25
- Clinical Quality Management Reports (2), dated 02-10-25
- 2025 Part A/MAI Standards of Care

Item: Administrative Agent Reports – Part B/SS**

Recommended Action: FYI: See the attached reports:

- FY24 Part B Procurement, dated 01-30-25
- FY24 Part B Service Utilization, dated 01-21-25
- FY24 Part SS** Procurement, dated 01-30-25
- FY24, Health Insurance Assistance Service Utilization, dated 01-23-25

Item: Information about Community Advisory Boards (CABs)

Recommended Action: FYI: See the attached information sheet on the purpose and regulations regarding Ryan White Agency CABs. This will be discussed at the March Quality Improvement Committee meeting at 12 noon on Tuesday, March 18, 2025.

Item: New Idea: Centralized Scheduling System

Recommended Action: FYI: The attached New Idea will be discussed at the Quality Improvement Committee meeting at 12 noon on March 18, 2025.

Item: Committee Vice Chair

Recommended Action: FYI: Isis Torrente was elected to be the 2025 Committee Vice Chair.

D. Priority and Allocations Committee

Item: 2025 Policy on Allocating Unspent Funds

Recommended Action: **Motion:** Approve the attached 2025 Policy on Allocating Unspent Funds.

Peta-gay Ledbetter and
Jay Bhowmick, Co-Chairs

Item: 2025 Principles & Criteria

*Recommended Action: **Motion:** Approve the 2025 Principles and Criteria.*

Item: FY 2026 Priority Setting Process

*Recommended Action: **Motion:** Approve the attached FY 2026 Priority Setting Process.*

Item: Committee Vice Chair

Recommended Action: FYI: TBA was elected to be the 2025 Committee Vice Chair.

E. Operations Committee

Caleb Brown and
Cecilia Ligons, Co-Chairs

Item: Personnel Subcommittee

Recommended Action: FYI: Verbal update regarding the Personnel Subcommittee.

Item: New Affiliate Member Orientation

Recommended Action: FYI: On Friday, February 21, 2025, the Operations Committee oriented 4 new Affiliate Committee members.

Item: 2025 Council Training Schedule

Recommended Action: FYI: See the attached 2025 Council Training Schedule.

Item: Council Bylaws

Recommended Action: FYI: The Operations Committee will review the sequence of events at a 2024 Council meeting to determine if the Council followed their Bylaws in taking action on a particular motion that was not on the agenda. If the Council did not follow the Bylaws, they will recommend a remedy.

Item: Committee Vice Chair

Recommended Action: FYI: Beatriz “Birdie” Rivera was elected to be the 2025 Committee Vice Chair.

IV. Report from the Office of Support

Staff, RW Office of Support

V. Report from Ryan White Grant Administration

Glenn Urbach, Manager

VI. Report from The Resource Group

Sha’Terra Johnson,
Health Planner

VII. Announcements

VIII. Adjournment

*MAI = Minority AIDS Initiative funding

** SS = Texas Department of Health State Services funding

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL



STEERING COMMITTEE

MINUTES

12 noon, Thursday, February 6, 2025

Meeting Location: Bering Church 1440 Harold Street; Houston, TX and Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Josh Mica, he/him/él, Chair	Caleb Brown	<i>Ryan White Grant Administration</i>
Ryan Rose, Vice Chair		Glenn Urbach
Bill Patterson, Secretary		Eric James
Skeet Boyle		James Supak
Carol Suazo		Jason Black
Robert Sliepka		
Steven Vargas	OTHERS PRESENT	<i>The Resource Group</i>
Cecilia Ligons	Charles Henley, Consultant	Sha'Terra Johnson
Peta-gay Ledbetter	Bobby Cruz	Tionna Cobb
Jay Bhowmick	Evelio Escamilla	
Yvonne Arizpe	Ronnie Galley	<i>Office of Support</i>
Tana Pradia	Megan Rowe	Tori Williams
	Isis Torrente	Diane Beck
		Rod Avila

Call to Order: Josh Mica, he/him/él, Chair, called the meeting to order at 12:03 p.m.

During the opening remarks, Mica welcomed the new members of the Steering Committee and thanked them for agreeing to serve as leaders. As most know, Patrick Martin passed away last month. There will be a Celebration of his life at 2 pm on Saturday, February 22nd. Please let Rod know if you did not receive this information. He then thanked the Operations Committee, under the leadership of Cecilia and Crystal, and the Office of Support staff for organizing the new member orientation, the mentor/mentee meeting and the Planning Council Orientation. Unfortunately Richon Ohafia will not be able to do the presentation scheduled for today. Instead, there will be a brief discussion about what Harris County is doing to defend the federal grant programs. It is especially important that Council members meet regularly and stay informed.

Mica then called for a Moment of Reflection.

Those selected to represent their committee at today's meeting are: Suazo for Affected Community, Vargas for Comprehensive HIV Planning, Ligons for Operations, Bhowmick for Priority and Allocations and Pradia for Quality Improvement.

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

Approval of the Minutes: *Motion #2:* *it was moved and seconded (Rose, Pradia) to approve the December 5, 2024 minutes.* **Motion carried.** Abstentions:.

Public Comment and Announcements: None.

Reports from Committees

Comprehensive HIV Planning Committee: Robert Sliepka, Co-Chair, reported on the following: 2025 Houston Area HIV Needs Assessment: The completion of The 2025 Houston Area HIV Needs Assessment was put on hold due to County funding rules, but it should be ready for use during the 2025 How To Best Meet the Need process.

Affected Community Committee: No report.

Quality Improvement Committee: No report.

Priority and Allocations Committee: No report.

Operations Committee: Ryan Rose, RWPC Vice Chair, reported on the following: 2025 New Member Orientation & Mentor/Mentee Meeting: Rose said that the meetings went well and that new members were very enthusiastic.

2025 Council Orientation: Rose said that the 2025 Orientation was well attended.

2025 Council Activities: See attached. Williams summarized the memorandum regarding Petty Cash procedures, Open Meetings Act Training and the 2025 Timeline of Critical Activities. These items will also be reviewed at the first meeting of each committee.

Report from Office of Support: Tori Williams said that Judge Hidalgo will interview the top three candidates for the Director position next week.

Report from Ryan White Grant Administration: Glenn Urbach, Manager, summarized the attached report. Vargas asked about the new service categories. Urbach said that they got one bid for the food category but not for the others so they will try again. Ligons said that she has spoken to clients who have insurance but have been turned away for 2-3 months now and are out of medications. Urbach urged her to have them call the complaint line.

Report from The Resource Group: Sha'Terra Johnson, Health Planner, summarized the attached report. She shared the RSVP link for Patrick's service in the chat. Vargas asked if the Texas Insurance Assistance Program numbers could be included in their report. Johnson said that about 530 clients signed up for the program, 86 of those are from the Houston area. She will include the enrollment numbers in future reports.

Motion #3: *it was moved and seconded (Arizpe, Boyle) to have the staff set up a meeting so that the Planning Council can go into Executive Session and seek counsel from the County Attorney's Office regarding the impact on the Ryan White Program of Executive Orders issued in 2025, HRSA instructions related to the Executive Orders and any related Court actions or orders.* **Motion Carried.**

Announcements: Vargas said that advocacy groups are meeting nationwide to discuss the funding freeze. He also reminded everyone that Advocacy Day is March 24th, information should be available soon. Johnson said that tomorrow is National Black HIV/AIDS Awareness Day.

Adjournment: Motion: *it was moved and seconded (Rose, Sliepka) to adjourn the meeting at 12:58 p.m. Motion Carried.*

Submitted by:

Approved by:

Tori Williams, Director Date

Committee Chair Date

2024 Steering Committee Voting Record for Meeting Date 02/06/25

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 PC Executive Session Carried			
	Absent	Yes	No	Abstain	Absent	Yes	No	Abstain	Absent	Yes	No	Abstain
Josh Mica, Chair				C				C				C
Ryan Rose, Vice Chair		X				X				X		
Bill Patterson, Secretary		X						X		X		
Carol Suazo, Aff		X				X				X		
Steven Vargas, Comp		X						X		X		
Cecilia Ligons, Op		X				X				X		
Jay Bhowmick, PA		X						X		X		
Tana Pradia, QI		X				X				X		
<i>Non-voting members at the meeting:</i>												
Skeet Boyle, Aff												
Robert Sliepka, Comp												
Crystal Starr, Op												
Peta-gay Ledbetter, PA												
Yvonne Arizpe, QI ja 12:15 pm												
<i>Absent members:</i>												
Caleb Brown, Op												

PUBLIC COMMENT – 02-18-25

Thank you for your time; I respectfully submit the following as a public comment for the committee meetings.

I kindly request that reports on the capacity of Spanish-language service delivery continue for all services, not just RW Primary Care clinics. We need to continue monitoring the needs that are being met and brainstorming solutions in joint meetings for better service delivery.

Reports on any reductions in utilization of services due to fear, trauma, or known immigration status due to the existing stigmatizing climate? Or, has there been any decrease in Latino/a/x/e numbers utilizing services? Should telemedicine be used more by these vulnerable populations? Easier and more accessible way of getting labs done? Does LPAP cover pharmacy drug home or mail delivery? We hope to maintain improving viral suppression numbers within the Ryan White system of care and perhaps improve enrolling those out of care.

Report on MCM for older adults, progress, utilization, and health outcome improvements. How are we examining the number of clients serviced, and how are we monitoring their health outcomes to demonstrate Quality of Life improvements? Should we consider adding a Non-Medical Case Management for Older Adults service category to assist in other social, housing, and economic needs? Remember, we need to address the earlier onset of aging symptoms, and the numbers demonstrate a faster-growing group of 45 years and above.

Also, I haven't seen any more quarterly clinical reports from the different services. When these are shared with the Clinical staff workgroup/committee, reports should also be shared at our QI Committee and Comprehensive Committee meetings. It is important to monitor any lack of utilization along with performance or improving health outcomes within the continuum of care.

I'm also curious about the conversation with the project officer. How will the Minority AIDS Initiative funding stream be affected? Since our incidence numbers are sadly still flat but growing, the formula should still benefit the Houston EMA with an increase. These funds are essential to the Houston area. However, providing any funding to any other entity is not our responsibility. We already have challenges within our EMA and must continue to address them.

We know that earlier treatments work, so Rapid Start should move forward as a standard of care. We should have the capacity within RW Part A to adapt to this change. Even though this administration implemented EHE funds, we can't depend on them always being there. Treatment as prevention is the goal and objective. This administration will look good if the outcomes are impactful.

I appreciate your time and effort on these topics, and hopefully, we can work together on them.

-Evelio Salinas Escamilla



Nuts and Bolts for New Members

Please take into account that the following describes Council procedures under normal circumstances (no COVID, hurricanes, freezes, chemical spills or other extreme situations).

Staff will mail meeting packets a week in advance; if they do not arrive in a timely manner, please contact Rod in the Office of Support. In the meantime, most reminder emails will include an electronic copy of the meeting packet.

The meeting packet will have the date and time of the meeting, along with the in person meeting address and the virtual link. When contacting Rod to RSVP, please let her know if you will or will not be in attendance AND if you will be participating in person or virtually. This will determine room set up and food orders.

If attending in person, please sign in upon arrival and use the extra agendas on the sign in table if you didn't bring your packet.

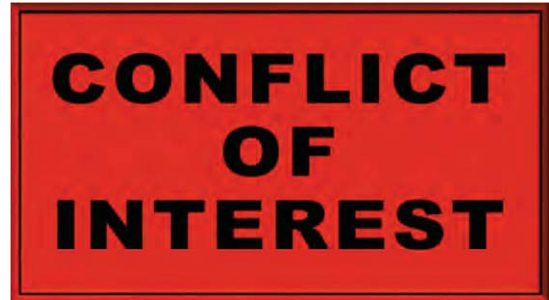
Only Council/committee members sit at the table since they are voting members; staff and other non-voting members sit in the audience.

The only members who can vote on the minutes are the ones who were present at the meeting described in the minutes. If you were absent at the meeting, please abstain from voting.

Due to County budgeting policy, there may be no petty cash reimbursements in March and April. Please turn in your receipts to Rod but be prepared to receive a reimbursement check in late April.

Be careful about stating personal health information in meetings as all meetings are tape-recorded and, due to the Open Meetings Act, are considered public record. Anyone can ask to listen to the recordings, including members of the media.

RYAN WHITE CONFLICT OF INTEREST



Short definition:

- You,
- someone with whom you share expenses,
- or the agency that employs you

will benefit from something that the Council is voting on.

HRSA/Council definition: “Conflict of Interest” (COI) is defined as an actual or perceived interest by a Ryan White Planning Council member in an action which results or has the appearance of resulting in personal, organizational, or professional gain.

COI does not refer to persons living with HIV whose sole relationship to a Ryan White funded provider is as a client receiving services.

The potential for conflict of interest is present in all Ryan White processes: needs assessment, priority setting, comprehensive planning, allocation of funds and evaluation.

EXAMPLES:

Agencies that receive Ryan White funding include:

- Legacy Community Health - Vision
- Montrose Center – Mental Health Services
- Thomas Street Health Center – Primary Medical Care & Case Management


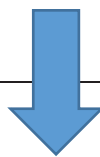




- 1.) If you are dating someone who works for Legacy Community Health, can you vote on allocating funds to the Vision program?
- 2.) If you and your roommate are “just friends” and he works for Thomas Street Health Center, can you vote on allocating funds to primary medical care? Food Pantry?
- 3.) If you are a client at Thomas Street Health Center, can you vote on allocating funds to case management?
- 4.) If you are a realtor and you have a contract to help the Montrose Center sell their building, can you vote on the service definition for mental health?

Affected
Community
Committee

Greeters for 2025 Council Meetings

(Revised: 02-26-25)

Captain of the Greeters: Kesh Lock

2025 Meeting Dates (Please arrive at 11:30 am unless otherwise noted. Meetings are held at Bering Church, 1440 Harold St in Montrose)	Greeter #1	Greeter #2	Greeter #3
2025			
Thurs. February 13			
Thurs. March 13	Marvin	Isis	Kesh
Thurs. April 10 – HTBMN Training	Lisa	Alaria	Charlotte
Thurs. May 8	Isis	Marvin	Ryan
Thurs. June 12	Charlotte	Lisa	Kesh
Thurs. July 10	Skeet	Alaria	Kesh
Thurs. August 14	Marvin	Isis	Kesh
Thurs. September 11	Rodney	Charlotte	Kesh
Thurs. October 9	TBD	TBD	TBD
Thurs. November 13			
Thurs. December 11			

Affected Community Committee Training

Purpose of the Planning Council
Participation in Health Fairs
Purpose of Public Hearings

February 25, 2025

Purpose of the Planning Council

- What does the Planning Council do?
 - Conducts a Needs Assessment
 - Creates a plan to improve HIV services in Houston
 - Reviews data about existing Ryan White funded HIV services
 - Designs HIV services that will be provided using Ryan White funds in the Houston EMA/HSDA
 - Makes a list of the most important services
 - Decides the amount of Ryan White funding that will be allocated to each of the services

Purpose of the Planning Council

- What does the Planning Council NOT do?
 - Review grant applications from agencies
 - Decide which agencies in Houston get money
 - Hire and fire staff at agencies
 - Respond to complaints from consumers about specific agencies
 - Write letters to politicians in Washington
 - March at protests
 - Conduct HIV prevention
- HRSA sets the rules for Planning Councils
 - HRSA says Planning Councils can only focus on services, not specific agencies.
 - The Administrative Agencies (Ryan White Grant Administration & The Resource Group) monitor grants and agencies.

Participation in Health Fairs



- | | |
|---|--|
| <ul style="list-style-type: none">● Tell the public about what the Ryan White Planning Council does● Tell the public about services by giving out the Blue Book● Tell the public how to volunteer with the Planning Council | <ul style="list-style-type: none">● Give out condoms or HIV prevention materials● Do HIV prevention● Tell the public about specific agencies |
|---|--|



Purpose of Public Hearings

- Twice a year
- Inform the community about recommended changes that the Planning Council will decide upon.
- Get feedback from consumers of Ryan White services as to how the recommended changes will affect their ability to receive care and support services.
- Community input is vital to all of the Planning Councils processes and is encouraged at every level.
 - Public Hearings are televised to help all PLWH participate in the planning process – especially PLWH who cannot travel to Planning Council meetings

Quality
Improvement
Committee

RYAN WHITE PART A & MAI PROCUREMENT & SERVICE UTILIZATION REPORTS

HOW TO READ RWGA REPORTS

FEBRUARY 2025

Glenn Urbach, LMSW

February 2025

PROCUREMENT & SERVICE UTILIZATION REPORTS SUPPORT THE HIGHLIGHTED ACTIVITIES COMMON TO PART A & PART B ADMINISTRATIVE AGENTS

- Needs Assessment incl. special studies & Unmet Need Framework
- Integrated Prevention and Care Planning (Comp Plan)
- **Priority Setting**
- **Directives** – How to Best Meet the Need (HTBMTN)
- **Resource Allocation**
- Coordination of Services
- **Procurement** (RFP, Reviews, Contracting, Invoices)
- Contract Monitoring (fiscal and programmatic)
- Clinical Quality Management

RESOURCE ALLOCATION

- After setting priorities, the Council allocates resources, which means it decides how much RWA and MAI, RWB and TDSHS funding will be used for each of these priorities
- The RWGA **Procurement Report** documents
 - The Council's **planned allocations** for Part A and MAI-funded services and how these funds are adjusted during the grant year (March 1 – February 28)
 - **Changes in allocations** made during the year
 - These changes are usually done in April (final NoA is issued from HRSA), July (for carryover funds from the previous fiscal year), October (mid-year review of underspending Agency contracts), and fourth quarter (sweep up funds of Agency underspending contracts)
 - The associated YTD **monthly expenditures** by service category/subcategory



PROCUREMENT

- RWGA, the Administrative Agency or “AA” for RW Part A & MAI, contracts with eligible entities to provide services
- RWGA uses Requests For Proposals, Interlocal Agreements and contract renewals to **procure** the services
- During the grant year, RWGA identifies funds that can be reallocated by the Council to other service priorities with unmet need (e.g., carryover, underspending contracts)
- These changes in Allocations are documented in the Procurement Report



EXPENDITURES

- The Procurement Report also documents the year-to-date (YTD) **expenditures** for each individual service category and subcategory the Council has allocated funds to
- Expenditures often lag behind reports because Agencies are required to submit their bills within 10 business days after the end of each month, but some take longer
- RWGA identifies service categories where expenditures are not on track and works with the Agency to resolve challenges
- RWGA will reduce contracts when spending has fallen behind
- Those funds are returned to the Council for reallocation



RULES / CAVEATS

- No less than 75% of RWA and MAI funds must be allocated to Core Services unless the Recipient has received a waiver from HRSA
- RWA and MAI **carryover** funds are also subject to the 75% Core Services Requirement
- Due to the time needed to issue an RFP, select new vendors and for those vendors to begin service delivery, new Service Categories or contracting with new Agencies is not an option after the April reallocation opportunity when HRSA issues its final Notice of Award for the current fiscal year
- After April, reallocations can only be made into existing Service Categories, with the sole exception of allocating funds to ADAP



OTHER CONSIDERATIONS

- Reading the Procurement Report when the Category has multiple subcategories (e.g., OAHS, LPAP, MCM, and SLW)
 - Each subcategory has its own row
 - The **bolded** row is the sum of all the subcategories
 - Otherwise, it is the same information
- **Procurement Date** is the date the contract begins
- The RWGA Procurement Report reflects Part A and MAI procurement and expenditures only



SERVICE UTILIZATION REPORT SUR

- The **SUR** mimics the Procurement Report and documents service utilization – how many clients have gotten the service
- **Goal** is the number of unduplicated clients (UDC) intended to be served for each service category during the grant year
- **UDC served YTD** is the unduplicated number of clients who have accessed the service so far in the grant year
- **Demographic** data for the UDC served YTD is listed for each category and subcategory
- **Bolded** rows are the unduplicated sum of all clients served per the HRSA Category



EXAMPLE

- Let's read the most recent SUR together

Presented by: Ryan White Grant Administration
 FY 2023 Ryan White Part A and MAI Service Utilization Report

Category	Subcategory	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040
Part A	Subcategory 1	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Subcategory 2	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Part A Total		200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200
MAI	Subcategory 1	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Subcategory 2	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
MAI Total		200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200

Page 1 of 2 Pages

Available Data As Of: 1/15/2025

OTHER CONSIDERATIONS

- Reading the SUR when the Category has multiple subcategories (e.g., OAHS, LPAP, MCM, and SLW)
 - Each subcategory has its own row
 - The **bolded** row is the sum of all the subcategories
 - Otherwise, it is the same information
- The RWGA SUR reflects Part A and MAI service utilization only
- At the request of the RWPC, RWGA can run reports that include all clients served under all funding streams the Council allocates money for (e.g., Part B and State Services)

QUESTIONS/DISCUSSION





THE HOUSTON REGIONAL HIV/AIDS
RESOURCE GROUP, INC.

HOW TO READ
TRG REPORTS
FEBRUARY 13TH, 2024

2024 TRG RWPC REPORT DUE

STATE SERVICES CONTRACT YEARS	RYAN WHITE PART B CONTRACT YEARS
Year 1: 9/1/23 - 8/31/24	Year 1: 4/1/23 - 3/31/24
Year 2: 9/1/24 - 8/31/25	Year 2: 4/1/24 - 3/31/25

ANNUAL REPORTS (DELIVERED TO QI COMMITTEE)	
2023 MEANINGFUL ENGAGEMENT REPORT NA**	2023 CHART REVIEW REPORTS NA**

***No Monitoring Activities were conducted in 2023 per DSHS two Year Monitoring Cycle.*

All Monthly & Quarterly Reports delivered on a one-month delay to allow the finalization of data.

QUARTERLY REPORTS (DELIVERED TO QI COMMITTEE)			
STATE SERVICES SERVICE UTILIZATION REPORTS		RYAN WHITE PART B SERVICE UTILIZATION REPORTS	
MONTHS COVERED	REPORT DUE	MONTHS COVERED	MONTH DUE
September November	January	April June	August
September February	April	April September	November
September May	July	April December	February
September August	October	April March	May

MONTHLY REPORTS (DELIVERED TO QI COMMITTEE)	
PROCUREMENT REPORTS	HEALTH INSURANCE ASSISTANCE REPORTS

Quarterly Service Utilization Reports

Purpose:

Provide quarterly updates on the number of people living with HIV (PLWH) who are access services by service category.

2018-2019 Ryan White Part B Service Utilization Report
 4/1/2018 - 3/31/2019 Houston HISDA (4816)
 3rd Quarter - 4/1/2018 to 12/31/2018

C. [] D. [] A. [] B. []

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 & Cost Sharing Assistance	1,250	3	100.00%	0.00%	0.00%	0.00%	75.00%	25.00%	0.00%	0.00%	0.00%	0.00%	8.82%	8.82%	23.53%	11.76%	44.12%	2.94%
Home & Community Based Health Services	30	34	70.59%	26.47%	0.00%	2.94%	58.82%	8.82%	32.35%	0.00%	0.00%	0.00%	66.67%	0.00%	33.33%	0.00%	0.00%	0.00%
Oral Health Care	3,100	856	72.90%	25.93%	0.00%	1.17%	49.65%	17.06%	31.43%	1.87%	0.00%	0.12%	1.75%	14.84%	18.69%	13.79%	43.46%	7.36%
Unduplicated Clients Served By RW Part B Funds	N/A	893	81.16%	17.47%	0.00%	1.37%	61.16%	16.96%	21.26%	0.62%	0.00%	0.11%	2.02%	14.78%	18.81%	13.77%	43.34%	7.17%

E. COMMENT: The delay in Data Upload from CPCDMS into ARIES is the reason for the discrepancy in the HIP/HIA YTD Total. Please see HINS Report for review on HIP/HIA totals.

Items of Note:

- A. Header this tells you three things:
 1. Which grant is being reported (either Ryan White Part B or State Services),
 2. What grant year is being reported, and
 3. What timeframe is being reported (the quarter and the dates of the quarter).
- B. Revision Date this tells you the last time that the report has updated.
- C. Service Categories being reported
- D. The Unduplicated Clients (UDC)
 1. Goal shows the number of PLWH that have been targeted to be served in the contract year by all funded agencies.
 2. Year-To-Date (YTD) number of PLWH who have been served and the progress toward achieving the goal based on the contract year.
- E. Comments This is where TRG will provide any notes that will help explain the information in the report.

Monthly Procurement Reports

Purpose:

Provide monthly updates on spending by service category.

The Houston Regional HIV/AIDS Resource Group, Inc.
 FY 1819 Ryan White Part B
 Procurement Report
 April 1, 2018 - March 31, 2019

B. [] Reflects spending through December 2018 E. [] F. [] G. [] Spending Target: 75% C. []

Priority	D. [] Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Oral Health Care	\$2,085,565	62%	\$0	\$2,085,565	62%	4/1/2018	\$1,333,620	64%
7	Health Insurance Premiums and Cost Sharing (1)	\$726,885	22%	\$0	\$726,885	22%	4/1/2018	\$393,976	54%
9	Home and Community Based Health Services (2)	\$202,315	6%	\$325,806	\$528,121	16%	4/1/2018	\$103,920	51%
	Unallocated funds approved by RWPC for Health Insurance	\$325,806	10%	-\$325,806	\$0	0%	4/1/2018	\$0	0%
Total Houston HISDA		3,340,571	100%	\$0	\$3,340,571	100%		1,831,516	55%

J. Note: Spending variances of 10% will be addressed:
 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. Agency usually expends all funds. H. [] I. []

Items of Note:

- A. Header this tells you three things:
 1. Which grant is being reported (either Ryan White Part B or State Services),
 2. What grant year is being reported, and
- B. What timeframe is being reported (the quarter and the dates of the quarter).
- C. Revision Date this tells you the last time that the report has updated.
- D. Service Categories being reported
- E. Original Allocation from the P&A Process
- F. Amendment Tracks any change in the allocation.

- G. Contractual Amount the amount of money that has been contracted to service providers.
- H. Expended YTD the amount of money that has been spend year-to-date based on the contract year.
- I. Percentage YTD the percentage of money that has been spent based on the contract year. (TRG considers +/- 10% to be on target for spending.)
- J. Comments This is where TRG will provide any notes that will help explain the information in the report.

Quarterly Service Utilization Reports

Purpose:

Provide quarterly updates on the number of people living with HIV (PLWH) who are access services by service category.

Houston Ryan White Health Insurance Assistance Service Utilization Report



A Period Reported: 09/01/2018-12/31/2018
B. Revised: 2/4/2019

C. Request by Type	Assisted			NOT Assisted		
	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	785	\$72,937.77	509			0
Medical Deductible	70	\$23,424.75	50			0
Medical Premium	2447	\$984,144.70	686			0
Pharmacy Co-Payment	1345	\$135,910.80	651			0
APTC Tax Liability	0	\$0.00	0			0
Out of Network Out of Pocket	0	\$0.00	0			0
ACA Premium Subsidy Repayment	9	\$1,042.00	8	NA	NA	NA
G Totals:	4656	\$1,215,376.02	1904	0	\$0.00	

Comments: This report represents services **D.** under all **E.** **F.**

Items of Note:

- A. Period Reported What timeframe is being reported.
- B. Revision Date this tells you the last time that the report has updated.
- C. Type of Request tells you the sub-services that was provided
- D. The number of the request that received service.
- E. The amount spent to provide the service.
- F. The number of unduplicated people living with HIV that have received service.
- G. Comments This is where TRG will provide any notes that will help explain the information in the report.

Priority	Service Category	Original Allocation <i>RWPC Approved Level Funding Scenario</i>	Award Reconciliation	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	-12,085	79,623	16,040	11,758,522	46.65%	11,758,522	0		\$9,587,178	82%	92%
1.a	Primary Care - Public Clinic (a)	4,109,697	144,599					4,254,296	16.88%	4,254,296	0	3/1/2024	\$3,874,506	91%	92%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,114,019	37,077	45,820		191,854	25,000	1,413,770	5.61%	1,413,770	0	3/1/2024	\$1,256,632	89%	92%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	952,840	33,369	39,082			20,000	1,045,291	4.15%	1,045,291	0	3/1/2024	\$1,436,198	137%	92%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,201,238	40,784	49,863			25,000	1,316,885	5.22%	1,316,885	0	3/1/2024	\$513,906	39%	92%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,151,088	40,784		-12,085	-137,231	-61,960	980,596	3.89%	980,596	0	3/1/2024	\$780,000	80%	92%
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	\$1,271,421	59%	92%
1.g	Primary Care - Pediatric (a.1)														
1.h	Vision	500,000				25,000	8,000	533,000	2.11%	533,000	0	3/1/2024	\$454,515	85%	92%
1.x	Primary Care Health Outcome Pilot	50,000	0					50,000	0.20%	50,000	0	3/1/2024	\$0	0%	92%
2	Medical Case Management	2,183,040	0	0	0	-92,938	-58,500	2,031,602	8.06%	2,031,602	0		1,210,720	60%	92%
2.a	Clinical Case Management	531,025	0			16,000		547,025	2.17%	547,025	0	3/1/2024	\$466,754	85%	92%
2.b	Med CM - Public Clinic (a)	301,129	0					301,129	1.19%	301,129	0	3/1/2024	\$195,144	65%	92%
2.c	Med CM - Targeted to AA (a) (e)	183,663	0					183,663	0.73%	183,663	0	3/1/2024	\$126,350	69%	92%
2.d	Med CM - Targeted to H/L (a) (e)	183,665	0					183,665	0.73%	183,665	0	3/1/2024	\$76,995	42%	92%
2.e	Med CM - Targeted to W/MSM (a) (e)	66,491	0					66,491	0.26%	66,491	0	3/1/2024	\$37,568	57%	92%
2.f	Med CM - Targeted to Rural (a)	297,496	0			-38,914	-48,500	210,082	0.83%	210,082	0	3/1/2024	\$139,371	66%	92%
2.g	Med CM - Women at Public Clinic (a)	81,841	0					81,841	0.32%	81,841	0	3/1/2024	\$122,236	149%	92%
2.h	Med CM - Targeted Geriatrics	400,899	0					400,899	1.59%	400,899	0	3/1/2024	\$7,671	0%	0%
2.i	Med CM - Targeted to Veterans	86,964	0			-70,024	-10,000	6,940	0.03%	6,940	0	3/1/2024	\$0	0%	92%
2.j	Med CM - Targeted to Youth	49,867	0					49,867	0.20%	49,867	0	3/1/2024	\$38,631	77%	92%
3	Local Pharmacy Assistance Program	2,067,104	0	33,513	12,085	140,880	50,010	2,303,592	9.14%	2,303,592	0		\$1,824,054	79%	92%
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	367,104	0					367,104	1.46%	367,104	0	3/1/2024	\$245,896	67%	92%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,700,000	0	33,513	12,085	140,880	50,010	1,936,488	7.68%	1,936,488	0	3/1/2024	\$1,578,157	81%	92%
4	Oral Health	166,404	0	0	0	10,050	11,250	187,704	0.74%	187,704	0		166,450	89%	92%
4.b	Oral Health - Targeted to Rural	166,404	0			10,050	11,250	187,704	0.74%	187,704	0	3/1/2024	\$166,450	89%	92%
5	Health Insurance (c)	1,583,137	0	311,204	0	0	0	1,894,341	7.52%	1,894,341	0		\$1,494,928	79%	92%
7	Medical Nutritional Therapy (supplements)	341,395	0	0	0	0	0	341,395	1.35%	341,395	0		\$280,699	82%	92%
8	Substance Abuse Services - Outpatient (c)	25,000	0	0	0	-5,000	0	20,000	0.08%	20,000	0		\$12,480	62%	92%
10	Emergency Financial Assistance	2,139,136	0	11,722	0	-39,204	-10,000	2,101,654	8.34%	2,101,654	0		\$1,547,539	74%	92%
10.a	EFA - Pharmacy Assistance	2,039,136	0	11,722		-19,204		2,031,654	8.06%	2,031,654	0	3/1/2022	\$1,488,076	73%	92%
10.b	EFA - Other	100,000	0			-20,000	-10,000	70,000	0.28%	70,000	0	3/1/2024	\$59,463	85%	92%
12	Non-Medical Case Management	1,267,002	0	0	0	1,267,411	-8,800	1,164,791	4.62%	1,164,791	0		\$949,857	82%	92%
12.a	Service Linkage targeted to Youth	110,793	0			-60,000		50,793	0.20%	50,793	0	3/1/2024	\$66,942	132%	92%
12.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0			-20,000		80,000	0.32%	80,000	0	3/1/2024	\$49,654	62%	92%
12.c	Service Linkage at Public Clinic (a)	370,000	0					370,000	1.47%	370,000	0	3/1/2024	\$309,543	84%	92%
12.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	0			-13,411	-8,800	663,998	2.63%	663,998	0	3/1/2024	\$523,718	79%	92%
13	Medical Transportation	424,911	0	0	0	0	0	424,911	1.69%	424,911	0		\$388,822	92%	92%
13.a	Medical Transportation services targeted to Urban	252,680	0					252,680	1.00%	252,680	0	3/1/2024	\$198,324	78%	92%
13.b	Medical Transportation services targeted to Rural	97,185	0					97,185	0.39%	97,185	0	3/1/2024	\$115,984	119%	92%
13.c	Transportation vouchering (bus passes & gas cards)	75,046	0					75,046	0.30%	75,046	0	3/1/2024	\$74,514	99%	92%
15	Outreach	320,000	0	0	0	0	0	320,000	1.27%	320,000	0		\$110,588	35%	92%
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		\$17,573,315	78%	92%
	Grant Administration	2,133,394	0	0	0	0	0	2,133,394	8.46%	2,133,394	0	N/A	\$1,833,076	86%	92%
FY23_RW_ADMIN	HCPH/RWGA Section (including indirect \$169,915)	1,543,860	0	0	0	0	0	1,543,860	6.13%	1,543,860	0	N/A	\$1,351,642	88%	92%
FY23_RW_ADMIN	RWPC Support	589,534	0	0	0	0	0	589,534	2.34%	589,534	0	N/A	\$481,434	82%	92%
FY23_RW_OM	Quality Management	522,214	0	0	0	0	0	522,214	2.07%	522,214	0	N/A	\$413,660	79%	92%
		24,342,150	370,766	491,204	0	0	0	25,204,120	100.00%	25,204,120	0		\$19,820,051	79%	92%
															92%
															92%
	Part A Grant Award:	25,204,121	Carryover:	491,204				Total Part A:		25,204,121					
									Unallocated	Unobligated					92%
									1	0					92%

Priority	Service Category	Original Allocation <i>RWPC Approved Level Funding Scenario</i>	Award Reconciliation	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 Reconciliation	July Adjustments (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	132,615	18,800	18,518,356	82.13%	13,081,580	81.92%	Formula			0
	Non-Core (may not exceed 25% of total service dollars)	4,151,049	0	11,722	0	-132,615	-18,800	4,030,156	17.87%	2,886,218	18.08%	Supplement			0
	Total Service Dollars (does not include Admin and QM)	21,686,542	370,766	491,204	0	0	0	22,548,512		15,967,799		Carry Over	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%			Totals	0	0	0
	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 <i>RWPC Approved Level Funding Scenario</i>	Award Reconciliation	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		\$1,878,260	88%	92%
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	\$1,002,365	92%	92%
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	\$875,895	83%	92%
2	Medical Case Management	314,060	4,536	0	0	0	0	318,596	12.93%	318,596	0		\$131,821	41%	92%
2.c (MAI)	MCM - Targeted to African American	157,030	2,268					159,298	6.46%	159,298	0	3/1/2024	\$94,612	59%	92%
2.d (MAI)	MCM - Targeted to Hispanic	157,030	2,268					159,298	6.46%	159,298	0	3/1/2024	\$37,208	23%	92%
	Total MAI Service Funds	2,382,115	34,892	47,459	0	0	0	2,464,466	100.00%	2,464,466	0		\$2,010,081	82%	92%
	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		\$2,010,081	82%	92%
	MAI Grant Award	2,464,466	Carry Over:	47,459				Total MAI:							92%
	Combined Part A and MAI Original Allocation Total	26,724,265							Unallocated	Unobligated					
									0	0		MAI Award	2,464,466		
												Total Part A & MAI Award	27,668,587		
Footnotes:															
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 - 1/31/2025 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	8,707	74%	23%	2%	43%	10%	2%	44%	0%	0%	5%	27%	28%	22%	15%	3%
1.a	Primary Care - Public Clinic (A)	3,113	2,860	69%	30%	1%	42%	7%	2%	49%	0%	0%	3%	17%	25%	27%	22%	5%
1.b	Primary Care - CBO Targeted to AA (A)	2,335	2,395	71%	26%	3%	99%	0%	1%	0%	0%	1%	6%	36%	29%	16%	10%	2%
1.c	Primary Care - CBO Targeted to Hispanic (A)	1,934	2,271	82%	14%	3%	0%	0%	0%	100%	0%	0%	6%	32%	29%	21%	10%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (A)	774	717	85%	12%	3%	0%	83%	17%	0%	0%	0%	3%	25%	27%	22%	19%	4%
1.e	Primary Care - CBO Targeted to Rural (A)	752	640	72%	26%	1%	40%	18%	2%	40%	0%	0%	5%	25%	30%	23%	15%	3%
1.f	Primary Care - Women at Public Clinic (A)	872	869	0%	99%	1%	52%	5%	2%	42%	0%	0%	3%	14%	26%	30%	20%	6%
1.g	Primary Care - Pediatric (A)																	
1.h	Vision	2,663	2,305	72%	26%	2%	45%	11%	3%	42%	0%	0%	3%	21%	25%	25%	20%	6%
2	Medical Case Management	5,719	3,490	70%	28%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
2.a	Clinical Case Management	967	646	73%	25%	2%	57%	13%	2%	28%	0%	0%	3%	27%	23%	20%	20%	7%
2.b	Med CM - Targeted to Public Clinic (A)	578	438	90%	7%	3%	50%	12%	1%	37%	0%	0%	2%	29%	24%	20%	20%	5%
2.c	Med CM - Targeted to AA (A)	1,479	873	67%	30%	3%	99%	0%	1%	0%	0%	0%	3%	30%	29%	20%	13%	4%
2.d	Med CM - Targeted to H/L (A)	728	486	81%	15%	5%	0%	0%	0%	100%	0%	0%	6%	30%	28%	22%	12%	3%
2.e	Med CM - Targeted to White and/or MSM (A)	460	189	84%	15%	1%	0%	86%	14%	0%	0%	0%	2%	17%	22%	28%	22%	9%
2.f	Med CM - Targeted to Rural (A)	554	545	69%	31%	0%	49%	25%	2%	24%	0%	0%	2%	21%	24%	22%	21%	9%
2.g	Med CM - Targeted to Women at Public Clinic (A)	259	240	1%	99%	0%	65%	7%	1%	27%	0%	0%	1%	28%	30%	22%	15%	4%
2.h	Med CM - Targeted to Geriatrics	532	64	63%	34%	3%	67%	11%	2%	20%	0%	0%	0%	0%	0%	0%	56%	44%
2.i	Med CM - Targeted to Veterans	148																
2.j	Med CM - Targeted to Youth	14	9	78%	11%	11%	67%	0%	0%	33%	0%	22%	78%	0%	0%	0%	0%	0%
3	Local Drug Reimbursement Program (A)	5,781	5,680	75%	22%	3%	41%	11%	2%	46%	0%	0%	4%	26%	28%	23%	15%	3%
4	Oral Health	348	328	67%	31%	1%	40%	26%	2%	32%	0%	0%	2%	17%	27%	29%	17%	9%
4.a	Oral Health - Untargeted (D)	NA	NA															
4.b	Oral Health - Rural Target	348	328	67%	31%	1%	40%	26%	2%	32%	0%	0%	2%	17%	27%	29%	17%	9%
5	Health Insurance (D)	2,034	2,143	78%	20%	2%	46%	20%	3%	31%	0%	0%	2%	15%	22%	21%	27%	13%

6	Mental Health Services (D)	NA	NA																
7	Medical Nutritional Therapy/Nutritional Supplements	515	439	76%	23%	1%	42%	17%	4%	37%	0%	0%	0%	6%	12%	27%	34%	21%	
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	1,314	74%	23%	3%	44%	8%	2%	45%	0%	1%	5%	24%	28%	24%	16%	2%	
10.a	Emergency Financial Assistance-Pharmacy Assistance	3,105	1,201	75%	23%	2%	42%	8%	2%	47%	0%	1%	6%	24%	29%	24%	14%	2%	
10.b	Emergency Financial Assistance - Other (MCC only)	113	116	67%	29%	3%	65%	10%	3%	22%	0%	0%	3%	17%	18%	21%	33%	9%	
11	Referral for Health Care - Non Core Service (D)	NA	NA																
12	Non-Medical Case Management	8,568	6,707																
12.a	Service Linkage Targeted to Youth	179	167	65%	30%	5%	53%	3%	3%	41%	0%	11%	89%	0%	0%	0%	0%	0%	
12.b	Service Linkage at Testing Sites	132	131	71%	26%	3%	56%	6%	6%	31%	0%	0%	0%	50%	25%	15%	7%	3%	
12.c	Service Linkage at Public Clinic Primary Care Program (A)	3,621	3,064	65%	34%	1%	49%	8%	2%	41%	0%	0%	0%	17%	24%	26%	25%	8%	
12.d	Service Linkage at CBO Primary Care Programs (A)	4,636	3,345	73%	25%	2%	49%	10%	2%	39%	0%	0%	4%	27%	29%	21%	14%	5%	
13	Transportation	2,358	1,464	70%	28%	3%	61%	9%	2%	28%	0%	0%	1%	15%	21%	25%	28%	9%	
13.a	Transportation Services - Urban	687	337	66%	32%	2%	54%	8%	4%	34%	0%	0%	1%	21%	25%	23%	19%	10%	
13.b	Transportation Services - Rural	195	124	67%	32%	1%	31%	31%	2%	35%	0%	0%	1%	19%	17%	30%	23%	11%	
13.c	Transportation vouchersing	1,476	1,131	70%	27%	3%	67%	6%	1%	26%	0%	0%	1%	13%	20%	25%	32%	8%	
14	Linguistic Services (D)	NA	NA																
15	Outreach Services	955	529	70%	26%	4%	61%	9%	2%	29%	0%	1%	6%	34%	26%	18%	13%	3%	
	Net unduplicated clients served - all categories	15,378	14,364	74%	24%	2%	47%	12%	2%	39%	0%	0%	4%	24%	25%	22%	18%	7%	
	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%	

RW MAI 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+
	Outpatient/Ambulatory Primary Care (excluding Vision)	3,129																
1.b	Primary Care - MAI CBO Targeted to AA (F)	1,676	1,961	71%	26%	3%	99%	0%	1%	0%	0%	0%	6%	36%	29%	17%	10%	2%
1.c	Primary Care - MAI CBO Targeted to HL (F)	1,453	1,809	83%	13%	3%	0%	0%	0%	100%	0%	0%	5%	33%	29%	21%	10%	2%
2	Medical Case Management (E)	1,535																
2.c	Med CM - MAI Targeted to AA (A)	907	380	68%	27%	4%	99%	0%	1%	0%	0%	1%	3%	38%	29%	13%	13%	3%
2.d	Med CM - MAI Targeted to H/L (A)	628	181	76%	18%	6%	0%	0%	0%	100%	0%	1%	6%	36%	28%	19%	8%	2%

RW Part A New Client Service Utilization Report																		
Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months																		
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	Primary Medical Care	1,929	1,842	76%	21%	3%	48%	11%	3%	38%	0%	1%	9%	35%	27%	16%	10%	2%
2	LPAP	969	815	78%	18%	4%	42%	11%	3%	43%	0%	0%	8%	33%	26%	19%	11%	2%
3.a	Clinical Case Management	110	50	82%	16%	2%	60%	14%	6%	20%	0%	0%	4%	32%	22%	20%	16%	6%
3.b-3.h	Medical Case Management (E)	1,050	626	70%	27%	3%	56%	13%	2%	29%	0%	1%	5%	32%	26%	19%	13%	4%
3.i	Medical Case Management - Targeted to Veterans	28																
4	Oral Health	49	29	79%	21%	0%	41%	24%	3%	31%	0%	0%	3%	24%	17%	28%	21%	7%
12.a. 12.c. 12.d.	Non-Medical Case Management (Service Linkage)	1,981	1,274	68%	30%	2%	55%	9%	3%	33%	0%	1%	6%	26%	24%	20%	17%	6%
12.b	Service Linkage at Testing Sites	100	130	71%	25%	5%	55%	4%	7%	34%	0%	4%	15%	42%	19%	11%	7%	3%

FOOTNOTES

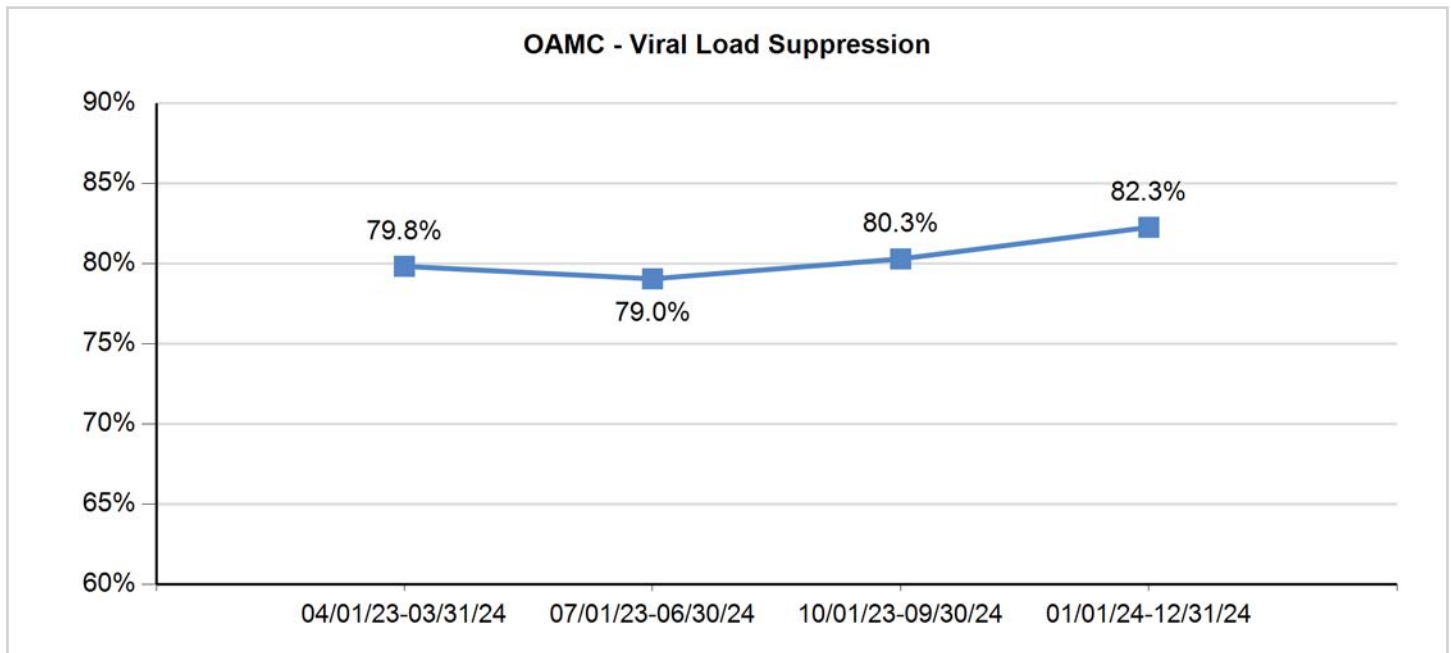
- (A) Bundled Category
- (B) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
- (D) Funded by Part B and/or State Services
- (E) Total MCM served does not include Clinical Case Management
- (F) CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA Clinical Quality Management Committee Quarterly Report

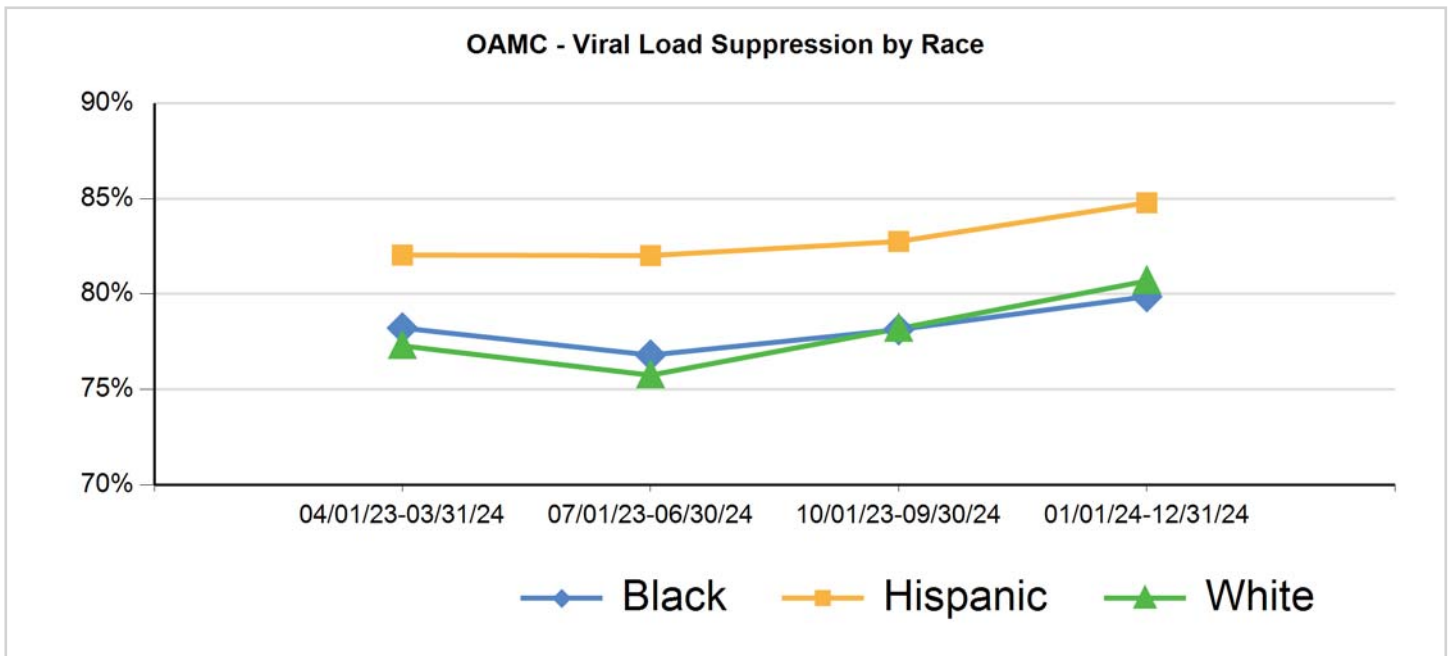
Last Quarter Start Date: 1/1/2024

Agency: ALL

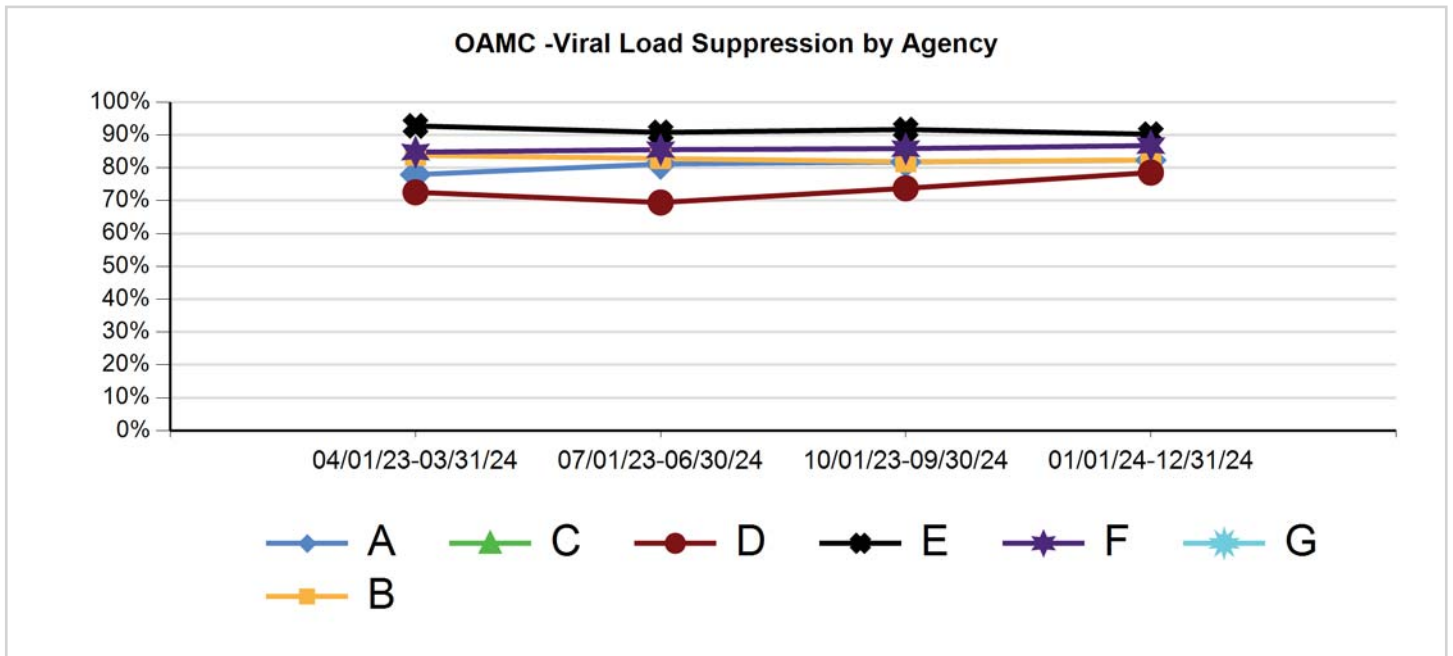
OAMC - Viral Load Suppression				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	5,199	5,157	5,218	5,211
Number of clients living with HIV, with at least one medical visit in the measurement year	6,513	6,524	6,499	6,335
Percentage	79.8%	79.0%	80.3%	82.3%
Change from Previous Quarter Results	-3.2%	-0.8%	1.2%	2.0%



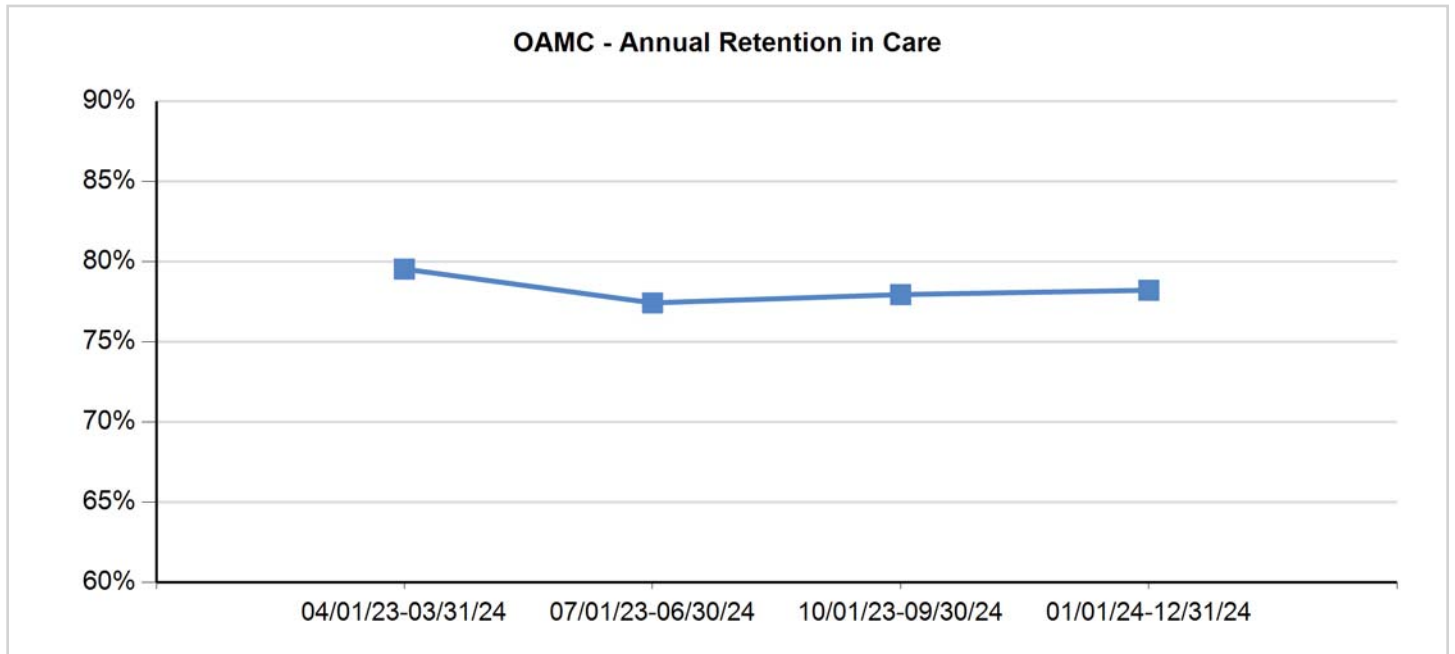
OAMC - Viral Load Suppression by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	2,264	2,394	406	2,269	2,442	405	2,257	2,446	401
Number of clients living with HIV, with at least one medical visit in the measurement year	2,948	2,919	536	2,904	2,951	518	2,826	2,885	497
Percentage	76.8%	82.0%	75.7%	78.1%	82.8%	78.2%	79.9%	84.8%	80.7%
Change from Previous Quarter Results	-1.4%	0.0%	-1.5%	1.3%	0.7%	2.4%	1.7%	2.0%	2.5%



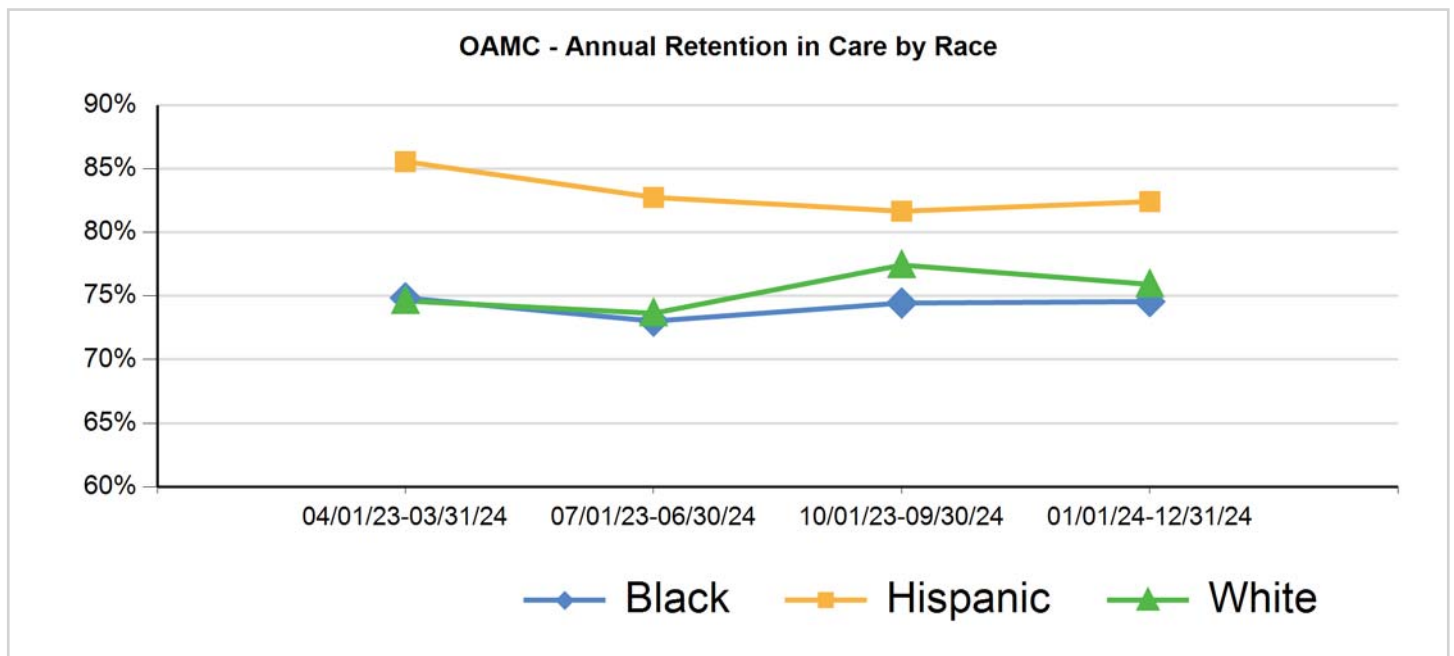
OAMC - Viral Load Suppression by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	719	1,911	0	1,443	77	1,099	0	704	1,850	0	1,495	74	1,116	0
Number of clients living with HIV, with at least one medical visit in the measurement year	879	2,334	0	1,956	84	1,280	0	855	2,246	0	1,903	82	1,286	0
Percentage	81.8%	81.9%	NaN	73.8%	91.7%	85.9%	0.0%	82.3%	82.4%	NaN	78.6%	90.2%	86.8%	0.0%
Change from Previous Quarter Results	0.6%	-1.0%	NaN	4.3%	0.9%	0.3%	NaN	0.5%	0.5%	NaN	4.8%	-1.4%	0.9%	NaN



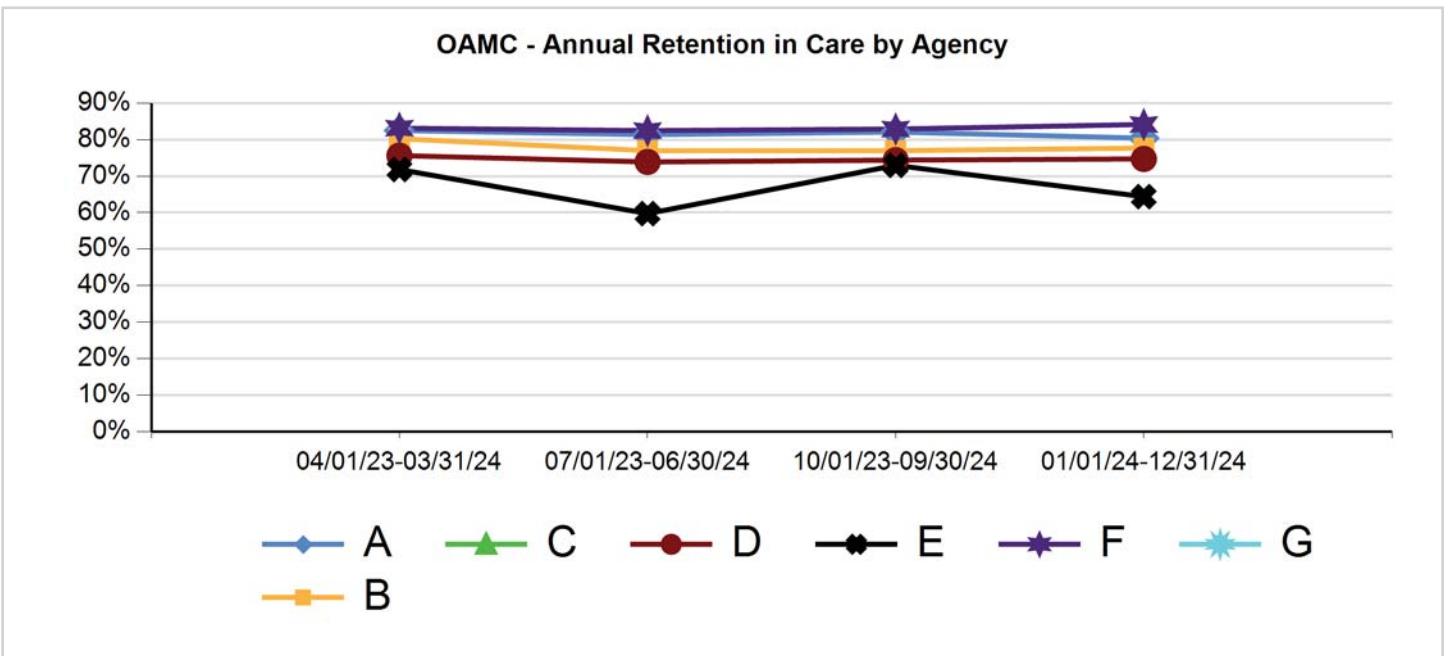
OAMC - Annual Retention in Care				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year.	4,725	4,643	4,678	4,594
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	5,941	5,997	6,002	5,874
Percentage	79.5%	77.4%	77.9%	78.2%
Change from Previous Quarter Results	-0.7%	-2.1%	0.5%	0.3%



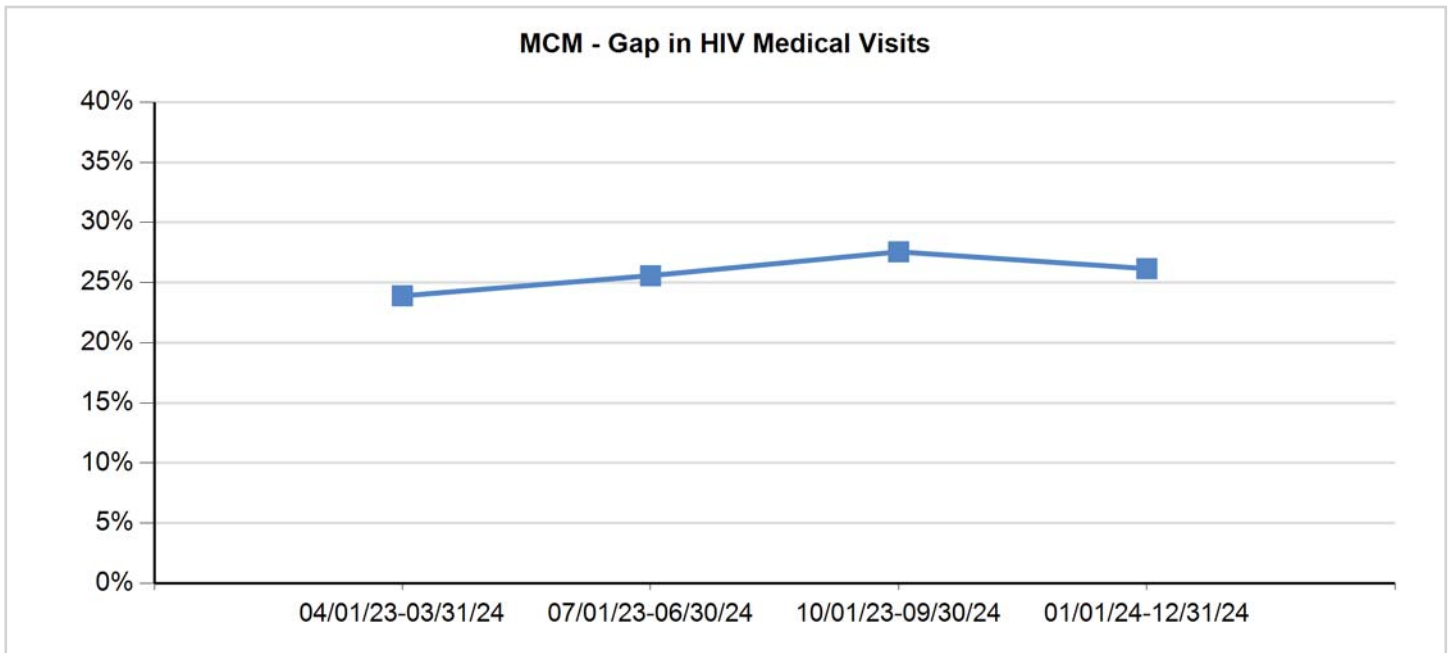
OAMC - Annual Retention in Care by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year.	1,979	2,217	366	1,984	2,235	374	1,937	2,227	353
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	2,710	2,679	497	2,665	2,737	483	2,598	2,702	465
Percentage	73.0%	82.8%	73.6%	74.4%	81.7%	77.4%	74.6%	82.4%	75.9%
Change from Previous Quarter Results	-1.8%	-2.8%	-1.0%	1.4%	-1.1%	3.8%	0.1%	0.8%	-1.5%



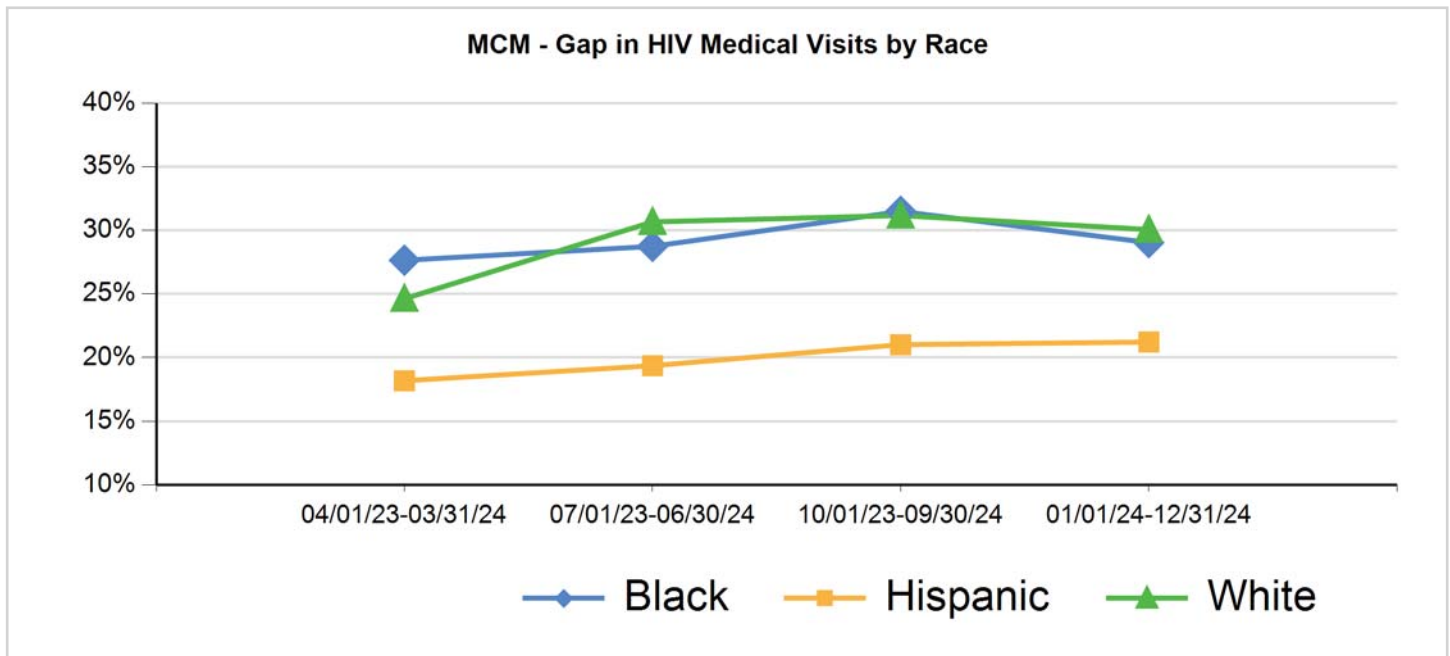
OAMC - Annual Retention in Care by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year.	701	1,689	0	1,380	54	878	0	665	1,650	0	1,357	47	903	0
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	854	2,194	0	1,855	74	1,059	0	827	2,124	0	1,816	73	1,073	0
Percentage	82.1%	77.0%	NaN	74.4%	73.0%	82.9%	0.0%	80.4%	77.7%	NaN	74.7%	64.4%	84.2%	0.0%
Change from Previous Quarter Results	0.7%	0.0%	NaN	0.5%	13.2%	0.4%	NaN	-1.7%	0.7%	NaN	0.3%	-8.6%	1.2%	NaN



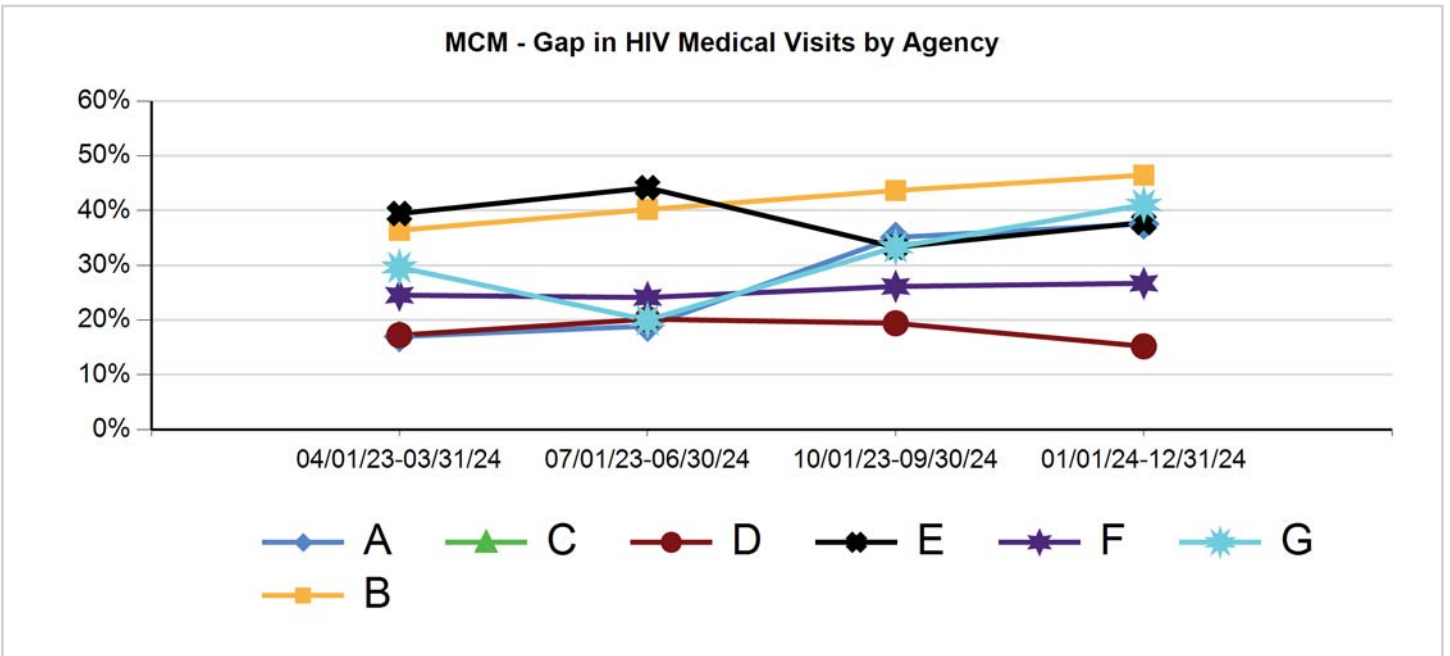
MCM - Gap in HIV Medical Visits				
	04/01/23-03/31/24	07/01/23-06/30/24	10/01/23-09/30/24	01/01/24-12/31/24
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	358	421	458	423
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	1,498	1,646	1,662	1,617
Percentage	23.9%	25.6%	27.6%	26.2%
Change from Previous Quarter Results	-0.9%	1.7%	2.0%	-1.4%



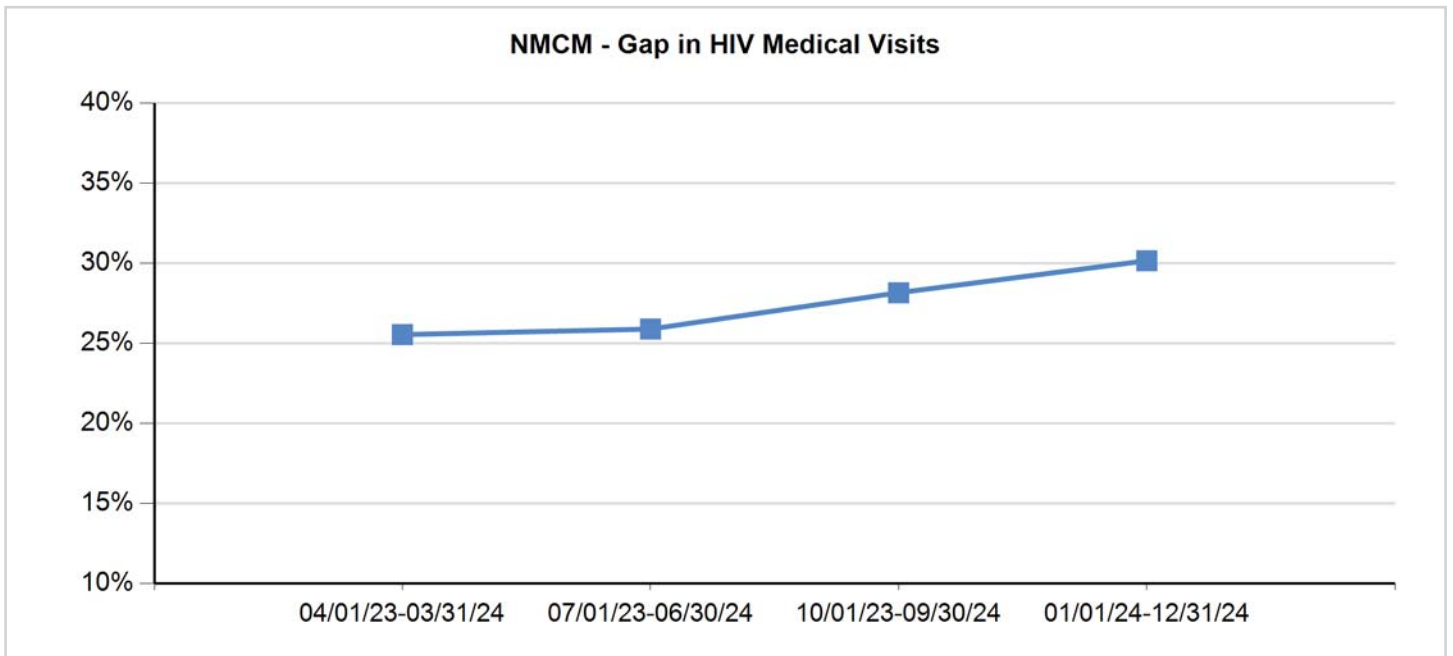
MCM - Gap in HIV Medical Visits by Race/Ethnicity									
	07/01/23-06/30/24			10/01/23-09/30/24			01/01/24-12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	240	122	46	268	132	48	239	132	46
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	835	630	150	851	628	154	823	622	153
Percentage	28.7%	19.4%	30.7%	31.5%	21.0%	31.2%	29.0%	21.2%	30.1%
Change from Previous Quarter Results	1.1%	1.2%	6.0%	2.7%	1.7%	0.5%	-2.5%	0.2%	-1.1%



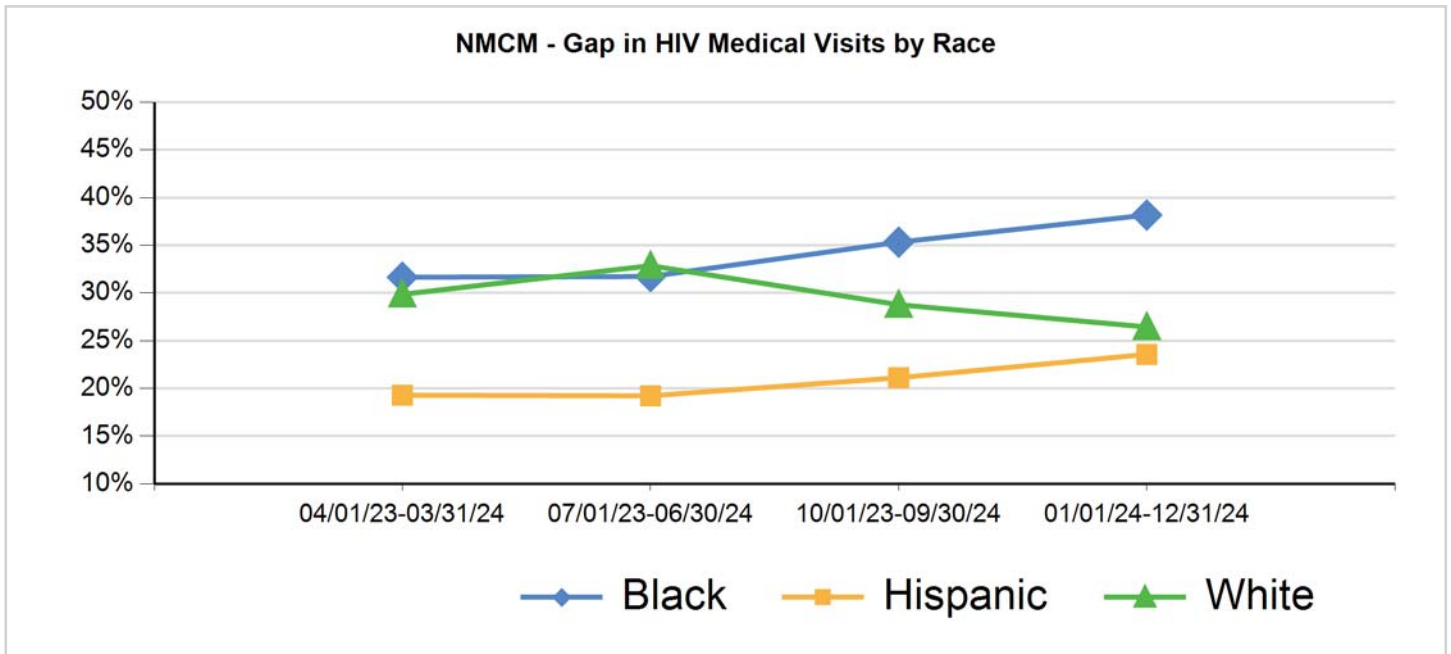
MCM - Gap in HIV Medical Visits by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	53	159	0	162	13	68	17	59	146	0	131	14	62	23
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	151	364	0	834	39	260	51	157	314	0	861	37	232	56
Percentage	35.1%	43.7%	NaN	19.4%	33.3%	26.2%	33.3%	37.6%	46.5%	NaN	15.2%	37.8%	26.7%	41.1%
Change from Previous Quarter Results	16.2%	3.5%	NaN	-0.8%	-10.9%	2.0%	13.3%	2.5%	2.8%	NaN	-4.2%	4.5%	0.6%	7.7%



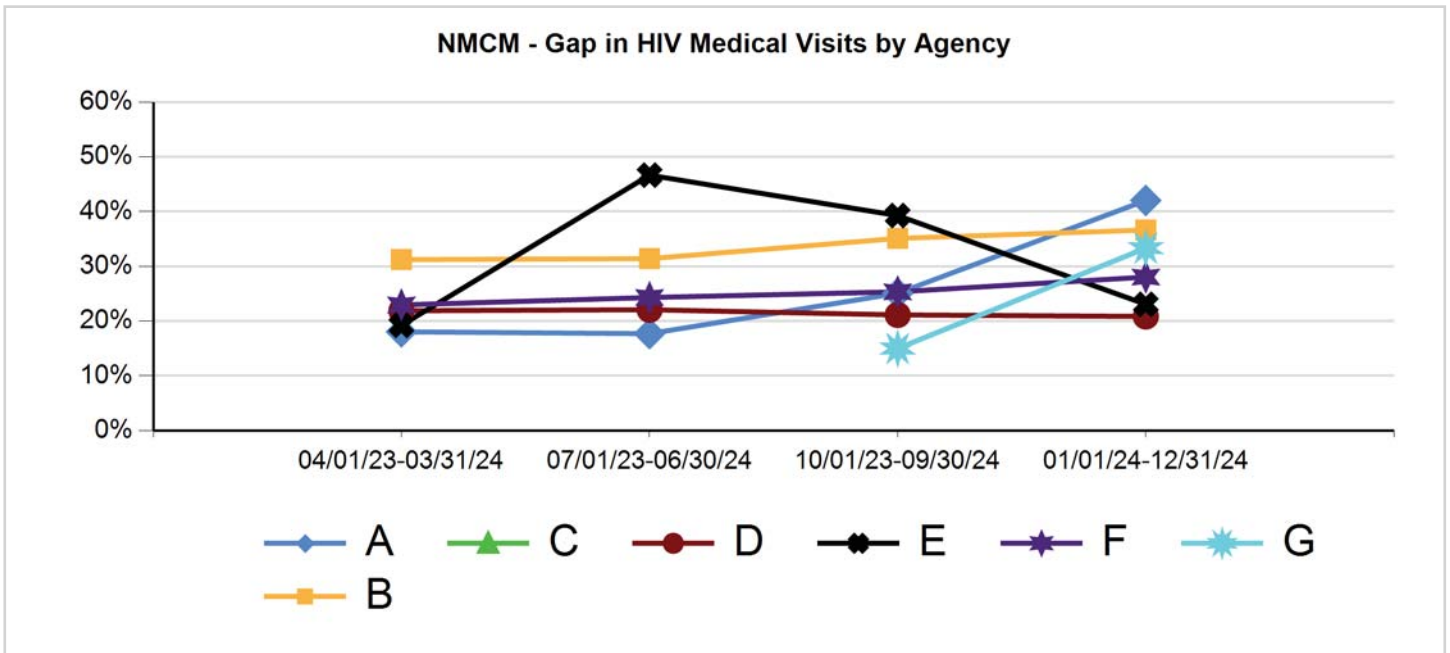
NMCM - Gap in HIV Medical Visits				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	903	899	991	1,020
Number of non medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	3,536	3,473	3,520	3,383
Percentage	25.5%	25.9%	28.2%	30.2%
Change from Previous Quarter Results	-1.1%	0.3%	2.3%	2.0%



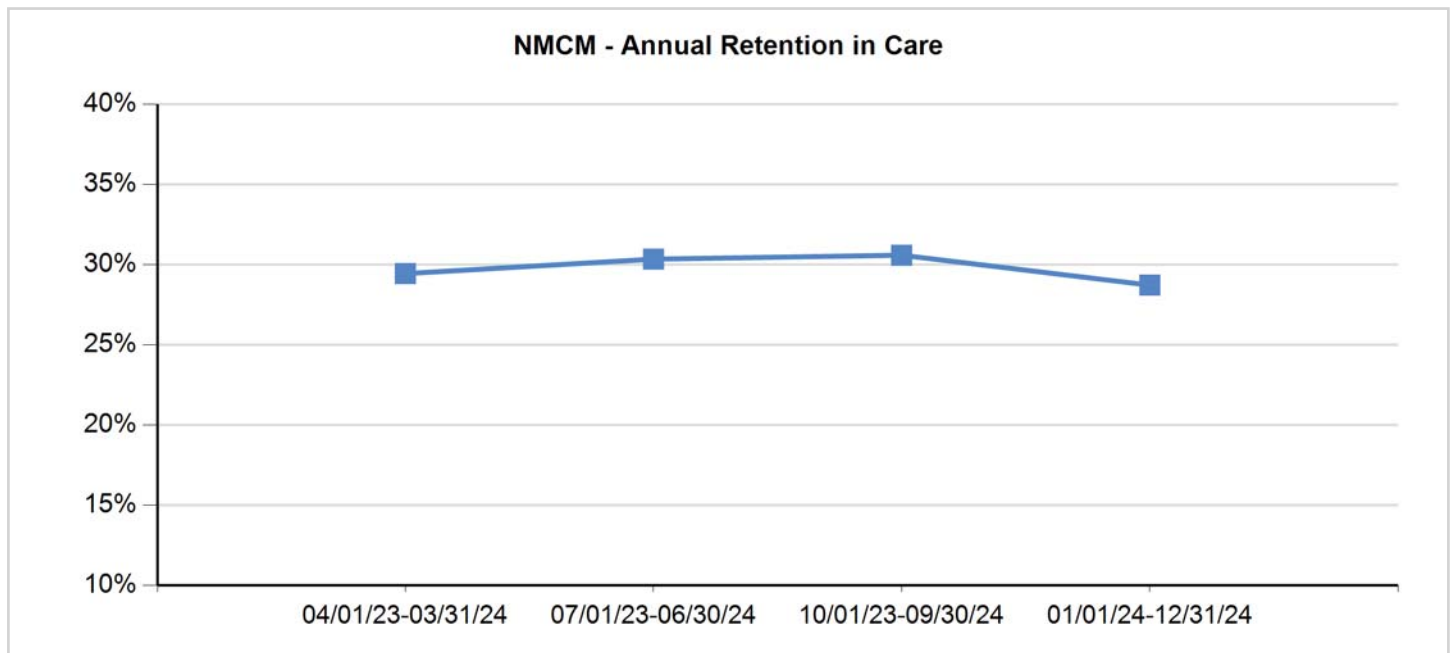
NMCM - Gap in HIV Medical Visits by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	475	313	93	531	352	82	542	386	69
Number of non medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	1,497	1,628	283	1,503	1,667	285	1,420	1,638	261
Percentage	31.7%	19.2%	32.9%	35.3%	21.1%	28.8%	38.2%	23.6%	26.4%
Change from Previous Quarter Results	0.1%	-0.1%	3.0%	3.6%	1.9%	-4.1%	2.8%	2.4%	-2.3%



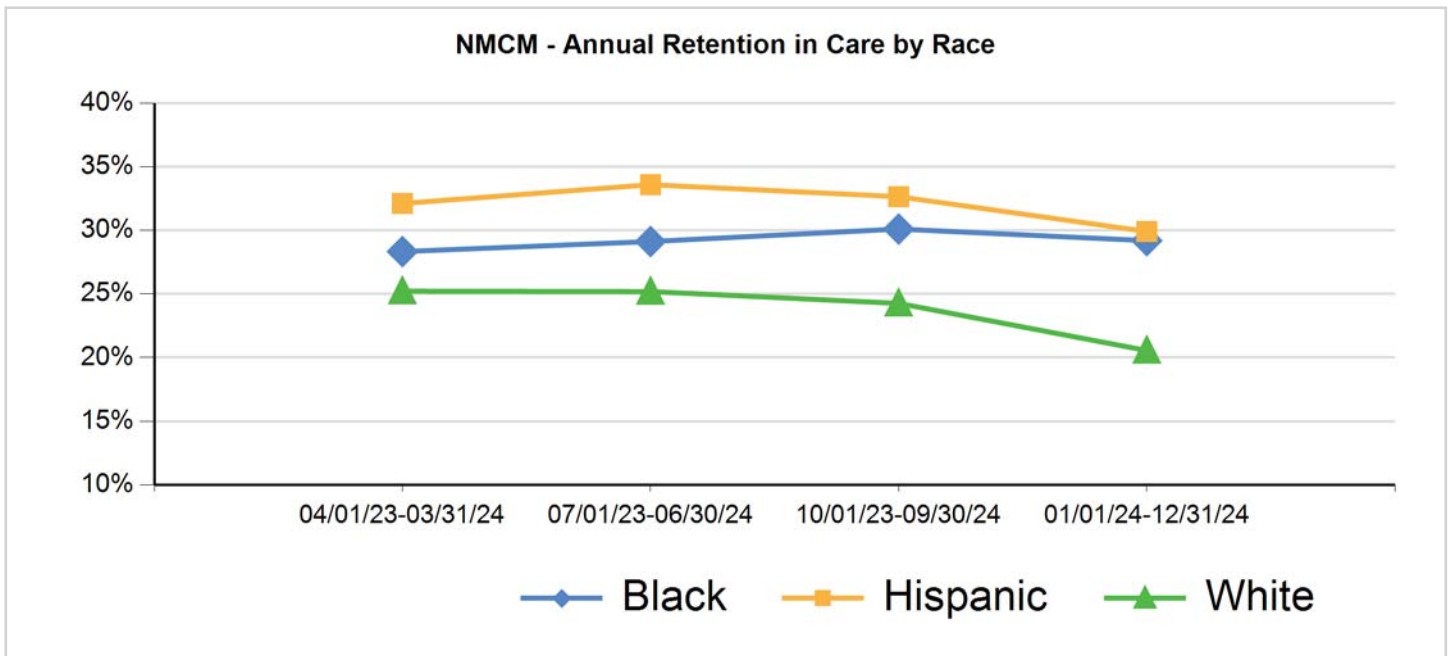
NMCM - Gap in HIV Medical Visits by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	74	554	0	309	11	74	3	111	557	0	293	6	76	17
Number of non medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	295	1,578	0	1,462	28	292	20	264	1,520	0	1,405	26	271	51
Percentage	25.1%	35.1%	NaN	21.1%	39.3%	25.3%	15.0%	42.0%	36.6%	NaN	20.9%	23.1%	28.0%	33.3%
Change from Previous Quarter Results	7.4%	3.7%	NaN	-0.9%	-7.4%	1.0%	NaN	17.0%	1.5%	NaN	-0.3%	-16.2%	2.7%	18.3%



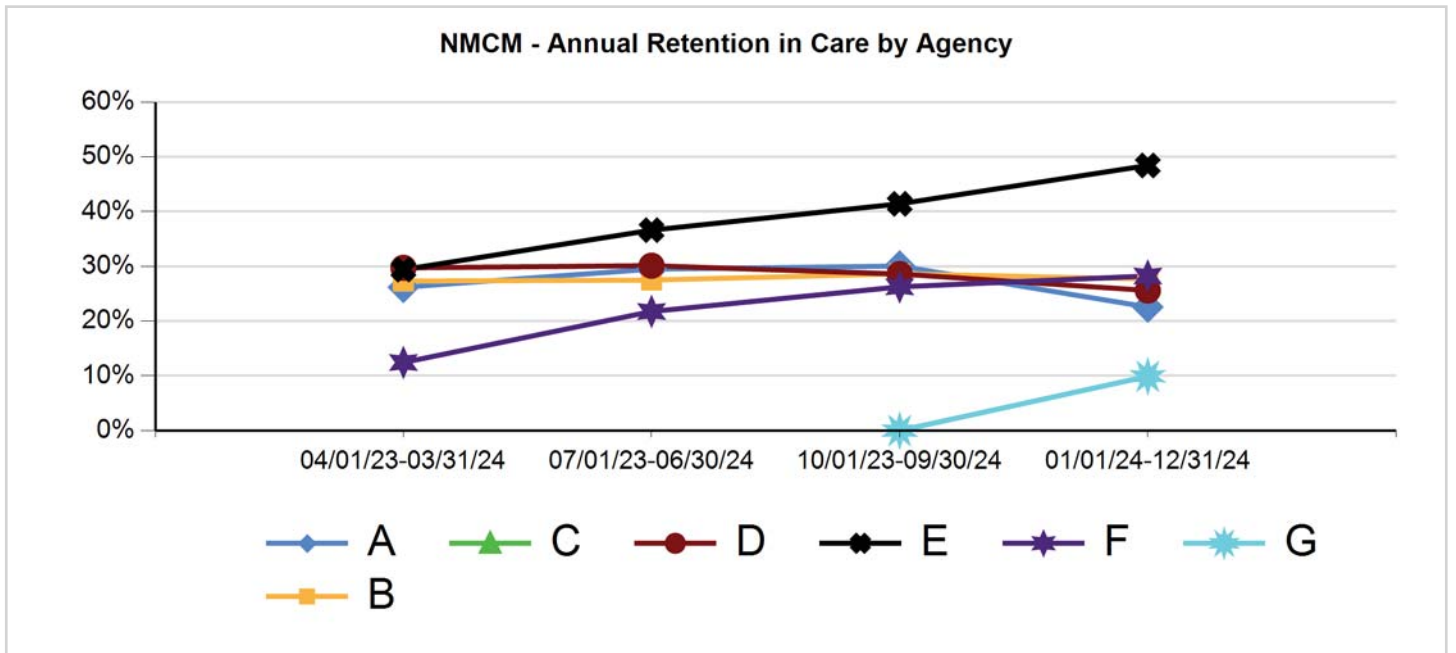
NMCM - Annual Retention in Care				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year.	2,184	2,228	2,186	2,025
Number of clients living with HIV who receive NMCM and had at least one encounter within the measurement year	7,420	7,344	7,148	7,052
Percentage	29.4%	30.3%	30.6%	28.7%
Change from Previous Quarter Results	0.3%	0.9%	0.2%	-1.9%



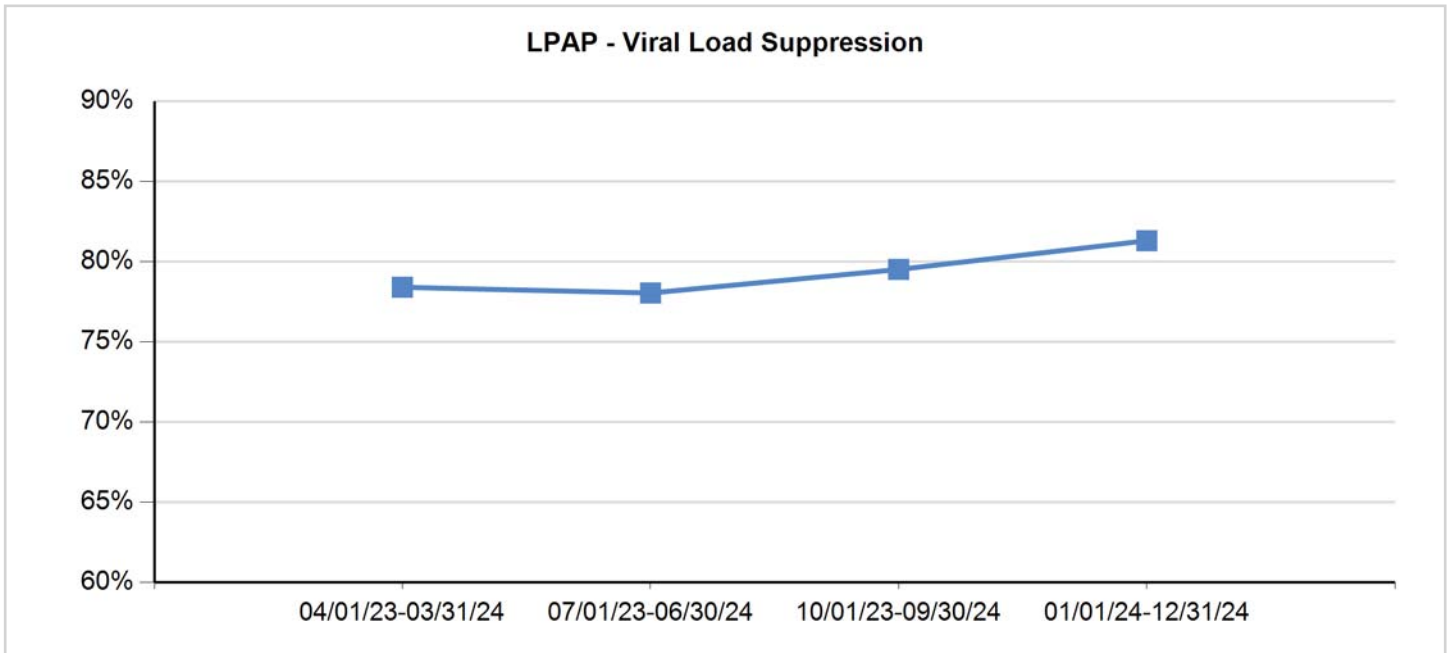
NMCM - Annual Retention in Care by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year.	1,121	909	164	1,120	875	148	1,069	788	126
Number of clients living with HIV who receive NMCM and had at least one encounter within the measurement year	3,849	2,706	651	3,720	2,680	610	3,662	2,634	613
Percentage	29.1%	33.6%	25.2%	30.1%	32.6%	24.3%	29.2%	29.9%	20.6%
Change from Previous Quarter Results	0.8%	1.5%	0.0%	1.0%	-0.9%	-0.9%	-0.9%	-2.7%	-3.7%



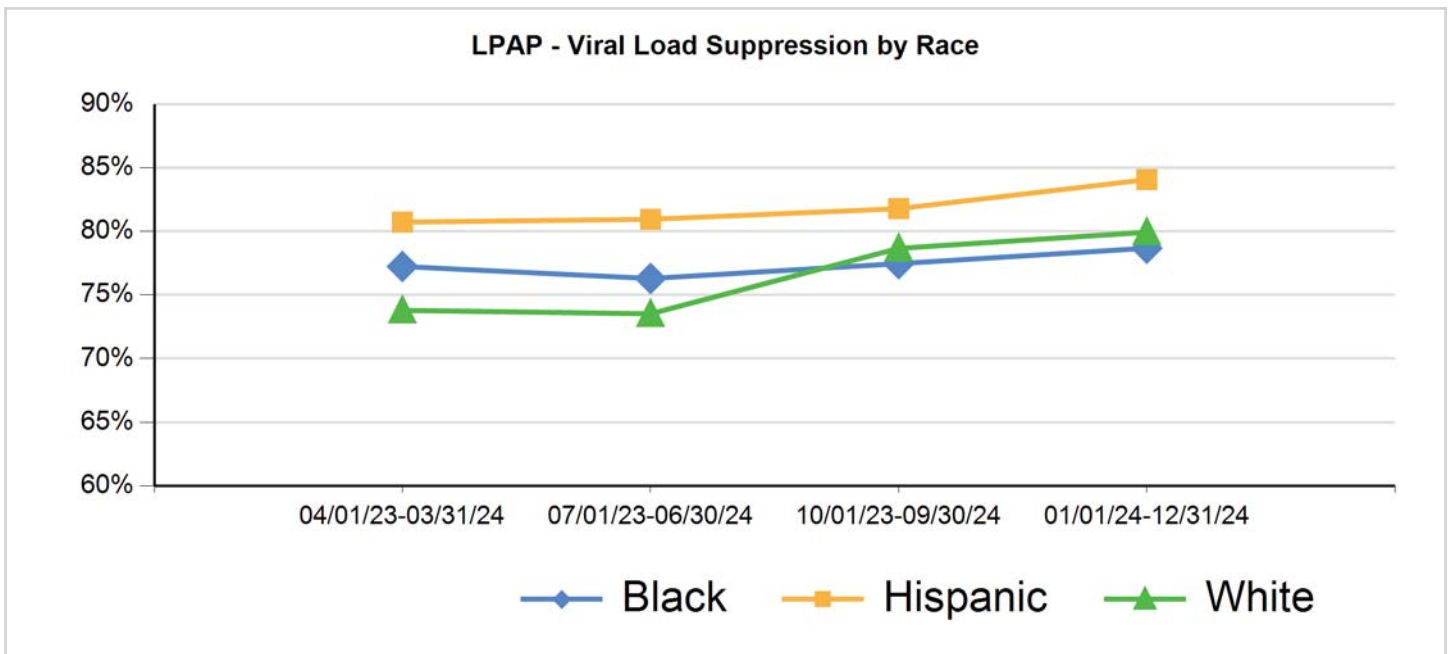
NMCM - Annual Retention in Care by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year.	116	1,042	0	793	29	125	0	86	997	0	675	31	135	12
Number of clients living with HIV who receive NMCM and had at least one encounter within the measurement year	386	3,638	0	2,772	70	476	44	381	3,601	0	2,637	64	478	121
Percentage	30.1%	28.6%	NaN	28.6%	41.4%	26.3%	0.0%	22.6%	27.7%	NaN	25.6%	48.4%	28.2%	9.9%
Change from Previous Quarter Results	0.6%	1.1%	NaN	-1.5%	4.8%	4.5%	NaN	-7.5%	-1.0%	NaN	-3.0%	7.0%	2.0%	9.9%



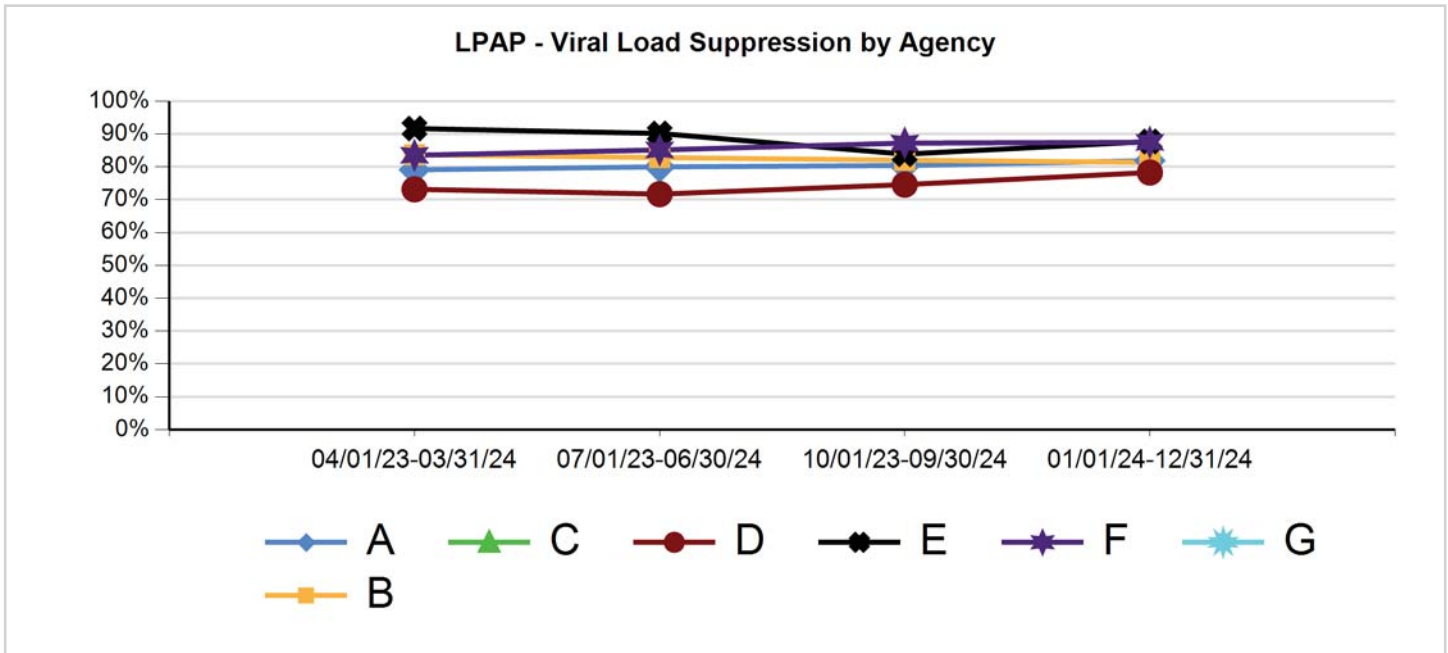
LPAP - Viral Load Suppression				
	04/01/23-03/31/24	07/01/23-06/30/24	10/01/23-09/30/24	01/01/24-12/31/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	3,117	3,134	3,119	3,117
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	3,976	4,016	3,923	3,834
Percentage	78.4%	78.0%	79.5%	81.3%
Change from Previous Quarter Results	-3.1%	-0.4%	1.5%	1.8%



LPAP - Viral Load Suppression by Race/Ethnicity									
	07/01/23-06/30/24			10/01/23-09/30/24			01/01/24-12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	1,413	1,428	236	1,375	1,446	236	1,332	1,483	239
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	1,852	1,764	321	1,775	1,768	300	1,693	1,764	299
Percentage	76.3%	81.0%	73.5%	77.5%	81.8%	78.7%	78.7%	84.1%	79.9%
Change from Previous Quarter Results	-0.9%	0.2%	-0.3%	1.2%	0.8%	5.1%	1.2%	2.3%	1.3%



LPAP - Viral Load Suppression by Agency														
	10/01/23-09/30/24							01/01/24-12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	435	717	0	1,268	52	718	0	425	725	0	1,297	50	691	0
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	541	874	0	1,700	62	823	0	519	891	0	1,657	57	790	0
Percentage	80.4%	82.0%	NaN	74.6%	83.9%	87.2%	0.0%	81.9%	81.4%	NaN	78.3%	87.7%	87.5%	0.0%
Change from Previous Quarter Results	0.4%	-0.8%	NaN	2.9%	-6.3%	2.1%	NaN	1.5%	-0.7%	NaN	3.7%	3.8%	0.2%	NaN





2025-2026 Houston EMA: RWGA Part A
 Standards of Care for HIV Services
 Ryan White Grant Administration Section
 SUMMARY OF CHANGES
 With Integration of EHE SOCs
 AS of 02/14/25

Location	2024-2025 (old)	2025-2026 (new)
General Standards 2.8	<u>Accountability</u> There is a system in place to document staff work time.	<u>Accountability</u> There is a system in place to document staff time and effort commensurate to appropriate funding source.
General Standard 4.7b		<u>Client Eligibility (EHE Only)</u> In order to be eligible for services, individuals must meet the following: <ul style="list-style-type: none"> • HIV+ • Payor of last resort
General Standard 4.9c		<u>Charges for Services (EHE Only)</u> Agency should not charge any of the above fees listed in 4.9 regardless of terminology to an EHE eligible patient regardless of income.
General Standard 6.1b		<u>EHE Only: Points of Entry (Primary Medical Care, Health Insurance Premium & Cost Sharing Assistance, Psychiatry, and Mental Health services only).</u> Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.
General Standard 7.2	<u>-IS-200.C: Basic Incident Command System for Initial Response</u> <u>-IS-700.B: An Introduction to the National Incident Management System</u>	<u>-IS-200.C: ICS for Single Resources and Initial Action Incidents</u> <u>-IS-700.B: National Incident Management System, An Introduction</u>
Case Management All 1.6	<u>Warm Handoff Procedure</u> Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	<u>Warm Handoff Procedure</u> Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system, and external service providers. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.

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 It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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Location	2024-2025 (old)	2025-2026 (new)
	<p>Non-Medical Case Management Services (Service Linkage Worker)</p>	<p><u>Non-Medical Case Management Services (Service Linkage Worker) (Part A & EHE Grants)</u></p>
SLW 1.1	<p>Minimum Qualifications</p> <p>Service Linkage Worker – unlicensed community case manager</p> <p>Service linkage workers must have a bachelor’s degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the bachelor’s degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1-year paid work experience with PLWH.</p> <p>Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish.</p> <p>Agency will provide Service Linkage Worker a written job description upon hiring.</p>	<p><u>Minimum Qualifications</u></p> <p>Service Linkage Worker – unlicensed community case manager:</p> <p>Service linkage workers must have a minimum of 1-year work experience with PLWH, or a community health worker/patient navigator. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish.</p> <p>Agency will provide Service Linkage Worker a written job description upon hire.</p>
SLW 2.1b		<p><u>EHE Only: Client Eligibility – Service Linkage Workers targeted to Re-engagement in care and Newly Diagnosed</u></p> <p>In addition to EHE criteria, individuals must meet the following in order to be eligible for non-medical case management services:</p> <ul style="list-style-type: none"> • Clients not receiving outpatient HIV primary medical care services within the previous twelve (12) months as documented by the CPCDMS or experiencing barriers to care engagement. • Newly diagnosed (within the last twelve (12) months) and not currently receiving outpatient HIV primary medical care services as documented in the CPCDMS • Client retained-in-care but who are not virally suppressed as documented in the CPCDMS.
SLW 2.4b		<p><u>(EHE Only): Transfer of Not-in-Care and Newly Diagnosed Clients</u></p> <p>Non-Medical Case Managers targeting their services to engagement support in return to care and newly diagnosed clients will work with clients for a maximum of 30 days. Clients must be transferred to a Ryan White-funded primary medical care provider, clinical case management or medical case management program, or a private (non-Ryan White funded) medical care provider within 30 days of the initiation of services (e.g., primary medical care visit).</p>

Location	2024-2025 (old)	2025-2026 (new)
		After 30 days of service under EHE, if continuing Non-Medical Case Management services must be billed to other Ryan White grant sources (e.g. Part A, B).
Medical Case Management 4.0		<u>Geriatric Medical Case Management</u>
4.1		<u>Criteria for Geriatric Medical Case Management</u> Clients living with HIV/AIDS, ages 60 and older.
4.2		<u>Service Provisions Oriented to Geriatric Clients</u> <ul style="list-style-type: none"> • Provide support, education, and established goal-directed medical interventions to achieve optimal treatment outcomes and improve quality of life. • Conduct comprehensive assessments to determine each client’s level of need for medical case management and health literacy. • Develop and implement a service plan for each client and provide an ongoing assessment of its efficacy. • Monitor the service plan to ensure its implementation. • Maintain regular contact with each client to monitor response to treatment and identify new needs. • Coordinate access to medically appropriate levels of health and support services, including facilitating and coordinating services from one service provider to another. • Coordinate and track referrals to internal and external services and programs. • Provide or refer to a licensed medical provider assessment involving ADL abilities, cognitive functioning, vision, hearing, nutrition, fall prevention, incontinence, Osteoporosis, and medication contraindications. • Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues. • Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues. • Provide benefits counseling by assisting clients in obtaining access to other public and private programs for which they may be eligible. • Provide advocacy on behalf of clients. • Provide emotional support on behalf of clients. Provide liaison services with medical providers on behalf of the client.

Location	2024-2025 (old)	2025-2026 (new)
<u>Emergency Financial Assistance (Prescriptions) – (Part A & EHE Grants)</u> 1.1b		<u>EHE Only: Client Eligibility</u> <ul style="list-style-type: none"> • HIV+
EFA 1.2b		<u>EHE ONLY: Timeliness of Service Provision</u> Newly diagnosed clients: Agency will process and approve prescriptions within 72 hours of a confirmed diagnosis for HIV testing conducted by the agency. Agency will process and approve prescription(s) within 72 hours of when the client presents themselves at the agency for initial services (e.g., date of doctor visit, initial Service Linkage Worker contact, etc.) for HIV testing conducted by an outside provider. Return-to-care clients: 72 hours of when the client presents themselves at the agency (e.g., date of doctor visit, initial Service linkage worker contact, etc.).
EFA 1.3	<u>Medication Formulary</u> RW funded prescriptions for program eligible clients shall be based on current medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	<u>Medication Formulary</u> RW funded prescriptions for program eligible clients shall be based on current medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications that are available over the counter (OTC) without a prescription, or drugs not on the approved formulary. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. If multiple waivers are required, they do not need to be submitted consecutively. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.
<u>Emergency Financial Assistance (Rental Assistance (EHE Grant Only))</u> Emergency Financial Assistance-Rental Assistance (EFA-RA) provides one-time or short-term payments, for up to six (6) months, to assist the client with an emergent need for essential housing. Emergency Financial Assistance-Rental Assistance can occur as a direct payment to a landlord or through a voucher program by an agency.		
1.0	Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.	
1.1		<u>EFA-RA funds may be used on the following essential services:</u> <ul style="list-style-type: none"> • One-Time Rental Assistance, or • Short-Term Rental Assistance for up to six (6) consecutive or non-consecutive months within a twelve (12) month period, or • Payment of security deposits, utility deposits,

Location	2024-2025 (old)	2025-2026 (new)
1.2		<p style="text-align: center;"><u>and application fees</u></p> <p><u>Client Eligibility</u> Applicants must demonstrate an urgent need resulting in their inability to pay their applicable rent without financial assistance necessary to maintain or improve health outcomes. Demonstrated need is made by the following:</p> <ul style="list-style-type: none"> • A significant increase in rent or bills • A recent decrease in income • High unexpected expenses on essential items • The cost of their shelter is more than 30% of the household income • They are unable to obtain credit necessary to provide for basic needs and shelter • A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the agency <p>The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g., lease agreement) is in another person's name, it directly benefits the client.</p>
1.3		<p><u>Client Confidentiality</u> Payment for rental assistance made to landlords will protect client confidentiality through use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.</p>
1.4		<p><u>Assessment</u> The service linkage worker will complete RWGA-approved brief assessment tool on all clients and within five (5) working days of the client visit. The brief assessment must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services will be documented in the assessment and kept in the client file. Emergent need must be documented each time funds are used.</p>
1.5		<p><u>Documentation</u> Plans are developed jointly with the client and must include an approach to mitigate the need in the future.</p>

Location	2024-2025 (old)	2025-2026 (new)
		Client's chart contains documented plan for EFA that indicates emergent need, other resources pursued, and outcome of EFA provided.
1.6		<u>Timeliness of Service Provision</u> All completed requests for assistance shall be approved or denied within three (3) business days following the completed request.
2.0	<u>Agency Requirements</u>	
2.1		<u>Budget Requirements or Restrictions</u> Direct cash payments to clients are not permitted. RWHAP funds will be the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. At least 75% of the total amount of the budget must be solely allocated to the actual cost of disbursements.
2.2		Agency providing emergency financial assistance shall have procedures in place to ensure that funds are distributed fairly and consistently.
2.3		Agency must have procedures in place to ensure EFA-RA funds are the payor of last resort. For clients eligible for HOPWA or other housing assistance funding, those funds must be expended before the agency disburses EFA-RA funds on the client's behalf.
2.4		Agency must have procedures to track returned security deposits, utility deposits, and refundable applicable fees.
2.5		Agency must maintain a copy of the client's lease agreement in the client file to ensure compliance outlined in the agency contract, service definition, and Standards of Care.
Title Change	<u>Health Insurance Assistance</u>	<u>Health Insurance Premium and Cost Sharing Assistance (Part A & EHE)</u>
New Service	<u>Home Delivered Meals (Part A Only)</u>	
1.0		Services are individualized and tailored to client needs.
1.1		<u>Eligibility</u> Persons with HIV living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA) who are homebound or require special dietary support in meeting nutritional outcomes based on dietary needs to improve and enhance their HIV care including persons with compromised nutritional status and limited ability to prepare his/her own meals. The client is actively enrolled in primary medical care along with the referral from the client's Primary Care provider's registered dietician or nutritionist.
1.2		<u>Culturally Competent</u>

Location	2024-2025 (old)	2025-2026 (new)
		<p>Home-delivered meals should be culturally representative and best meet the eligible client’s traditional food options and have the ability to supply a variety of meal options with daily, weekly or on an as-needed basis delivery.</p> <p>The contractor must incorporate practices that honor clients’ beliefs, being sensitive to cultural diversity and diverse cultural and ethical backgrounds, including supporting clients with limited English proficiency or disabilities, and regardless of gender, sexual orientation, or gender identity. This includes fostering attitudes and interpersonal communication styles in staff and providers which respect recipients’ cultural backgrounds.</p>
2.0		Services adhere to professional standards and regulations.
2.1		<p><u>Referrals and Consultation</u> The prepared meals should be nutritious and individualized to client’s dietary needs, and shall be based on current federal dietary guidelines (<u>Dietary Guidelines for Americans, 2020-2025 and Online Materials Dietary Guidelines for Americans</u>).</p> <p>All meal plans must be reviewed and approved by a registered dietician.</p> <p>Subrecipient shall receive consultation from a registered and/or licensed dietitian regarding the nutrition, caloric needs, and other dietary issues of people with HIV, and has incorporated that guidance into its food pantry and/or home-delivered meals program.</p> <p>Consultation should be done on an annual basis and must be documented.</p>
2.2		<p><u>Regulations</u> Subrecipient shall comply with local, state, and federal food safety, sanitization, and safety regulations.</p>
2.3		<p><u>Licensure</u> Subrecipient shall comply with the USDA Department of Agriculture food handling guidelines.</p> <p>Staff members packaging bulk foods shall have current and valid food handling permits or license.</p>
2.4		<p><u>Inspections</u> Subrecipient shall maintain and show evidence that all required inspections are current and resulted in acceptable findings.</p>
2.5		<p><u>Facility</u> Subrecipient shall provide adequate space and equipment to store food in a sanitary manner.</p>
2.6		<u>Procurement</u>

Location	2024-2025 (old)	2025-2026 (new)
		Subrecipient shall comply with procedures for purchasing, receiving, sorting, issuing, preparing, and service of safe food and beverage products.
2.7		<u>New Staff Training</u> All new staff members shall attend educational seminars regarding food safety within three months of hire and annually thereafter.
3.0		<u>Food Processing & Delivery</u>
3.1		<u>Condition of Food Items</u> <ul style="list-style-type: none"> • All milk and cheese products shall have the word pasteurized on the label. • Fresh food such as bread shall be free of any mold. • Fruits and vegetables shall be free from insects and mold. • All packaged products shall be labeled properly, and within the expiration period as stated on the product in accordance with FDA regulations. Frozen foods shall be packaged, kept completely frozen and stored in a proper freezer at 0° Fahrenheit or below.
3.2		<u>Delivery vehicle and driver</u> <ul style="list-style-type: none"> • Vehicle will be insured. Driver will be free of past moving violations.
3.3		<u>Delivery of meals</u> <ul style="list-style-type: none"> • Delivered timely at proper temperature. • Delivery must be directly to client or authorized representative.
4.0		<u>Client Eligibility</u>
5.0		<u>Client Screening</u> <ul style="list-style-type: none"> • Agencies shall ensure that clients have exhausted access through other funding sources prior to issuing a food voucher. Agencies shall receive consultation from a registered and/or licensed dietitian regarding the nutrition, caloric needs, and other dietary issues of people with HIV. Agencies shall incorporate such guidance into its home-delivered meals program. Consultations should be done on a quarterly basis and must be documented.
5.1		<u>Discharge</u>
5.2		Clients may be discharged from home delivered meals services when the client: <ul style="list-style-type: none"> • Has achieved all goals listed in the Nutritional Care Plan • Has become ineligible for services • Has relocated out of the service area • Is incarcerated • Is deceased • Decides to discontinue services • Is found to be improperly utilizing the service and/or is asked to leave the agency.

Location	2024-2025 (old)	2025-2026 (new)
		Is found to be in violation of the signed Food Rights and Responsibilities form.
		The client will be notified in writing of termination from home-delivered meals services including the reason indicated for discharge.
New Service	<u>Legal Assistance - Expungement of Criminal Record (Part A Only)</u>	
1.0		Services are part of the coordinated continuum of HIV/AIDS services.
1.1		<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.
2.0		Legal services adhere to professional standards and regulations.
2.1		<u>Licensure</u> Attorneys are licensed to practice law in the state of Texas and have a minimum educational level of a doctorate in Jurisprudence.
2.2		<u>Non-Licensed Staff</u> Non-licensed staff members are supervised by attorneys.
3.0		<u>Service providers are knowledgeable, accepting and respectful of the needs of people living with HIV/AIDS.</u>
3.1		<u>Ongoing Staff Training</u> Staff has access to appropriate training and resources needed to deliver services. Staff members are trained and knowledgeable and remain current in legal issues in accordance with the rules of the State Bar of Texas. Staff shall maintain knowledge of legal issues that may impact the legal assistance needs of PLWHA. Agency paid legal staff and contractors must complete two (2) hours of HIV-specific training annually. New agency paid legal staff and contractors must complete two (2) hours of HIV-specific training within 90 days of start date. Volunteer legal staffs are encouraged to complete HIV-specific legal training.
4.0		<u>Client is kept informed and participates in decisions about his/her case.</u>
4.1		<u>Service Agreement</u> Clients are kept informed and work together with staff to determine the objective of the representation and to achieve expungement of criminal record.
4.2		<u>Case Closure</u> Agency will develop case closure criteria and procedures. Cases may be closed when the client's legal record is expunged, or when the client: <ul style="list-style-type: none"> • is determined to be ineligible for criminal expungement • has had no direct program contact for over six months

Location	2024-2025 (old)	2025-2026 (new)
		<ul style="list-style-type: none"> • is deceased • no longer needs the service • discontinues the service • improperly utilizes the service • has not complied with the client services agreement <p>Agency will attempt to notify clients about case closure.</p>
<u>Local Pharmacy Assistance Program (Part A Grant Only)</u>		
LPAP 1.3	<u>LPAP Medication Formulary</u> RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.	<u>LPAP Medication Formulary</u> RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications, or drugs not on the approved formulary, that are available over the counter (OTC) without a prescription. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.
LPAP 2.2	<u>Ongoing Training</u> Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	<u>Ongoing Training</u> Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist (in accordance with the period of their licensure) and pharmacy tech staff.
<u>Medical Nutritional Therapy/Supplements (Part A Grant Only)</u>		
2.1	<u>Nutritional Supplement Formulary</u> RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Providers wishing to prescribe/order other supplements not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Department of Health and Human Services guidelines for ART and treatment of opportunistic infections.	<u>Nutritional Supplement Formulary</u> RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Department of Health and Human Services guidelines for ART and treatment of opportunistic infections.
New Service	<u>Mental Health Services (EHE Grant Only)</u>	
1.0	Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons living with HIV.	
1.1		<u>Minimum Qualifications</u> Mental health counseling, services including outpatient mental health therapy and counseling provided to persons living with HIV, shall be provided solely by Mental Health Practitioners

Location	2024-2025 (old)	2025-2026 (new)
		licensed by the State of Texas.
1.2		<p><u>Licensing, Knowledge, Skills and Experience</u> All staff maintain current organizational licensure (and/or applicable certification) and professional licensure.</p> <ul style="list-style-type: none"> • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates. • Physician extenders must obtain this experience within six months of hire. • All staff receive professional supervision. <p>Staff show training and/or experience with the medical care of adults living with HIV.</p>
1.3		<p><u>Mental Health Services</u> Outpatient mental health therapy and counseling services provided solely by Mental Health Practitioners licensed in the State of Texas includes:</p> <ul style="list-style-type: none"> • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Psychotropic medication assessment, prescription, and monitoring (physician, midlevel provider, and psychiatrist only) • Psychotropic medication management (physician, midlevel provider, psychiatrist, or Doctor of Pharmacy (PharmD) only) • Emergency/Crisis Intervention <p>Mental health services can be delivered via telehealth, subject to federal guidelines, Texas State law, and DSHS policy.</p> <p>Individual psychotherapy is defined as 1:1 counseling or family-based crisis intervention provided by a licensed mental health practitioner.</p>
1.4		<p><u>Mental Health Assessment</u> A licensed mental health professional shall conduct a mental health assessment for all clients referred to the program. Staff must complete this assessment no later than the third counseling session and should ensure the assessment includes, at a minimum:</p> <ul style="list-style-type: none"> • Presenting problem(s) • Completed mental status evaluation • Cognitive assessment • Current risk of danger to self and others • Living situation • Social support and family relationships, including client strengths • and challenges, coping mechanisms, and self-help strategies

Location	2024-2025 (old)	2025-2026 (new)
		<ul style="list-style-type: none"> • Medical history • Current medications • Substance use history • Psychosocial history, which may include: <ul style="list-style-type: none"> ○ 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 <p>Clients are assessed for care coordination needs, and referrals are made to case management programs as appropriate. If pressing mental health needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client’s primary record.</p>
1.5		<p><u>Treatment Plan and Services</u> All client files should contain a detailed treatment plan and documentation of services provided. The provider must complete a treatment plan within five (5) business days of the mental health assessment. This plan must be developed in conjunction with the client.</p> <p>The treatment plan should include: Diagnosed mental health issue(s) Goals and objectives of treatment Treatment type (individual, group) Start date for mental health services Recommended number of sessions (up to three (3) sessions) Any recommendations for follow up</p> <p>Treatment should include counseling regarding the following, as clinically appropriate: Healthy behaviors and health promotion Substance use disorder Treatment adherence Development of social support systems Community resources Maximizing social and adaptive functioning The role of spirituality and religion in a client’s life, health, and future goals</p> <p>The mental health professional must sign the</p>

Location	2024-2025 (old)	2025-2026 (new)
		<p>treatment plan; electronic signatures are acceptable. The professional must provide services according to the individual's treatment plan and document services in the client's primary record. Staff should complete progress notes according to the agency's standardized format for each session and notes should include:</p> <ul style="list-style-type: none"> • Client name • Session date • Focus of the session • Interventions • Progress on treatment goals • Newly identified issues or goals • Counselor signature and authentication (credentials) <p>In urgent, non-life-threatening circumstances, agencies should make an appointment for the client within 1 business day. If an agency cannot provide the needed services, the agency will offer to refer the client to another organization that can provide the services and must make this referral within 1 business day.</p>
1.6		<p><u>Psychiatric Referral</u> Providers should evaluate clients to determine if there is a need for psychiatric intervention. Providers should refer clients with a need for psychiatric intervention to a psychiatric service provider.</p>
1.7		<p><u>Psychotropic Medication Management</u> Agencies should ensure psychotropic medication management services are available for all clients either directly or through referral. A physician, midlevel provider, or Doctor of Pharmacy (PharmD) can provide psychotropic medication management services.</p> <p>Mental health professionals should discuss any concerns about prescribed medication with the client (side effects, dosage, interactions with HIV medications, etc.). Mental health professionals should also encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician so that medications can be managed effectively.</p> <p>Mental health providers with prescriptive authority will follow all regulations required for prescribing psychoactive medications, as outlined by the Texas Administrative Code, <u>Title 25, Part1, Chapter 415, Subchapter A, Rule 415.10</u></p>
1.8		<p><u>Coordination of Care</u> Providers should coordinate care across the mental health team. Agencies should ensure the client is involved in all decision-making, including whether</p>

Location	2024-2025 (old)	2025-2026 (new)
		to initiate or defer treatments. The full care team should assist in educating the client, providing support, and monitoring mental health treatment adherence. Providers can use problem-solving strategies or referrals for clients who need to improve adherence (e.g., behavioral contracts). Medical care providers, psychiatric care providers, and pharmacists should be consulted as appropriate regarding medication management, interactions, and treatment adherence.
1.9		<p><u>Referrals</u></p> <p>As needed, mental health providers should refer clients to a full range of medical and mental health services, including:</p> <ul style="list-style-type: none"> • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization <p>Family or couples therapy</p>
1.10		<p><u>Discharge Planning</u></p> <p>Providers should conduct discharge planning with each client when treatment goals are met, when, after three (3) sessions, the client is referred to long-term mental health care, or when the client has discontinued therapy, either by initiating closure or as evidenced by non-attendance of scheduled appointments. Documentation for discharge planning will include, as applicable:</p> <ul style="list-style-type: none"> • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Discharge plan • Signature of provider • Counselor authentication, in accordance with current licensure requirements
Outreach Service Definition (Local)	Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services.	Providing allowable Ryan White Program outreach and service linkage activities to PLWH who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is

Location	2024-2025 (old)	2025-2026 (new)
		<p>a high probability that individuals with HIV will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services.</p>
Outreach 1.6	<ul style="list-style-type: none"> Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff. 	<ul style="list-style-type: none"> Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff. Documentation of warm handoff in the client record.
Outreach 2.2	<p><u>Eligibility Criteria for Outreach</u> Eligibility for outreach will vary and is specific to each agency. Criteria can include, but is not limited to clients:</p> <p><u>Cusp of Falling Out of Care Clients:</u></p> <ul style="list-style-type: none"> Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks. Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks. Clients who have not been seen in 4 months by their primary care provider; and/or Three missed appointments in past 12 months (do not have to be consecutive). <p><u>Lost-to-Care Clients:</u></p> <ul style="list-style-type: none"> (HRSA) Lost to care definition <p><u>Newly Diagnosed Clients:</u></p> <ul style="list-style-type: none"> Applies to clients with a diagnosis within the last 12 months but have not engaged in care. Clients who have not been seen in 4 months by their primary care provider; and/or: Three missed appointments in the past 12 months(do not have to be consecutive). 	<p><u>Eligibility Criteria for Outreach</u> Eligibility for outreach will vary and is specific to each agency. Criteria must include:</p> <p><u>Cusp of Falling Out of Care Clients:</u></p> <ul style="list-style-type: none"> Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks. Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks. Clients who have not been seen in 4 months by their primary care provider; and/or Three missed appointments in past 12 months (do not have to be consecutive). <p><u>Lost-to-Care Clients:</u></p> <ul style="list-style-type: none"> (HRSA) Lost to care definition <p><u>Newly Diagnosed Clients:</u></p> <ul style="list-style-type: none"> Applies to clients with a diagnosis within the last 12 months but have not engaged in care.
<u>New Service</u>	<u>Outreach and Community Engagement Services (EHE Only)</u>	
	<p>Outreach and Community Engagement services provides strategic outreach and community engagement activities aimed at improving health outcomes for underserved populations. Outreach and Community Engagement Services focus on raising awareness, offering education, and linking individuals to care, particularly those who are newly diagnosed with HIV or living with HIV (PLWH) but not actively engaged in medical care, or clients unaware of their status. Through venue-based outreach, community awareness events, and personalized linkage to care services, Outreach and Community Engagement Services reduce health disparities, promote early detection and diagnosis, and ensure continuous, sustained access to care and treatment. Outreach efforts are designed to target individuals who are at disproportionate risk for HIV infection, as identified through local epidemiological data and service utilization review.</p>	
1.0		Staff Training

Location	2024-2025 (old)	2025-2026 (new)
1.1		<p><u>Minimum/Qualifications</u> Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.</p>
1.2		<p><u>Scope of Services</u> Venue-based outreach must target high-priority locations identified through epidemiological and behavioral data to engage populations disproportionately impacted by HIV, offering evidence-based prevention strategies, educational materials, and on-site testing services. Community awareness events must be designed to increase public knowledge of HIV prevention and care resources, reduce stigma, and foster engagement through culturally and linguistically responsive messaging. Services must establish and maintain efficient linkage-to-care protocols to connect individuals newly diagnosed or lost to care to appropriate medical, behavioral health, and support services, ensuring adherence to care and improving viral suppression outcomes.</p>
1.3		<p><u>Ongoing Education/Training for Outreach and Community engagement Workers</u> Staff who provide field-based services must receive at least two (2) hours of field safety training within their first six (6) months of employment.</p> <p>The Outreach and Community Engagement Workers are required to attend a minimum of five (5) of the six (6) Outreach Worker meetings and four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & Houston Health Department.</p>
1.4		<p><u>Outreach Brief Intervention</u> Outreach and Community Engagement staff will, on occasion, be called to assist a client with a low/intermittent need, (such as, CPCDMS eligibility renewal, ADAP application renewal, bus pass renewal, or information about a service, etc.) and have no other needs. In this situation the staff may provide a <i>brief intervention</i> with the client.</p> <p>However, if during the visit the staff assesses the client may have further needs than originally presented, the Outreach Worker will refer the client to appropriate services using an assessment (brief / comprehensive) to better address the client’s needs.</p>

Location	2024-2025 (old)	2025-2026 (new)
1.5		<u>Documentation and Reporting</u> Outreach and Community Engagement Workers are trained in the agency’s policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with DSHS Child Abuse Screening, Documenting and Reporting Policy prior to interaction.
1.6		<u>Warm Handoff Procedure</u> Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., Outreach and Community Engagement worker to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.
2.0		<u>Timeliness of Service/Documentation</u>
2.1		<u>Progress Notes</u> All Outreach and Community Engagement Worker activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of the occurrence.
2.2		<u>Eligibility Criteria for Outreach and Community Engagement Activities</u> Eligibility for Outreach and Community Engagement will vary and is specific to each agency. Criteria must include: <ul style="list-style-type: none"> • Conducting outreach at community hubs, particularly in high incidence zip codes, including but not limited to health fairs, HIV-related community events, shelters, clinics, bars, AIDS Services Organizations, non-profit organizations, faith-based organizations, and local businesses • Promoting rapid start services and other EHE programs through distribution of promotional materials within the Houston EMA • Collaborate with HIV testing providers to offer on-site HIV testing and rapid start to promote linkage into care for clients who have been diagnosed with HIV Provide navigation support for those newly diagnosed or identified as a Person living with HIV(PLWH) who is not in care
<u>Primary Medical Care (Part A & EHE Grants)</u>		
PCARE 1.3	<u>Peer Review</u> Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e., MD, NP, PA).	<u>Peer Review</u> Agency/Provider will conduct peer review for all levels of licensed /credentialed providers (i.e., MD, DO, CNS, NP, PA).

Location	2024-2025 (old)	2025-2026 (new)
PCARE 1.16	<p>Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.</p>	<p><u>Adherence Assessment</u> Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD, DO, CNS licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.</p>
PCARE 1.19	<p><u>Intimate Partner Violence Screening Policy</u> The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: Process for ensuring clients are screened for IPV no less than annually Intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management. State reporting requirements associated with IPV. Description of required medical record documentation. Procedures for patient referral including available resources, procedures for follow-up and responsible personnel. Plan for training all appropriate staff (including non-RW funded staff)</p>	<p><u>Intimate Partner Violence Screening Policy</u> The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address:</p> <ul style="list-style-type: none"> • Process for ensuring clients are screened for IPV no less than annually (by a health care provider, e.g. MA, RN, NP, PA, MD, DO, CNS, etc.). • Intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management. • State reporting requirements associated with IPV. • Description of required medical record documentation. • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel. <p>Plan for training all appropriate staff (including non-RW funded staff)</p>
<u>NEW SERVICE</u>	Psychiatry (EHE Grant Only)	
	<p>Psychiatry services include diagnostic evaluations, emergency psychiatric care and psychopharmacotherapy, and counseling services offered to individuals with a diagnosed mental illness, conducted in an individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State of Texas to provide such services, typically psychiatrists.</p>	
1.0		<p>Psychiatric care for persons with HIV should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines.</p>

Location	2024-2025 (old)	2025-2026 (new)
1.1		<p><u>Minimum Qualifications</u> Psychiatric care for persons living with HIV shall be provided by MD, DO, NP, CNS or PA licensed in the State of Texas.</p>
1.2		<p><u>Licensing, Knowledge, Skills and Experience</u></p> <ul style="list-style-type: none"> • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure. • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 people living with HIV patients within the last year. • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates. • Physician extenders must obtain this experience within six months of hire. • All staff receive professional supervision. <p>Staff show training and/or experience with the medical care of adults living with HIV.</p>
1.3		<p><u>Psychiatric Guidelines</u> Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry-guidelines.</p>
1.4		<p><u>Psychiatric Services</u></p> <ul style="list-style-type: none"> • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24-hour basis including emergency room referral.

Location	2024-2025 (old)	2025-2026 (new)
		<ul style="list-style-type: none"> • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.
1.5		<p><u>Staff Requirements</u> Director of the Program must be a Board-Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director’s credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices.</p>
1.6		<p><u>Special Requirements</u> Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy.</p>
<u>Ride Share Services (EHE Grant Only)</u>		
	RWGA defines Ride Share services as a “support service that provides conveyance services directly to a client so that he or she may access health care services.” EHE funding Ride Share services include transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Medical and Support services and/or medical and health-related care services, including clinical trials, essential to their well-being. All drivers utilized by the program must have a valid Texas Driver’s license and must complete a “Community Safety Education” course as provided by Lyft. The platform requires that each vehicle has automobile	

Location	2024-2025 (old)	2025-2026 (new)
	liability insurance as required by the State and	all vehicles have current Texas State Inspection.
1.0		Ride Share services are offered to eligible clients to ensure individuals most in need have access to services.
1.1		<p><u>Ride Share Guidelines</u> Ride Share: Eligible clients in the Houston or Galveston HSDA area have access to ride share services with a focus on newly diagnosed and re-engaged to care clients but also include retained-in-care clients established in medical care. This form of transportation can be provided to any HIV-related Core Medical and Support service appointments, specifically:</p> <ul style="list-style-type: none"> • Rapid Start Appointment • Rapid Start Medication Pick-up • RWA medical appointment • Eligibility appointment • RW Pharmacy (Refills) • Mental health • Case management • Dental Visit • Psychosocial Support • Grocery/Food bank • Job support (Work source etc.) • Job interview • Housing Support • Rehabilitation Services • Other <p>*Denotes usage of ride share for those service types no more than 3 times within the fiscal year per service category, unless the agency is funded to provide the service under Part A or EHE.</p>
2.0		Accessibility: Ride Share services are offered in such a way as to overcome barriers to access and utilization.
2.1		<p><u>Notification of Service Availability</u> Prospective and current clients are informed of service availability, prioritization, and eligibility requirements.</p>
2.2		<p><u>Access</u> Clients must notify their agency’s point of contact of their need for ride share to/ from their appointment. Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle. This statement should include the consequences of violating the agreement.</p>
2.3		<p><u>HSDA Accessibility</u> Services are available throughout the Houston/Galveston HSDAs as contractually defined in the RFP.</p>
2.4		<p><u>Service Availability</u> The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and</p>

Location	2024-2025 (old)	2025-2026 (new)
		coverage must be available for medical and health-related appointments on Saturdays.
2.5		<u>Service Capacity</u> Agency will notify RWGA EHE Staff when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services.
3.0		Timeliness and Delays: Ride Share services are provided in a timely manner.
3.1		<u>Timeliness</u> There is a maximum waiting time for ride share; appointments are kept <ul style="list-style-type: none"> • Waiting times longer than 20 minutes will also be documented in the client record • If a cumulative incident of clients kept waiting for more than 20 minutes reaches 75 clients in the contract year, this must be reported in writing within one business day to RWGA
3.2		<u>Immediate Service Problems</u> Clients are made aware of problems immediately (e.g., vehicle breakdown) and notification documented.
3.3		<u>Future Service Delays</u> Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur.
3.4		<u>Confirmation of Appointments</u> Agency must allow clients to confirm appointments at least 48 hours in advance.
3.5		<u>“No Shows”</u> “No Shows” are documented in Ride Share Log and client record. Passengers who do not cancel scheduled rides for two (2) consecutive times or who “no show” for two (2) consecutive times or three times within the contract year may be removed from the ride share roster for 30 days. If client is removed from the roster, he or she must be referred to other transportation services. One additional no show and the client can be suspended from service for six (6) months.
3.6		<u>System Abuse</u> If an agency has verified that a client has falsified the existence of an appointment in order to access transportation, the client can be removed from the agency roster. If a client cancels ride share appointments in excess of three (3) times per month on the same day of ride, the client may be removed from the ride share roster for 30 days. If a client continues to exhibit form of abuse, the client will be removed from the ride share roster for one (1) year.

Location	2024-2025 (old)	2025-2026 (new)
		Agency must have published rules regarding the consequences to the client in situations of system abuse.
3.7		<u>Client Incidents</u> If an agency is charged a cleaning fee due to an incident resulting from a client’s action, the fee is reimbursable.
3.8		<u>Documentation of Service Utilization</u> <ul style="list-style-type: none"> • Transportation Provider must ensure: • Requested via the Lyft platform • Record of service entered into CPCDMS • Scheduling of transportation services by scheduling agency’s point of contact <p>The content of the proof of service will include:</p> <ul style="list-style-type: none"> • Requesting agency • Pick-up and drop-off date/time • Pick up and drop off address • CPCDMS client code <p>Name of agency’s staff who requested the ride</p>
4.0		Records Administration: Ride Share services are documented consistently and appropriately
4.1		<u>Transportation Consent</u> Prior to receiving transportation services, clients must read and sign the Ride Share Consent.
4.2		<u>Ride Share</u> Agency must ensure documentation in Lyft for Business is accurate and includes the clients CPCDMS Client Code
NEW SERVICE	<u>Transitional Housing - Temporary Assisted Living</u>	
	<p>Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client’s linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).</p> <p>Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.</p>	
1.0		Service Specific Requirements
1.1		<p>Services to be provided should be designed to support ongoing HIV care, increased functioning, and the return to self-sufficiency for PLWH through the provision of treatment and activities of daily living. Services must include:</p> <ul style="list-style-type: none"> • Room and daily nutritious meals and snacks, • Skilled Nursing to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, ongoing monitoring of client’s physical condition and communication

Location	2024-2025 (old)	2025-2026 (new)
		<p>with attending physician(s) and personal care team</p> <ul style="list-style-type: none"> Other Therapeutic Services including physical and occupational therapies.
1.2		<p>Patient Medication Education Services must adhere to the following requirements: Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA), Nurse (RN, LVN), licensed Social Worker, or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.</p>
2.0		Staff Requirements
2.1		<p>Staff must have all required federal, state and local licensure, certifications, permits and must comply with local, state, and federal regulations.</p> <p>The contractor is responsible for ensuring that services are provided by State licensed MDs, NPs, PAs, RNs, LVNs, social workers, and pharmacists.</p>
2.2		<p>The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV care, to provide the medication and adherence educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV care may also provide adherence education and counseling.</p>
3.0		Facility Requirements
3.1		<p>Facility must have all required federal, state and local licenses, certifications and permits and must comply with local, state, and federal regulations.</p>
4.0		Client Eligibility and Referral
4.1		<p>Eligibility:</p> <ul style="list-style-type: none"> Client must receive referral for service from an MD, NP, or PA. Client must have a qualifying inpatient hospital stay of at least three (3) days in a row defined as the day of admission, but not counting the day of discharge. <p>Client must enter the facility within 30 days of discharge from a hospital.</p>
		<p>Services must be provided in accordance with doctor's referral. As part of the intake process, doctor's orders must be obtained to guide service provision to client.</p>
5.0		Initial Assessment and Care Plan

Location	2024-2025 (old)	2025-2026 (new)
5.1		<p>A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care.</p> <p>Client will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or within thirty (30) days, whichever is earlier.</p>
5.2		<p><u>Comprehensive Assessment</u></p> <p>A comprehensive assessment, including nursing, nutritional, therapeutic, and educational is completed for each client within seven (7) days of intake. A measure of the client’s acuity will be incorporated into the assessment tool to track increased functioning. A comprehensive evaluation of the PLWH’s health, psychosocial status, functional status, and home environment should be completed to include:</p> <ul style="list-style-type: none"> • Assessment of PLWH's access to primary care • adherence to therapies, disease progression, symptom management and prevention • need for skilled nursing or rehabilitation services. <p>Information to determine client’s ability to perform activities of daily living and the level of attendant care assistance the client needs to maintain living independently.</p>
5.3		<p><u>Plan of Care</u></p> <p>A written plan of care is completed for each client within seven (7) days of intake. Development of plan of care incorporates a multidisciplinary team approach.</p>
5.4		<p><u>Implementation of Care Plan</u></p> <p>In coordination with the medical care coordination team, professional staff will:</p> <ul style="list-style-type: none"> • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's referring provider. • Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation. • Monitor changes in client's physical health and level of functionality. • Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service-related needs, challenges and barriers. • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.

Location	2024-2025 (old)	2025-2026 (new)
		<ul style="list-style-type: none"> • Provide attendant care services which include taking vital signs if medically indicated • Assist with client's self-administration of medication. • Promptly report any problems or questions regarding the client's adherence to medication. • Report any changes in the client's condition and needs. • Current assessment and needs of the client, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services. • Types, quantity and length of time services are to be provided.
5.5		<p><u>Provision of Services/ Progress Notes</u> Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of housing – temporary assisted living services.</p> <ul style="list-style-type: none"> • Progress notes will be kept in the client's primary service record and must be written the day services are rendered. • Progress notes will then be entered into the client record within (5) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines. <p>Care Team will document in the client's primary service record progress notes throughout the course of the treatment, including evidence that the PLWH is not in need of acute care.</p>
6.0		Billing Requirements
6.1		Agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payers.
		<p><u>Restrictions</u></p> <ul style="list-style-type: none"> • Housing activities cannot be in the form of direct cash payments to clients. <p>Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.</p>
7.0		Discharge
7.1		<p>Services will end when one or more of the following takes place:</p> <ul style="list-style-type: none"> • Referral period ends or thirty (days) pass without additional referral and approved waiver. • Client acuity indicates self-sufficiency and care plan goals completed. • Client expresses desire to discontinue/transfer services.

Location	2024-2025 (old)	2025-2026 (new)
		<ul style="list-style-type: none"> Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility) Client is unable or unwilling to adhere to Care Plan. Client is unable or unwilling to adhere to agency policies. PLWH relocates out of the service delivery area <p>When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a PLWH's home, in the company of an escort or not. The agency may discontinue services or refuse the PLWH for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable.</p>
7.2		All services discontinued before completion of the client's Care Plan must be accompanied by a referral to an appropriate service provider agency.
<u>Transportation Services (Part A Grant Only)</u>		
TRANS 1.1	<ul style="list-style-type: none"> Income no greater than 300% of the Federal Poverty level 	<ul style="list-style-type: none"> Income no greater than 500% of the Federal Poverty level
TRANS 1.2	<p><u>Voucher Guidelines (Distribution Sites)</u></p> <ul style="list-style-type: none"> Bus Card Voucher (Renewal): Eligible clients who reside in the Metro service area will be issued a Metro bus card voucher by the client's record-owning agency for an annual bus card upon new registration and annually thereafter, within 15 days of bus pass expiration. Bus Card Voucher (Value-Based): Otherwise, eligible clients who are not eligible for a renewal bus card voucher may be issued a value-based bus card voucher per RWGA business rules. <ul style="list-style-type: none"> ➤ In order for an existing bus card client to <u>renew</u> their bus card (i.e., obtain another bus card voucher for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV, or 	<p><u>Voucher Guidelines (Distribution Sites)</u></p> <ul style="list-style-type: none"> <u>Bus Card Voucher (Renewal)</u>: Eligible clients who reside in the METRO service area will be issued an initial METRO bus card voucher from any Ryan White subrecipient and annually thereafter, within 15 days of bus pass expiration. <u>Bus Card Voucher (Value-Based)</u>: Otherwise, eligible clients who are not eligible for a renewal bus card voucher may be issued a value-based bus card voucher per RWGA business rules. <ul style="list-style-type: none"> ➤ For an existing bus card client to renew their bus card (i.e., obtain another bus card voucher for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV, or <p>This has been added to the MEASURE section.</p> <ul style="list-style-type: none"> Issuance of bus voucher must be entered into CPCDMS within 12 hours.

Information about Community Advisory Boards (CABs) in Ryan White Programs — 02-19-25

Definition:

Community Advisory Boards (CABs) provide clinics with input and guidance from patients regarding the design and delivery of care. To be effective, CABs follow operating procedures to guide them to carry out tasks like selecting members, convening meetings, gathering feedback, and working with clinics to improve their operations. (Target HIV [Community Advisory Boards | TargetHIV](#)) *This link was recently reactivated and may be pulled down again, therefore recommend pulling down the related information ASAP.*

CAB FAQ:

Does the RWHAP Part A require subrecipients to have a Consumer Advisory Board? No. A subrecipient CAB is not a RWHAP Part A requirement, however it is one of many options often listed as a method to collect client input.

Why does the Houston EMA have this requirement? Several years ago this requirement was added to the Houston EMA's local Standards of

Care: https://publichealth.harriscountytexas.gov/Portals/hcph/Documents/FY2024-2025_RWGA_Standards%20of%20Care_Final.pdf?ver=mdpts4dK26eIjUJFar90PQ%3d%3d

Standard

General Standards, Section 3: Client Rights and Responsibilities

3.8 Client Feedback

Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually). Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB).

- Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.

Measure:

- Documentation of CAB and public meeting minutes

Who pays for the cost of an agency's CAB?

The subrecipients pay these costs. Any allowable costs incurred by a subrecipient related to the implementation and support of a CAB are administrative costs and if reasonable and allowable, may be allocated proportionally to the grant. Keep in mind such costs are not direct service costs and thus count against the agency's 10% admin cap for expenses charged to Ryan White.

Who defines the scope and operational details of an agency CAB?

The operation of the CAB is the sole responsibility of the subrecipient. The Administrative Agency (AA) (RWGA) does not regulate the agency CAB. The AA monitors the Agency per the SOC (see above). The AA does not mediate disputes between a CAB and its host agency.

What if clients are dissatisfied with a Ryan White funded service received from a Ryan White-funded agency, including applying for and/or receipt (or lack of receipt) of eligible services?

Clients are encouraged to avail themselves of the published Grievance Process all Ryan White funded subrecipients must have, alternatively, contact the applicable AA directly. See below:

Standard

Grievance Procedure

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. Grievance procedure includes but is not limited to:

- To whom complaints can be made.
- Steps necessary to complain.
- Form of grievance if any.
- Timelines and steps taken by the agency to resolve the grievance.
- Documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client.
- All complaints or grievances initiated by clients are documented on the Agency's standardized form.
- Resolution of each grievance/complaint is documented on the Standardized form and shared with client.
- Confidentiality of grievance
- Addresses and phone numbers of licensing authorities and funding sources
- Language outlining that clients cannot be retaliated against for filing grievances

Other HAB resources regarding guidance on implementing or managing consumer input:

2023 HAB Part A Manual:

Section IV. Clinical Quality Management

This is the general resource for RWHAP Part A Quality Management activities and requirements. There is no specific requirement for agency CABs in the Part A manual.

2022 HRSA National Monitoring Standards

These standards support the Houston's Standard of Care related to CABs, but do not mandate subrecipient CABs, only that there are "...structured and ongoing efforts to obtain input from people with HIV in the design and delivery of services."

Universal Standards

Section A: Access to Care

A.1. Structured and ongoing efforts to obtain input from people with HIV in the design and delivery of services.

A.1.i. Performance Measure/Method

a) Documentation of people with HIV participating in committees and contributing to public meetings minutes.

- b) Documentation of the existence of appropriate mechanism(s) for obtaining client input.
- c) Documentation of content, use, and confidentiality of client satisfaction surveys or focus groups conducted at least annually.

A.1.ii. Recipient Responsibility

- a) Review documentation at the subrecipient level to determine methods used for obtaining client input into the delivery of services.

A.1.iii. Subrecipient Responsibility

- a) Maintain a file of materials documenting the consumer committee's membership and meeting attendance, including minutes.
- b) Regularly implement client satisfaction survey tools, focus groups, and/or public meetings, with analysis and use of results documented.
- c) Implement appropriate mechanism(s) for obtaining client input.

A.1.iv. Source Citations

- PHS Act § 2602(b)(4)
- PHS Act § 2617(b)(7)(A)
- RWHAP Part A Manual
- RWHAP Part B Manual

2012 Capacity Building Letter: <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/capa-city-development-2012.pdf>

From the letter

“Programmatic Intent and Legislative Authority Regarding Capacity Development Parts A and B: There is no specific legislative language or authority for capacity development for Parts A and B. However, the Division of Service Systems (DSS)/HAB has reminded grantees and Part A HIV Planning Councils/planning bodies that system-wide program support or technical assistance may be considered capacity development activities. DSS defines capacity development as activities that increase core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system and reduce disparities in care among underserved persons living with HIV/AIDS. Under Part A, planning for capacity development activities is expected to be identified primarily in two ways: 1) needs assessment process within the Eligible Metropolitan Area (EMA)/ Transitional Grant Area (TGA) should identify disparities in access and services, and 2) establishment of priorities by the EMA/TGA Planning Council or other advisory body based on disparities identified in the needs assessment.”

Other capacity development activities under Parts A and B may include but are not limited to:

“Increasing the capability of a grantee/subgrantee to implement and/or manage consumer involvement. This may include staff training on the identification and retention of consumers; involvement of consumers in the development and implementation of the program, and in continuous quality improvement initiatives; and engagement and support of peers who serve on interdisciplinary care teams..”

2013 Supporting Community Engagement

Letter: <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hab-community-engagement-program-letter.pdf>

Additionally, RWHAP recipients and subrecipients engage community through Planning Councils, Planning Bodies, consortia, integrated planning groups, **community advisory boards**, and community involvement in clinical quality management activities.

TargetHIV <https://targethiv.org/library/topics/community-advisory-boards>

This webpage contains links related to CABs (see below)

Target HIV Links:

[Project ACCEPT | TargetHIV](#)

[A Guide to Consumer Involvement: Improving the Quality of Ambulatory HIV Programs | TargetHIV](#)

[Getting Started: A Consumer Advisory Board Manual for Title IV Programs | TargetHIV](#)

Prepared by: Charles Henley, Consultant to the Houston EMA Ryan White Program

REVISED DRAFT

2023-2024 Proposed Idea

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

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

Control Number: **#1/2025**

Date Received: **02/01/25**

Proposal will be reviewed by the: Quality Improvement Committee at: **12 pm, on 2/18/25**
HTBMN Workgroup on: **04/14/25 or 04/15/25**
Priority & Allocation Committee on: **TBD**

THIS PAGE IS FOR THE QUALITY IMPROVEMENT COMMITTEE
(See Glossary of HIV-Related Service Categories & Criteria for Reviewing New Ideas)

1. SERVICE CATEGORY: **Referral for Health Care & Support Services**
(The service category must be one of the Ryan White Part A or B service categories as described in the HRSA Glossary of HIV-Related Service Categories.)

This will provide ~500 clients based upon 2020 new diagnoses with ~2 units of service/client.

2. ADDRESS THE FOLLOWING:

A. DESCRIPTION OF SERVICE:

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other Ryan White Funded services for which they may be eligible. e.g. (CPCDMS, provider care, case management, other Ryan White related services).

This service will be provided by case managers and other staff employed by providers.

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

Patients who are newly diagnosed or have fallen out of care and receive treatment through the Ryan White program.

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

- Streamlined referral and care coordination across multiple providers.
- Reduced wait times and improved access to services for clients.
- Enhanced tracking of client engagement and outcomes, aiding in quality improvement efforts.

D. ANTICIPATED HEALTH OUTCOMES (Related to Knowledge, Attitudes, Practices, Health Data, Quality of Life, and Cost Effectiveness):

Implementing a centralized scheduling system for Ryan White providers, along with enhanced referral services, is expected to lead to significant

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improvements in health outcomes for people living with HIV (PLWH). These improvements include:

Improved Linkage to Care:

- A centralized system will enable faster and more efficient referrals to HIV care providers. Newly diagnosed individuals will experience shorter delays in connecting to care, thereby reducing the risk of disease progression.
- The assessment identifies primary care, local medication assistance, case management, oral health care, and vision care as the top five most needed services among clients.

Higher Retention in Care:

- Simplifying appointment scheduling and reminders will increase the likelihood of clients attending follow-up visits and remaining engaged in their care over time. Coordinated efforts between providers will help minimize missed appointments and lapses in treatment.

Improved Viral Suppression Rates:

- Consistent engagement in care and adherence to antiretroviral therapy will lead to higher rates of viral suppression, which lowers the risk of HIV transmission and enhances individual health.

Better Integration of Support Services:

- Enhanced referral services will connect clients with a wider range of supportive services (such as mental health care, housing assistance, and substance use treatment), addressing social determinants of health that impact long-term outcomes.

Enhanced Patient Experience:

- A user-friendly system will reduce frustration and confusion for clients navigating complex healthcare systems, thus improving overall satisfaction with care.

Reduction of Barriers to Care:

- The 2020 Needs Assessment notes that the percentage of participants reporting a need for case management and primary care services has decreased, while the need for other services has increased. Centralized scheduling can help address these shifting needs by efficiently allocating resources and reducing barriers to accessing various services.
- By improving care coordination and reducing redundancies, unnecessary hospitalizations, emergency room visits, and late-stage treatments can be minimized.

These outcomes directly support the national goal of ending the HIV epidemic by improving access to testing, care, and support services while ensuring long-term engagement in effective treatment.

3. ATTACH DOCUMENTATION IN ORDER TO JUSTIFY THE NEED FOR THIS NEW IDEA. AND, DEMONSTRATE THE NEED IN AT LEAST ONE OF THE FOLLOWING PLANNING COUNCIL DOCUMENTS:

X Current Needs Assessment (Year: 2020)

Page(s): 5,19_Paragraph:4, 1&2

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<input type="checkbox"/>	Current HIV Comprehensive Plan (Year: _____)	Page(s): <input type="checkbox"/>	Paragraph: <input type="checkbox"/>
<input type="checkbox"/>	Health Outcome Results: Date: _____	Page(s): <input type="checkbox"/>	Paragraph: <input type="checkbox"/>
<input type="checkbox"/>	Other Ryan White Planning Document:		
<input type="checkbox"/>	Name & Date of Document: _____	Page(s): <input type="checkbox"/>	Paragraph: <input type="checkbox"/>

RECOMMENDATION OF QUALITY IMPROVEMENT COMMITTEE:					
<input type="checkbox"/>	Recommended	<input type="checkbox"/>	Not Recommended	<input type="checkbox"/>	Sent to How To Best Meet Need
REASON FOR RECOMMENDATION:					

(Continue on Page 3 of this application form)

Proposed Idea

THIS PAGE IS FOR THE PRIORITY AND ALLOCATIONS COMMITTEE
(See Criteria and Principles to Guide Decision Making)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY AND INCLUDE A BRIEF HISTORY OF RELATED SERVICE CATEGORY, IF AVAILABLE.

CURRENTLY APPROVED RELATED SERVICE CATEGORY ALLOCATION/UTILIZATION:

Allocation: **\$141,000** **Note: PC allocated funds for Referral – Incarcerated**

Expenditure: **\$ 0** **Year-to-Date – underwritten by alternative funding source**

Utilization: _____ Unduplicated Clients Served Year-to-Date
_____ Units of Service Provided Year-to-Date

AMOUNT OF FUNDING REQUESTED:

\$49,900 This will provide funding for the following purposes which will further the objectives in this service category: (describe how): This funding will facilitate the integration of a centralized scheduling system into CPCDMS, improving efficiency and streamlining operations. This service will be provided by case managers and other staff employed by providers.

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

1. **Addresses Core Medical and Support Service Needs:**
 - The centralized scheduling system and enhanced referral services directly align with the Ryan White Program’s focus on improving access to core medical services (e.g., HIV primary care) and support services (e.g., mental health care, housing).
 - By streamlining processes, clients will have greater access to services that improve health outcomes and support retention in care.
2. **Supports the Ryan White Program’s Key Principles:**
 - **Client-Centered Care:** Simplifies navigation, reduces barriers, and ensures timely access to needed services.
 - **Outcome-Driven Decisions:** Directly supports improvements in key metrics, including viral suppression and retention in care.
3. **Resource Optimization:**
 - Reduces duplication of services and missed opportunities for engagement by enabling better coordination among providers.

Principles to Guide Decision-Making:

1. **Evidence-Based Approach:**

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- Proven models show that care coordination and centralized scheduling improve retention in care and health outcomes.
 - The system will integrate data analytics to monitor progress and adapt strategies as needed.
2. **Community Input and Engagement:**
- Implementation will involve input from PLWH, providers, and community stakeholders to ensure the system addresses real-world challenges.
3. **Sustainability:**
- By integrating with existing systems and leveraging technology, the initiative will be cost-effective and scalable over time.

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

Recommended for Funding in the Amount of: \$ _____

Not Recommended for Funding

Other:

REASON FOR RECOMMENDATION:

Priority and
Allocations
Committee

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 December 2024

Spending Target: 75%

Revised 1/30/25

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	4/1/2024	\$1,138,354	54%
4	Oral Health Service -Prosthodontics	\$631,145	18%		\$631,145		\$631,145	4/1/2024	\$526,486	83%
5	Health Insurance Premiums and Cost Sharing (1)	\$805,845	23%		\$805,845		\$805,845	4/1/2024	\$773,159	96%
					\$0		\$0			
		\$0	0%		\$0					
Total Houston HSDA		3,538,038	100%	0	3,538,038	\$0	\$3,538,038		2,438,000	69%

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

(1) HIA costs have increased per client

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 2425 DSHS State Services
Procurement Report
September 1, 2024 - August 31, 2025



Chart reflects spending through December 2024

Spending Target: 33.33%

Revised 1/30/2025

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)	\$1,114,689	38%	\$0	\$1,114,689	\$0	\$1,114,689	9/1/2024	\$936,719.84	84%
6	Mental Health Services (2)	\$300,000	10%	\$0	\$300,000	\$0	\$300,000	9/1/2024	\$37,265.59	12%
11	Hospice	\$293,832	10%	\$0	\$293,832	\$0	\$293,832	9/1/2024	\$97,020.00	33%
13	Non Medical Case Management (4)	\$275,000	9%	\$0	\$275,000	\$0	\$275,000	9/1/2024	\$36,775.22	13%
16	Linguistic Services (5)	\$68,000	2%	\$0	\$68,000	\$0	\$68,000	9/1/2024	\$0.00	0%
	ADAP/Referral for Healthcare (3)	\$525,000	18%	\$0	\$525,000	\$0	\$525,000	9/1/2024	\$29,016.35	6%
	Food Bank	\$6,120	0.2%	\$0	\$6,120	\$0	\$6,120	9/1/2024	\$1,139.63	19%
	Medical Transportation	\$83,880	3%	\$0	\$83,880	\$0	\$83,880	9/1/2024	\$25,379.94	30%
	Emergency Financial Assistance (Compassionate Care)	\$279,052	9%	\$0	\$279,052	\$0	\$279,052	9/1/2024	\$60,618.54	22%
		2,945,573	100%	\$0	\$2,945,573	\$0	\$2,945,573		1,223,935.11	42%

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

- (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) Mental Health- due to RFP, services have been slow to start (2 new providers)
- (3) ADAP/Referral for Healthcare Services is under spent due to payroll process delays and vacant positions.
- (4) Reduced spending due to staff vacancy
- (5) Change in access points has reduced utilization

2024-2025 Ryan White Part B Service Utilization
4/1/2024- 3/31/2025 Houston HSDA (4816)
3rd Quarter 4-1-24 to 12-31-24

Revised 1/21/2025

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	49.35%	36.36%	0.00%	14.29%	16.51%	25.88%	47.87%	9.74%	0.00%	0.17%	2.08%	16.58%	22.32%	23.96%	24.76%	10.13%
Oral Health Care	3,465	2,249	81.74%	17.65%	0.15%	0.46%	34.06%	27.65%	33.91%	4.38%	0.00%	0.15%	0.94%	15.46%	18.75%	23.14%	30.78%	10.78%
Unduplicated Clients Served By State Services Funds:	NA	2,889	65.55%	27.01%	0.08%	7.36%	25.29%	26.77%	40.89%	7.05%	0.00%	0.16%	1.51%	16.02%	20.54%	23.55%	27.77%	10.45%

Completed by: C. Aguirre

Houston Ryan White Health Insurance Assistance Service Utilization Report



Period Reported:

09/01/2024-12/31/2024

Revised: 1/23/2025

Request by Type	Assisted			NOT Assisted		
	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	379	\$48,760.71	203	0	\$0.00	0
Medical Deductible	68	\$35,637.07	46	0	\$0.00	0
Medical Premium	2281	\$894,512.29	682	0	\$0.00	0
Pharmacy Co-Payment	5705	\$324,624.71	957	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:	8433	\$1,303,534.78	1888	0	\$0.00	

Comments: This report represents services provided under all grants.

Operations Committee

Memo

TO: Members of the Houston Ryan White Planning Council
FROM: The Operations Committee
DATE: Monday, February 24, 2025
RE: Business to be Considered at Council Meetings

From: BYLAWS of the HOUSTON AREA HIV HEALTH SERVICES

RYAN WHITE PLANNING COUNCIL - Revised October 14, 2021

Section 9.04. Business to be Considered. Any business coming before the Council shall be considered at a duly constituted and noticed Regular Meeting or Special Meeting. Only items approved by the Steering Committee for presentation to the Council and posted on the agenda may be voted on.

Training Topics for 2025 Ryan White Planning Council Meetings (updated: 02-25-25)

DRAFT

Shading = may be room on agenda for a second speaker

Month 2024	Topic	Speaker
Jan 23	Council Orientation – Updates on ADAP	Rachel Sanor, TX Dept. of State Health Services
Feb 13	HIV & Hispanic Women in Harris County	Roxana Guzman, Latino AIDS Commission
March 13	Ryan White Committee Training	Cecilia Ligons and Ryan White Committee Co-Chairs
April 11	Criteria for Justifying FY26 RW Service Categories 1:30 - 3 pm How To Best Meet the Need Training	Yvonne Arizpe & Tana Pradia, Co-Chairs, Quality Improvement Committee
May 9	HIV & Coercive Violence	Thecia Jenkins, Harris County Domestic Violence Coordinating Council
June 13	TENT: Updates on ADAP	Rachel Sanor, TX Dept. of State Health Services
July 11	Priority Setting and Allocations Processes	Jay Bhowmick & Peta-gay Ledbetter, Co-Chairs, Priority & Allocations Committee
Aug 8	TENT: HHSC Medicaid Benefits (& HIV)	Roxane May, Medicaid Rep.
Sept 12	TENT: The Opioid Epidemic	Representative, The National Opioid Network
Oct 10	TENT: Trauma Informed Care	_____, HAWC
Nov 14	We Appreciate Our Affiliate Committee Members Election Policy Project LEAP and Proyecto VIDA Presentations	Josh Mica, Chair, Ryan White Planning Council Caleb Brown & Cecilia Ligons, Co-Chairs, Operations Comm. 2025 Project LEAP and Proyecto VIDA Students
Dec 12	Elections for the 2026 Officers	Caleb Brown & Cecilia Ligons, Co-Chairs, Operations Committee

Required: Opioid and Other Drug Use, Prevention of Domestic & Sexual Violence and Trauma Informed Care

Other: Transgender Health Issues by Dr. Lake – recommended by Dr. Patel

Updates from the Texas Department of State Health Services (TDSHS) – 1-2 x per year