**Houston Area HIV Services RW Planning Council**
**Office of Support**
**1310 Prairie Street, Suite 800, Houston, Texas 77002**
**832 927-7926 telephone; http://rwpchouston.org**

# MEMORANDUM

To: Members, Houston Ryan White Planning Council

Copy: Glenn Urbach, RW Grant Admin
Eric James, RW Grant Admin
Francisco Ruiz, RW Grant Admin
Tiffany Shepherd, TRG
Sha'Terra Johnson, TRG
Jeff Benavides, TRG
Tionna Cobb, TRG
James Supak, RW Grant Admin
Diane Beck, Office of Support

**Email Copy Only**:
Tara Hixson, HRSA
Commander Rodrigo Chavez, PACE
Marlene McNeese, Houston Health Dept.
Jason Black, RW Grant Admin
Charles Henley, Consultant

From: Tori Williams, Director, Office of Support
Date: Tuesday, March 4, 2025
Re: Meeting Announcement

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We look forward to seeing everyone at the Council meeting next week. Although the meeting is hybrid, to make quorum, **we need 14 people to attend in-person.** *Come 10 minutes early if you would enjoy Titan's soothing exercises to release stress. (Thank you, Titan!)*

**IMPORTANT:** The funds for the new fiscal year have not yet been loaded into our account with the County so watch your email reminders to see if we will have sandwiches for those with a medical need. If not, you will be able to pick up lunch and we will reimburse you at a later date. As always, others are encouraged to bring a brown bag lunch. Meeting details are as follows:

**Ryan White Planning Council Meeting**
*11:50 a.m., Titan's breathing exercises*
12 noon, Thursday, March 13, 2025

**Meeting Location**

**In Person:** Bering Church, 1440 Harold St, Houston, Texas 77006. Park in the lot behind the church on Hawthorne Street and **use the code that was given to Council members only to enter the building.**

**Online or via telephone:** Click on the following link to join the Zoom meeting:
https://us02web.zoom.us/j/995831210?pwd=UnlNdExMVFFqeVgzQ0NJNkpieXlGQT09
Meeting ID: 995 831 210 Passcode: 577264
Or, use the following telephone number: 346 248-7799

Please contact Rod to RSVP virtually or in person, even if you cannot attend. This will let us know how close we are to making quorum. Rod can be reached at: 832 927-7926 or by responding to her email reminders. Thank you!

**REVISED: 03-06-25**

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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*We envision an educated community where the needs of all persons living with and/or affected by HIV are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system.*

*The community will continue to intervene responsibly until the end of the epidemic.*

*The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.*

# AGENDA

12 noon, March 13, 2025
In Person Meeting Location: 1440 Harold Street, Houston, Texas 77006

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

Join Zoom Meeting by clicking onto:
https://us02web.zoom.us/j/995831210?pwd=UnlNdExMVFFqeVgzQ0NJNkpieXlGQT09
Meeting ID: 995 831 210 Passcode: 577264
Or, dial in by calling 346 248-7799

I. Call to Order — Josh Mica, he/him/él, Chair, Ryan White Planning Council

A. Welcome, Moment of Reflection
B. Introductions
- Richon Ohafia, MPH, Director
- Amber Barrow, MPH, Health Planner

C. Adoption of the Agenda – **Add motion from Steering Committee**
D. Approval of the Minutes
E. *Ryan White Committee Cross Training Competition* — Caleb Brown & Cecilia Ligons, Co-Chairs, Operations Comm.

II. Public Comments 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 the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

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 — Yvonne Arizpe and Tana Pradia, Co-Chairs

*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.

*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:* Community Advisory Boards (CABs)
*Recommended Action:* **Motion:** Ask the Office of Support to provide the Part A Administrative Agency with the template that The Resource Group developed to assist agencies in setting up a CAB. And, ask the Quality Improvement Committee to review the materials before they are sent to the Administrative Agency.

*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 — Peta-gay Ledbetter and Jay Bhowmick, Co-Chairs

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

*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: Peta-gay Ledbetter 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. They oriented additional new volunteers and staff on March 10, 2025.

*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.

V. Report from the Office of Support — Staff, RW Office of Support

| | | |
|---|---|---|
| VI. | Report from Ryan White Grant Administration | Glenn Urbach, Manager |
| VII. | Report from The Resource Group | Sha'Terra Johnson,<br>Health Planner |
| VIII. | Medical Updates | Shital Patel, MD, she/her/hers<br>Baylor College of Medicine |

IX. New Business (**During Virtual Meetings, Reports Will Be Limited to Written Reports Only**)

| | |
|---|---|
| A. AIDS Educational Training Centers (AETC) | Shital Patel, she/her/hers |
| B. Ryan White Part C Urban and Part D | |
| C. HOPWA | Megan Rowe, she/her/hers |
| D. Community Prevention Group (CPG) | Kathryn Fergus, she/her/hers |
| E. Update from Task Forces: | |
| • Sexually Transmitted Infections (STI) | |
| • African American | Sha'Terra Johnson, she/her/hers |
| • Latino | |
| • Youth | |
| • MSM | |
| • Hepatitis C | Steven Vargas, he/him/él |
| • Project PATHH (Protecting our Angels Through Healing Hearts) formerly Urban AIDS Ministry | |
| F. HIV and Aging Coalition | Skeet Boyle, he/him/his |
| G. Texas HIV Medication Advisory Committee | |
| H. Positive Women's Network | |
| I. Texas Black Women's Initiative | Sha'Terra Johnson, she/her/hers |
| J. Texas HIV Syndicate | Steven Vargas, he/him/él |
| K. END HIV Houston | |

IX. Announcements

X. Adjournment

* *RWPC = Ryan White Planning Council*
** *ADAP = Ryan White Part B AIDS Drug Assistance Program*
*** *TDSHS = Texas Department of State Health Services*

# HOUSTON AREA HIV SERVICES
# RYAN WHITE PLANNING COUNCIL

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*We envision an educated community where the needs of all persons living with HIV and/or affected individuals are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system. The community will continue to intervene responsibly until the end of the epidemic.*

*The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.*

## MINUTES

12 noon, Thursday, February 13, 2025

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

| MEMBERS PRESENT | MEMBERS PRESENT | OTHERS PRESENT |
|---|---|---|
| Josh Mica, he/him/él, Chair | Beatriz E.X. Rivera | Charles Henley, Consultant |
| Ryan Rose, Vice Chair | Yolanda Ross | Shabaura Perryman |
| Bill Patterson, Secretary | Megan Rowe | Roxana Guzman, Latino |
| Kevin Aloysius | Evelio Salinas Escamilla | Commission on AIDS |
| Servando Arellano | Ramón Sanchez | Judith Montenegro, Latino |
| Yvonne Arizpe | Alamou Sanoussi | Commission on AIDS |
| Jay Bhowmick | Robert Sliepka | Joe Fuentes, El Centro Corazón |
| Ardry “Skeet” Boyle | Carol Suazo | Gabriela Ortiz, El Centro Corazón |
| Caleb Brown | Isis Torrente | Adrian Villagomez, El Centro Corazón |
| Titan Capri | Steven Vargas | A. Daniel Ramos |
| Johnny Deal | | Higinio Fernandez-Sanchez |
| Kathryn Fergus | | Gloria Sierra |
| Kenia Gallardo | | Robert Cruz |
| Ronnie Galley | | |
| Georgina German | **MEMBERS ABSENT** | **STAFF PRESENT** |
| Mary Guidry | Laura Alvarez | *Ryan White Grant Administration* |
| Glen Hollis | Johanna Castillo | Glenn Urbach |
| Kenneth Jones | Michael Elizabeth | Eric James |
| Denis Kelly | Roxane May | Jason Black |
| Peta-gay Ledbetter | Norman Mitchell, excused | James Supak |
| Cecilia Ligons | Shital M. Patel | |
| Rodney Mills | | Sha’Terra Johnson, The Resource Group |
| Oscar Perez | | Jeff Benavides, The Resource Group |
| Arnold Portales | | |
| Tana Pradia | | Tori Williams, Office of Support |
| | | Diane Beck, Office of Support |

**Call to Order:** Josh Mica, he/him/él, Chair, called the meeting to order at 12:04 p.m. During the opening remarks, Mica welcomed the new members to the Council. He also reminded members that 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 need a copy of the invitation. Mica 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. Needless to say, this has been a stressful couple of weeks for anyone who receives or provides social service support. The Council will have its work cut out for it this year. Although no one knows when things will settle down, if staff receives information that relates to our grant, they will share it with members. It is especially important right now that members meet regularly and stay informed.

In the handouts there a motion that the Steering Committee made to direct staff to set up a meeting for Planning Council members to meet in Executive Session with the County Attorney's Office for advice on the impact of Executive Orders on the work of the Council. If the motion is approved, it is important to understand that Executive Session is subject to the Open Meetings Act and discussion will be confined to the impact of the Executive Orders on the Ryan White Program and Court actions and Orders that impact the Executive Orders. The meeting would only be open to Council Members, specific staff members and the County Attorney's Office. The meeting is not open to the public, nor is it recorded. Tori reached out to the County Attorney's Office and they have not yet responded. If they agree to meet with the Council, they many not feel that an Executive Session is warranted. If the motion is approved, it will allow the Council to hold the conversation in public or in executive session.

Mica then called for a Moment of Reflection.

**Introductions:** Mica asked all Council Members to briefly introduce themselves.

**Adoption of the Agenda:** ***Motion #1:*** *it was moved and seconded (Escamilla, Rose) to adopt the agenda with the addition of the attached motion from Steering.* **Motion carried unanimously.**

**Approval of the Minutes:** ***Motion #2:*** *it was moved and seconded (Vargas, Torrente) to approve the December 12, 2024 minutes.* **Motion carried.** Abstentions: Arellano, Brown, Gallardo, Galley, German, Hollis, Jones, Perez, Portales, Rowe, Sanchez, Sanoussi, Torrente.

**HIV and Hispanic Women in Harris County:** Roxana Guzman, Research Associate, Latino Commission on AIDS and RWPC Affiliate Member presented the attached PowerPoint. The information presented can also be accessed online: https://ilhe.org/2024-texas-hiv-update/

**Public Comment and Announcements**: Arizpe said that she was part of the new HIV program at El Centro de Corazón Community Health Center; her team members introduced themselves.

**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 2025Houston 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. Vargas added that Gina German was elected committee Vice Chair.

**Affected Community Committee:** No report.

**Quality Improvement Committee:** No report.

**Priority and Allocations Committee:** No report.

**Operations Committee:** Cecilia Ligons, Co-Chair, reported on the following:
2025 New Member Orientation & Mentor/Mentee Meeting: Ligons said that the meetings were very successful and new members feel better prepared. Orientation for new affiliate members is next Friday.

2025 Council Orientation: Ligons said that orientation was well attended and successful.

**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, Director, said that the Personnel Subcommittee screened 48 qualified candidates. The top 3 were scheduled to meet with the Judge on Tuesday but she got called away and they met with her staff. If the Judge accepts the recommendation from the Personnel Committee and her staff then you will soon have a new Director. Because of the recent Executive Orders, we have to remove certain words from the Blue Book. This has been forwarded to the County Attorney to decide if we need to delete text or not.

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

***Motion #3:*** *it was moved and seconded (Vargas, Rose) to include in the RWGA report, an update on CABS at Houston Ryan White funded agencies and also the responsibilities of CABs.* **Motion Carried.** Abstention: Boyle, Jones.

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

**Task Force Reports:** The Council agreed some time ago that they preferred not to have verbal Task Force Reports while meeting virtually. The Office of Support is happy to receive and distribute written reports in advance of Council meetings.

**Announcements:** Rowe said that the updated HOPWA manual is now available.

**Adjournment:** *it was moved and seconded (Kelly, Escamilla) to adjourn the meeting at 1:42 p.m.* **Motion Carried.**

Respectfully submitted,

_____ Date _____
Victoria Williams, Director

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

# Council Voting Records for February 13, 2025

| C = Chair of the meeting<br>ja = Just arrived<br>lm = Left the meeting<br>lr = Left the room | **Motion #1** Agenda **Carried** | | | | **Motion #2** Minutes **Carried** | | | | **Motion #3** CAB info on RWGA report **Carried** | | | | | **Motion #1** Agenda **Carried** | | | | **Motion #2** Minutes **Carried** | | | | **Motion #3** CAB info on RWGA report **Carried** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MEMBERS | ABSENT | YES | NO | ABSTAIN | ABSENT | YES | NO | ABSTAIN | ABSENT | YES | NO | ABSTAIN | MEMBERS | ABSENT | YES | NO | ABSTAIN | ABSENT | YES | NO | ABSTAIN | ABSENT | YES | NO | ABSTAIN |
| Josh Mica, he/him/él, Chair | | | | C | | | | C | | | | C | Oscar Perez | | X | | | | | | X | | X | | |
| Ryan Rose, Vice Chair | | X | | | | X | | | | X | | | Arnold Portales | | X | | | | | | X | | X | | |
| Bill Patterson, Secretary | | X | | | | X | | | | X | | | Tana Pradia | | X | | | | X | | | | X | | |
| Kevin Aloysius ja 12:51pm | X | | | | X | | | | | X | | | Beatriz E.X. Rivera | | X | | | | X | | | | X | | |
| Servando Arellano | | X | | | | | | X | | X | | | Yolanda Ross | | X | | | | X | | | | X | | |
| Yvonne Arizpe | | X | | | | X | | | | X | | | Megan Rowe | | X | | | | | | X | | X | | |
| Jay Bhowmick | | X | | | | X | | | | X | | | Evelio Salinas Escamilla | | X | | | | X | | | | X | | |
| Ardry “Skeet” Boyle | | X | | | | X | | | | | | X | Ramón Sanchez | | X | | | | X | | | | X | | |
| Caleb Brown | | X | | | | | | X | | X | | | Alamou Sanoussi | | X | | | | | | X | | X | | |
| Titan Capri | | X | | | | X | | | | X | | | Robert Sliepka | | X | | | | X | | | | X | | |
| Johnny Deal | | X | | | | X | | | | X | | | Carol Suazo | | X | | | | X | | | | X | | |
| Kathryn Fergus | | X | | | | X | | | | X | | | Isis Torrente | | X | | | | | | X | | X | | |
| Kenia Gallardo | | X | | | | | | X | | X | | | Steven Vargas | | X | | | | X | | | | X | | |
| Ronnie Galley | | X | | | | | | X | | X | | | | | | | | | | | | | | | |
| Georgina German | | X | | | | | | X | | X | | | | | | | | | | | | | | | |
| Mary Guidry | | X | | | | | | X | | X | | | **MEMBERS ABSENT** | | | | | | | | | | | | |
| Glen Hollis | | X | | | | | | X | | | X | | Laura Alvarez | | | | | | | | | | | | |
| Kenneth Jones | | X | | | | | | X | | | | X | Johanna Castillo | | | | | | | | | | | | |
| Denis Kelly lm 1:04pm | | X | | | | X | | | X | | | | Michael Elizabeth | | | | | | | | | | | | |
| Peta-gay Ledbetter | | X | | | | X | | | | X | | | Roxane May | | | | | | | | | | | | |
| Cecilia Ligons | | X | | | | X | | | | X | | | Norman Mitchell | | | | | | | | | | | | |
| Rodney Mills | | X | | | | X | | | | X | | | Shital M. Patel | | | | | | | | | | | | |

# 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?

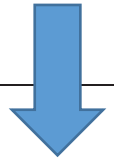
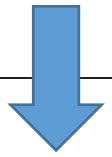
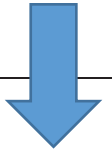
4.) If you are a realtor and you have a contract to help the Montrose Center sell their building, can you vote on the service definition for mental health?

# 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

- 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

- 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

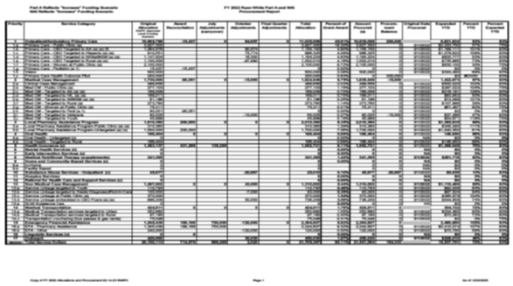


# RULES / CAVEATS

- 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

# EXAMPLE

- Let's read the most recent Procurement Report together





# MEDICAL NUTRITIONAL THERAPY

| Priority | Planned Allocation | Award Reconciliation | Total Allocation | Amount Procured | Expended YTD | Percent Expended YTD | Percent Expected YTD |
|---|---|---|---|---|---|---|---|
| 8 | $341,395 | $0 | $341,395 | $341,395 | $281,716 | 83% | 83% |

# 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

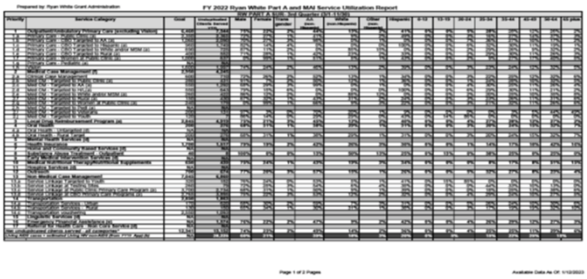


# SERVICE UTILIZATION REPORT SUR

- 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

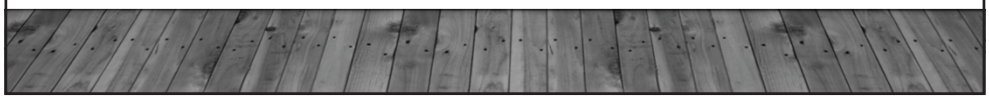


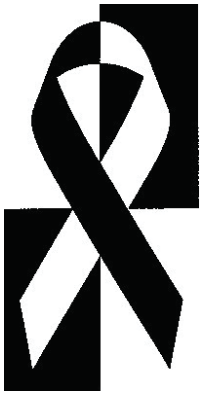


# OTHER CONSIDERATIONS

- 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<br>Year 2: 9/1/24 - 8/31/25 | Year 1: 4/1/23 - 3/31/24<br>Year 2: 4/1/24 - 3/31/25 |

| **ANNUAL REPORTS**<br>*(DELIVERED TO QI COMMITTEE)* | |
|---|---|
| 2023 MEANINGFUL ENGAGEMENT REPORT<br>NA** | 2023 CHART REVIEW REPORTS<br>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**<br>*(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**<br>*(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** (A)
**4/1/2018 - 3/31/2019 Houston HSDA (4816)**
**3rd Quarter - 4/1/2018 to 12/31/2018**

(C.) (D) (B.)

Revised 2/21/2019

| 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% | 0.00% | 66.67% | 0.00% | 33.33% | 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: | *NA* | **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.** (A.)
**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%

Revised 2/19/2019 (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 HSDA** | 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) | | 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* |
| Totals: | 4656 | $1,215,376.02 | 1904 | 0 | $0.00 | |

G

Comments: This report represents services [D.] under all g[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.

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

**FY 2024 Ryan White Part A and MAI**
**Procurement Report**

| Priority | Service Category | Original Allocation *RWPC Approved Level Funding Scenario* | Award Reconcilation | July Adjustments (carryover) | August 10% Rule Adjustments (f) | October Adjustments | Final Quarter Adjustments | Total Allocation | Percent of Grant Award | Amount Procured (a) | Procure-ment Balance | Original Date Procured | Expended YTD | Percent YTD | Percent Expected YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | **Outpatient/Ambulatory Primary Care** | **11,169,413** | **370,766** | **134,765** | **-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** | 3/1/2024 | **$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** | 3/1/2024 | **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** | | **311,204** | **0** | **0** | **0** | **1,894,341** | **7.52%** | **1,894,341** | **0** | 3/1/2024 | **$1,494,928** | **79%** | **92%** |
| **7** | **Medical Nutritional Therapy (supplements)** | **341,395** | **0** | | | | | **341,395** | **1.35%** | **341,395** | **0** | 3/1/2024 | **$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** | 3/1/2024 | **$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** | **-93,411** | **-8,800** | **1,164,791** | **4.62%** | **1,164,791** | **0** | 3/1/2024 | **$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 | | | | | **320,000** | **1.27%** | 320,000 | **0** | 3/1/2024 | **$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 | 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 | 589,534 | 2.34% | 589,534 | 0 | N/A | $481,434 | 82% | 92% |
| FY23_RW_QM | **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%** |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | Unallocated | Unobligated | | | | | 92% |
| | ***Part A Grant Award:*** | **25,204,121** | ***Carryover:*** | **491,204** | | | ***Total Part A:*** | **25,204,121** | 1 | **0** | | | | | 92% |

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

**FY 2024 Ryan White Part A and MAI**
**Procurement Report**

| Priority | Service Category | Original Allocation *RWPC Approved Level Funding Scenario* | Award Reconcilation | July Adjustments (carryover) | August 10% Rule Adjustments (f) | October Adjustments | Final Quarter Adjustments | Total Allocation | Percent of Grant Award | Amount Procured (a) | Procure-ment Balance | Original Date Procured | Expended YTD | Percent YTD | Percent Expected YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | | Original Allocation | Award Reconcilation | July Adjsuments (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 |
| | | | | | | | | | | | | Totals | 0 | 0 | 0 |
| | **Total Admin** (must be ≤ 10% of total Part A + MAI) | **2,133,394** | **0** | **0** | **0** | **0** | **0** | **2,133,394** | **7.71%** | | | | | | |
| | **Total QM** (must be ≤ 5% of total Part A + MAI) | **522,214** | **0** | **0** | **0** | **0** | **0** | **522,214** | **1.89%** | | | | | | |

**MAI Procurement Report**

| Priority | Service Category | Original Allocation *RWPC Approved Level Funding Scenario* | Award Reconcilation | July Adjustments (carryover) | August 10% Rule Adjustments (f) | October Adjustments | Final Quarter Adjustments | Total Allocation | Percent of Grant Award | Amount Procured (a) | Procure-ment Balance | Date of Procure-ment | Expended YTD | Percent YTD | Percent Expected YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | **Outpatient/Ambulatory Primary Care** | **2,068,055** | **30,356** | **47,459** | **0** | **0** | **0** | **2,145,870** | **87.07%** | **2,145,870** | **0** | | **$1,878,260** | **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:*** | **2,464,466** | | | | | | | 92% |
| | ***Combined Part A and MAI Orginial 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 vouchering | 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 Manangement - 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.<br>12.c.<br>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

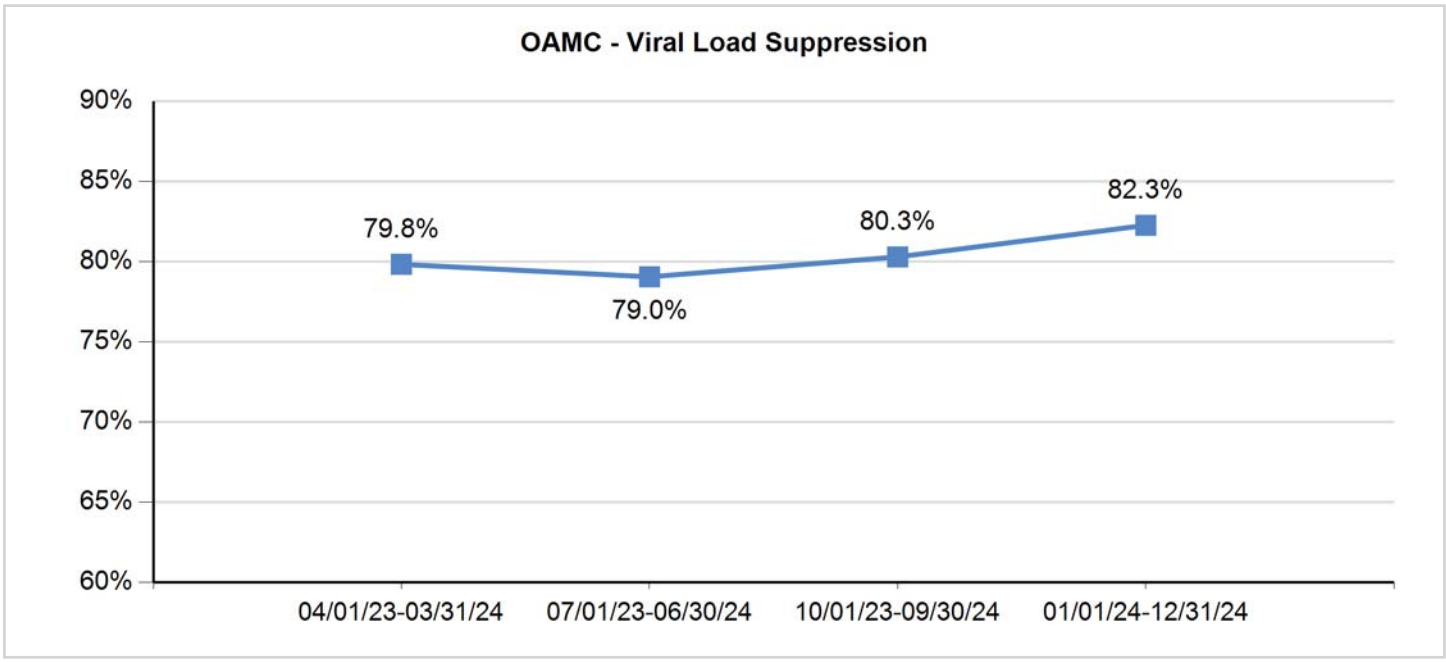
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

# Clinical Quality Management Committee Quarterly Report

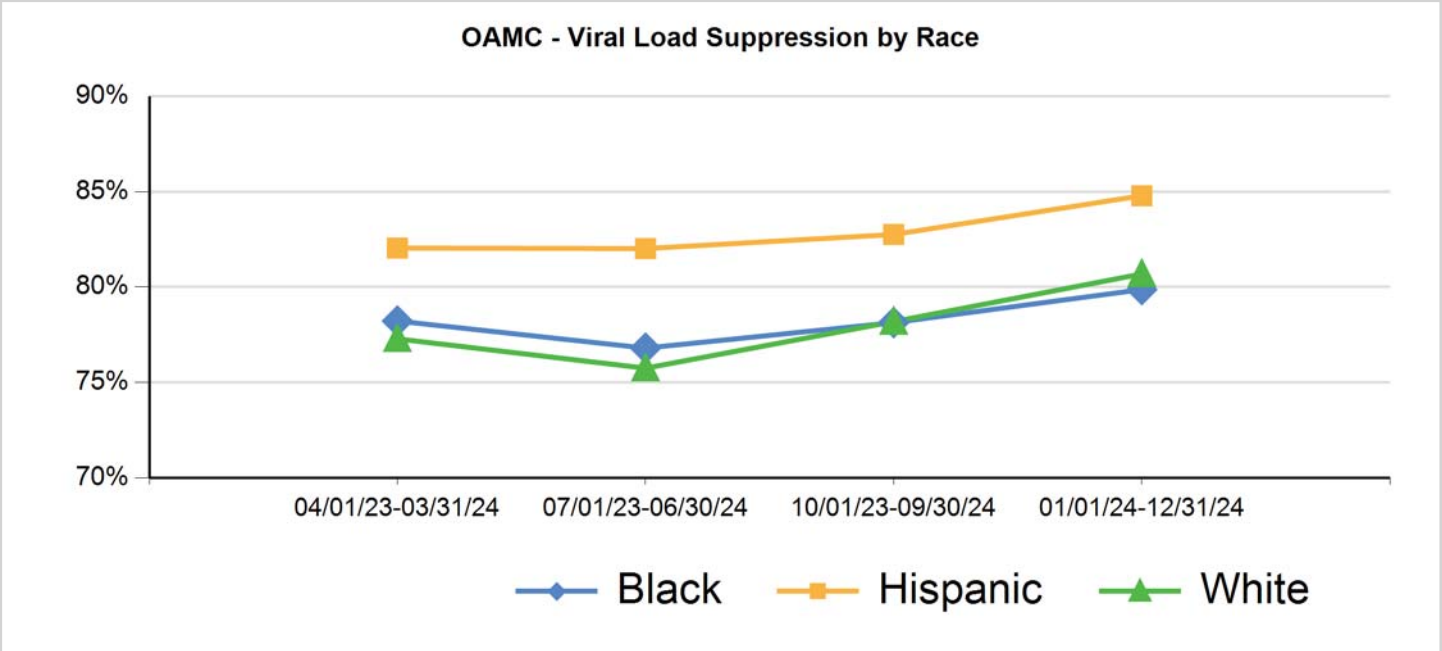
Last Quarter Start Date: **1/1/2024**

Agency: **ALL**

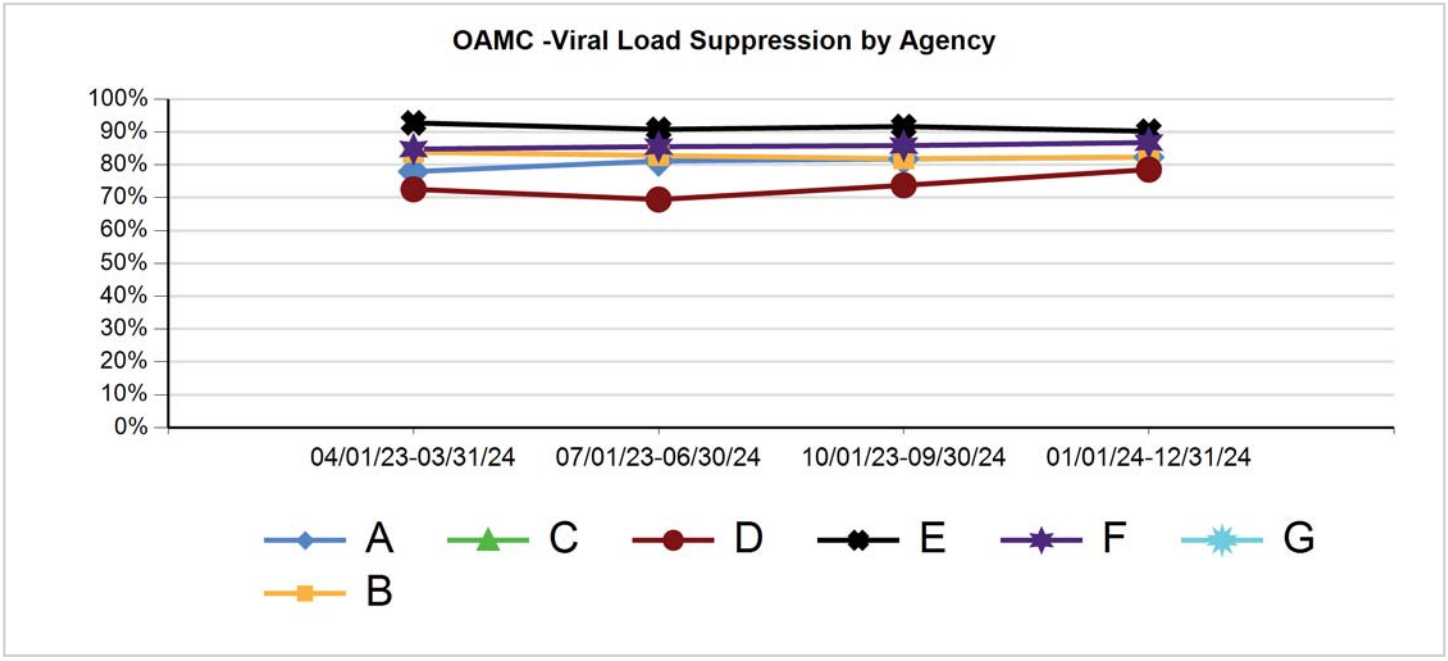
| OAMC - Viral Load Suppression | | | | |
|---|---|---|---|---|
| | 04/01/23 - 03/31/24 | 07/01/23 - 06/30/24 | 10/01/23 - 09/30/24 | 01/01/24 - 12/31/24 |
| Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year | 5,199 | 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% |



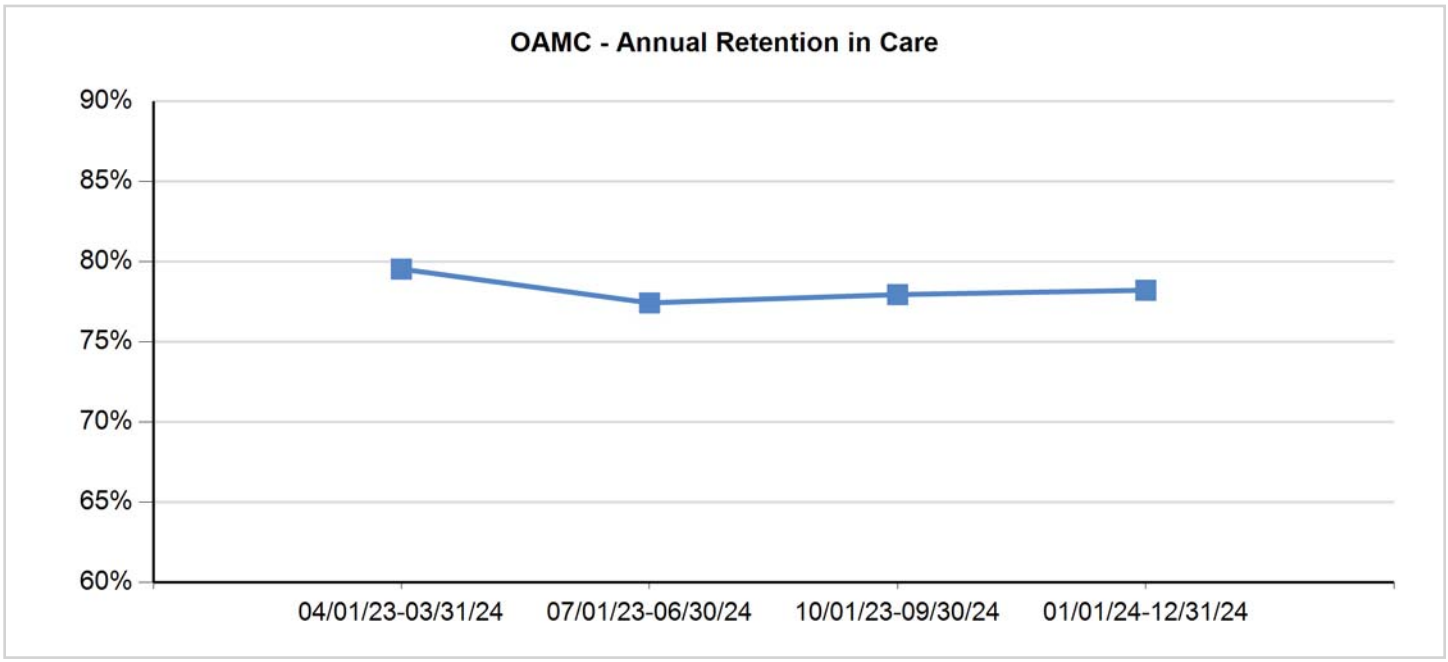
| OAMC - Viral Load Suppression by Race/Ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 07/01/23 - 06/30/24 | | | 10/01/23 - 09/30/24 | | | 01/01/24 - 12/31/24 | | |
| | Black | Hisp | White | Black | Hisp | White | Black | Hisp | White |
| Number of clients in the denominator 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% |



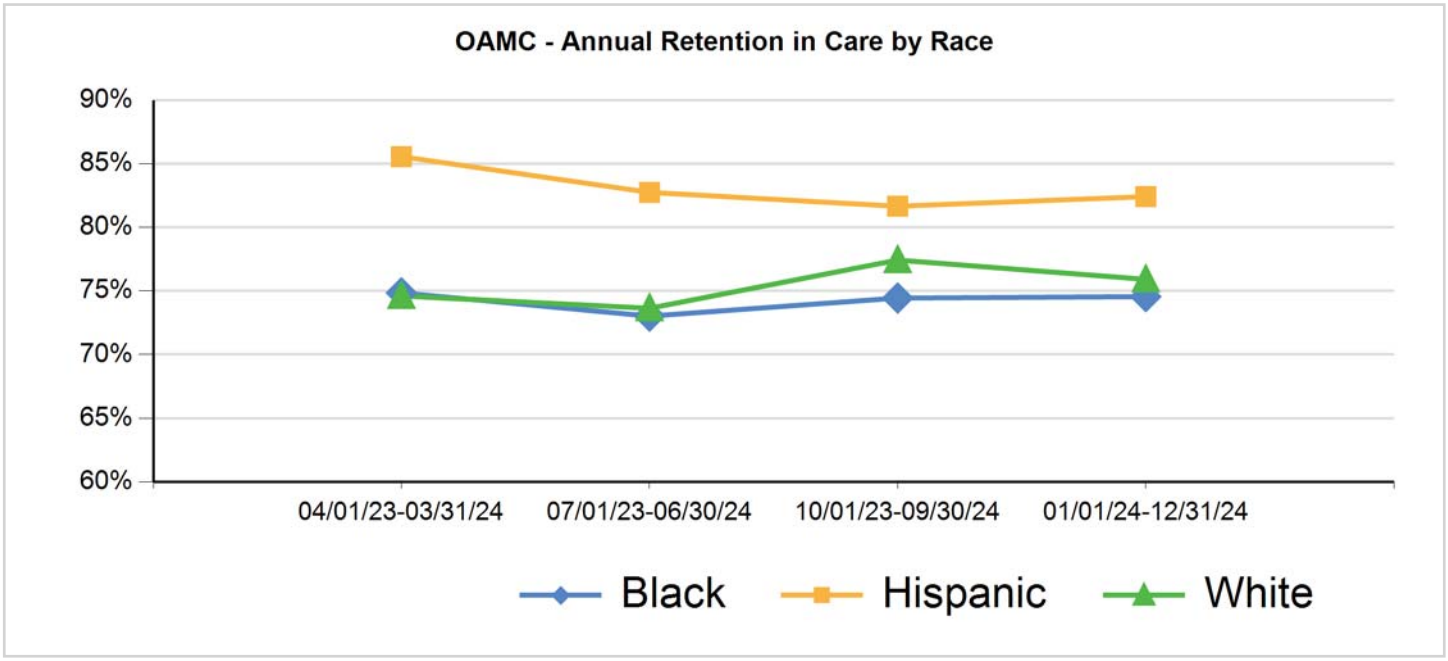
| OAMC - Viral Load Suppression by Agency | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10/01/23 - 09/30/24 | | | | | | | 01/01/24 - 12/31/24 | | | | | | |
| | A | B | C | D | E | F | G | A | B | C | D | E | F | G |
| Number of clients in the denominator 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 |



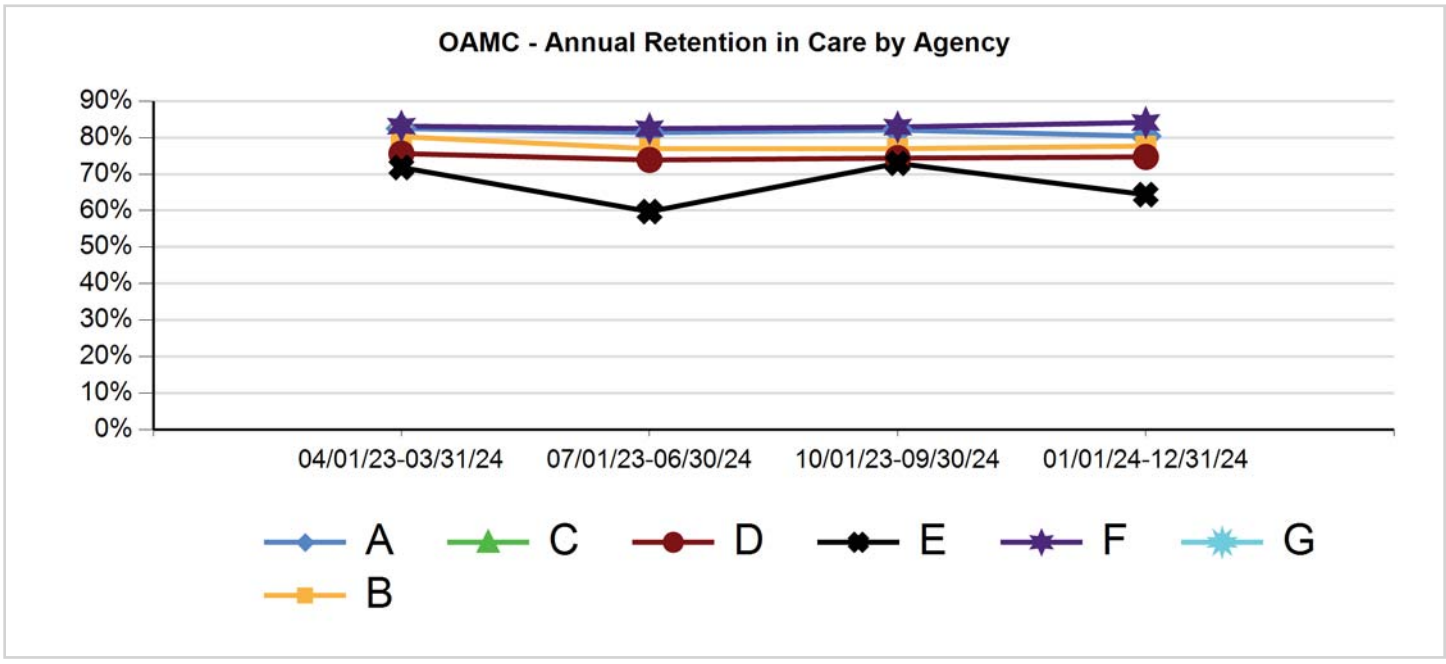
| OAMC - Annual Retention in Care | | | | |
|---|---|---|---|---|
| | 04/01/23 - 03/31/24 | 07/01/23 - 06/30/24 | 10/01/23 - 09/30/24 | 01/01/24 - 12/31/24 |
| Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year. | 4,725 | 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% |



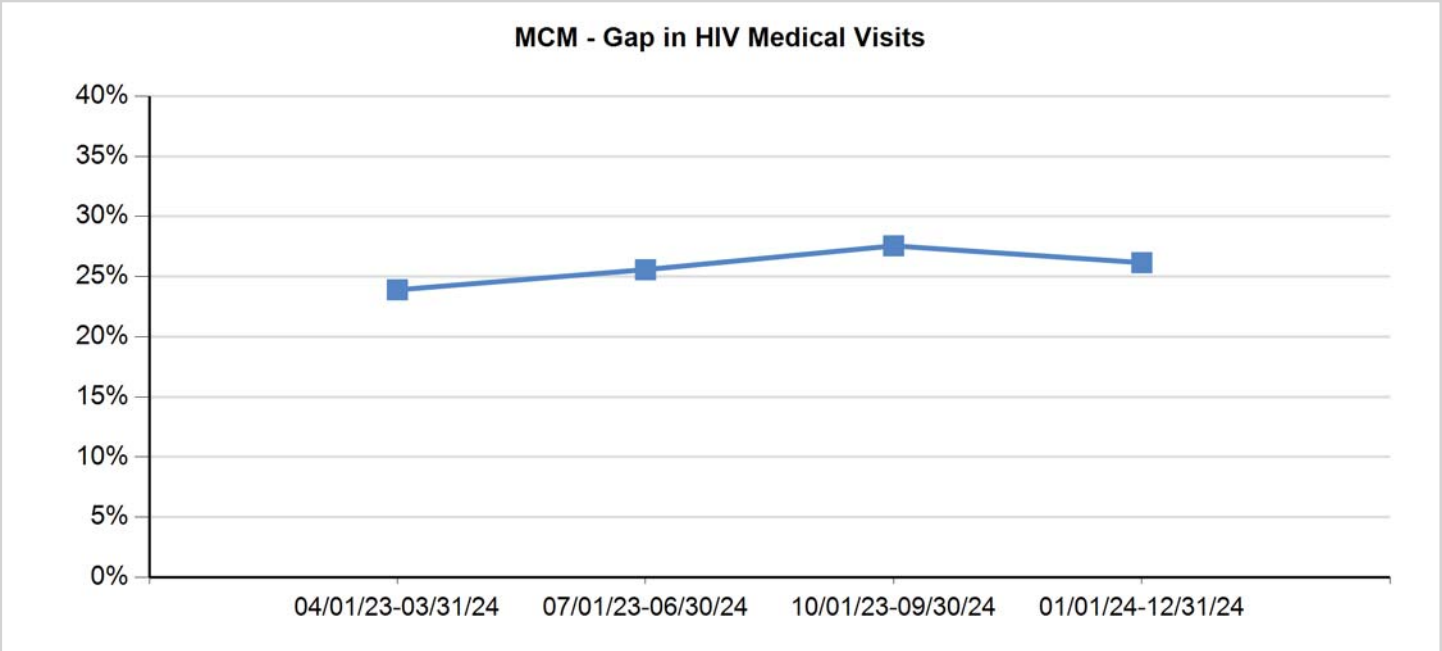
| OAMC - Annual Retention in Care by Race/Ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 07/01/23 - 06/30/24 | | | 10/01/23 - 09/30/24 | | | 01/01/24 - 12/31/24 | | |
| | Black | Hisp | White | Black | Hisp | White | Black | Hisp | White |
| Number of clients in the denominator 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% |



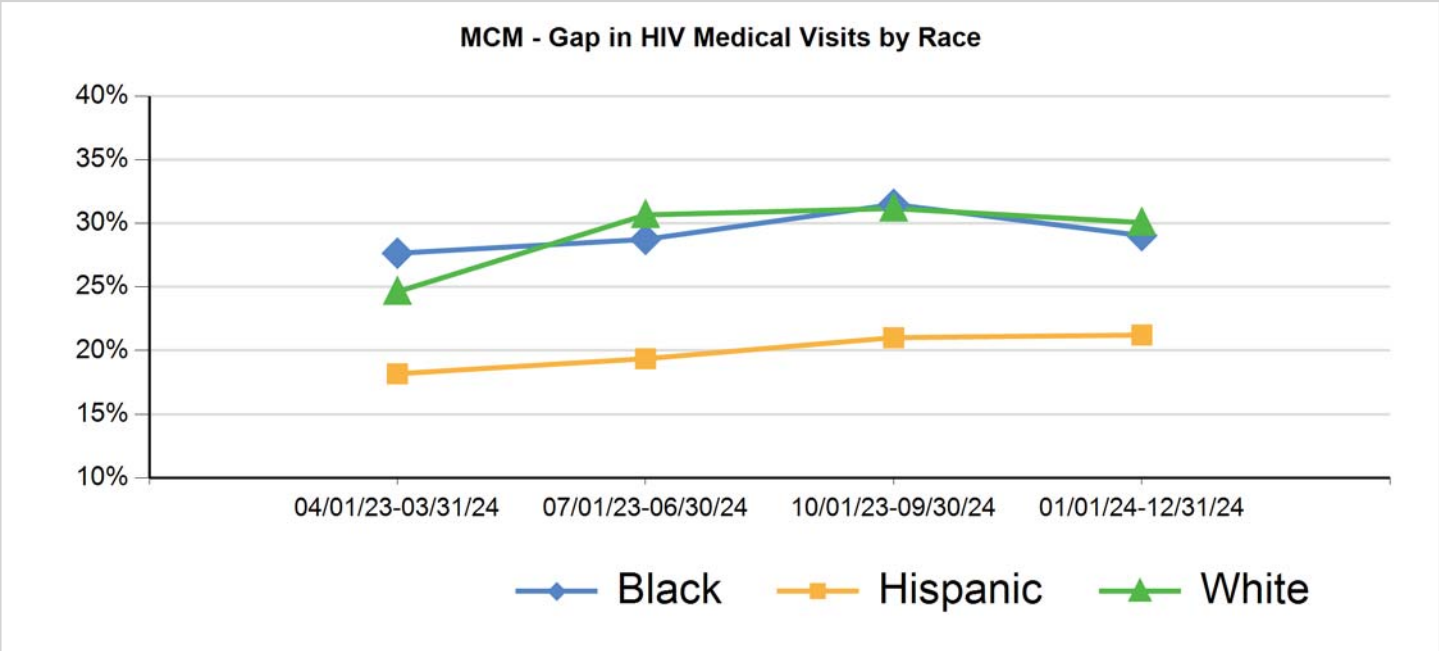
| OAMC - Annual Retention in Care by Agency | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10/01/23 - 09/30/24 | | | | | | | 01/01/24 - 12/31/24 | | | | | | |
| | A | B | C | D | E | F | G | A | B | C | D | E | F | G |
| Number of clients in the denominator 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 |



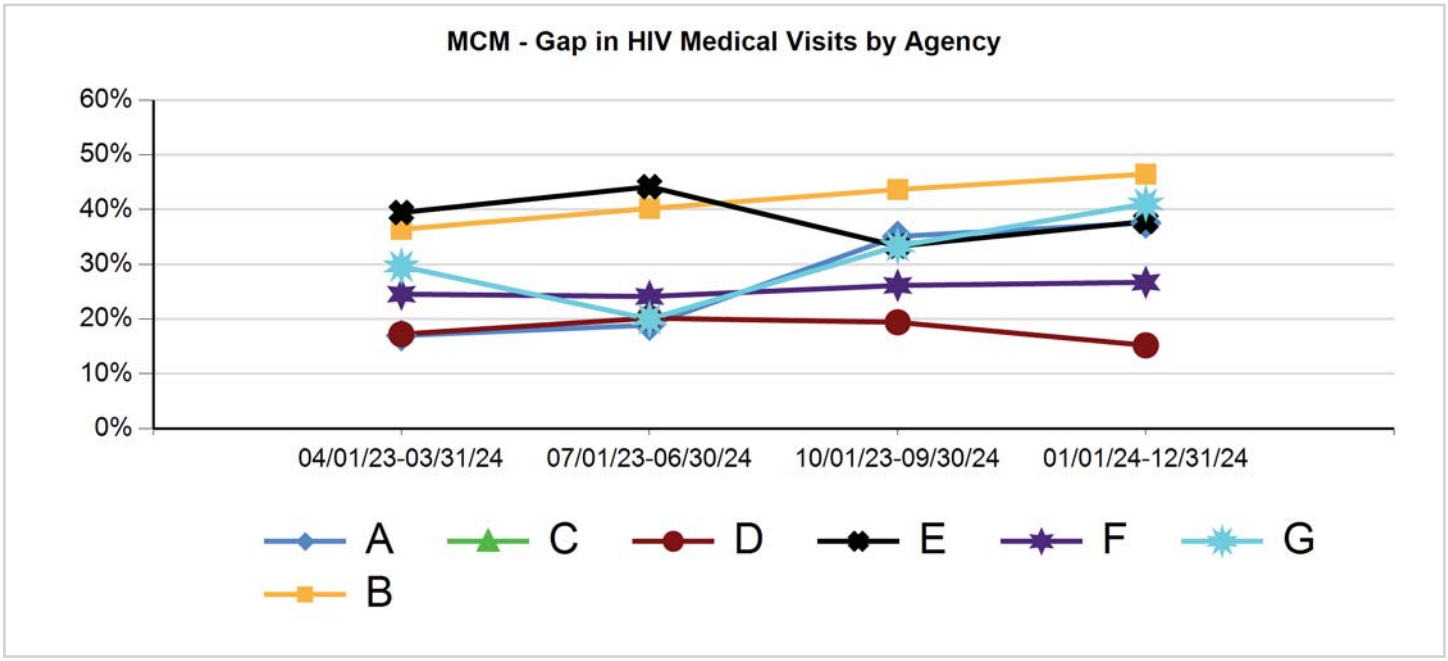
| MCM - Gap in HIV Medical Visits | | | | |
|---|---|---|---|---|
| | 04/01/23-03/31/24 | 07/01/23-06/30/24 | 10/01/23-09/30/24 | 01/01/24-12/31/24 |
| Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year | 358 | 421 | 458 | 423 |
| Number 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% |



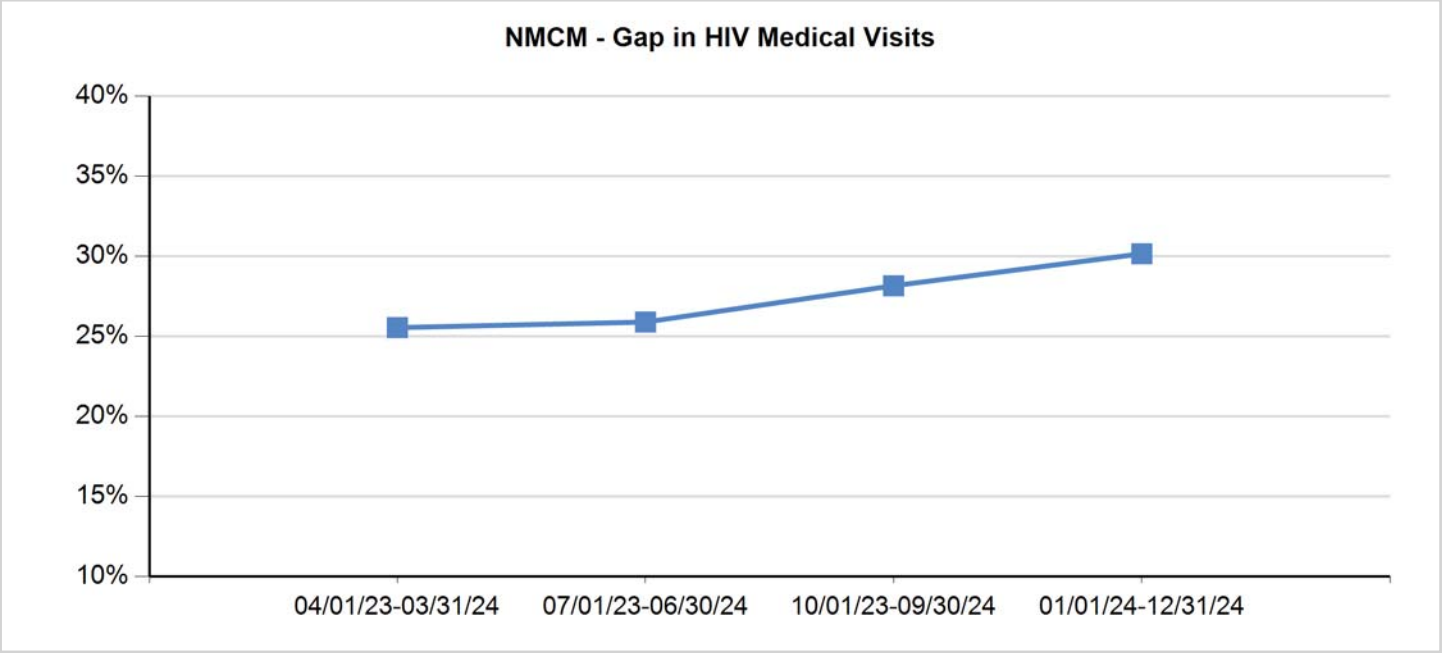
| MCM - Gap in HIV Medical Visits by Race/Ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 07/01/23-06/30/24 | | | 10/01/23-09/30/24 | | | 01/01/24-12/31/24 | | |
| | Black | Hisp | White | Black | Hisp | White | Black | Hisp | White |
| Number of clients in the denominator 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% |



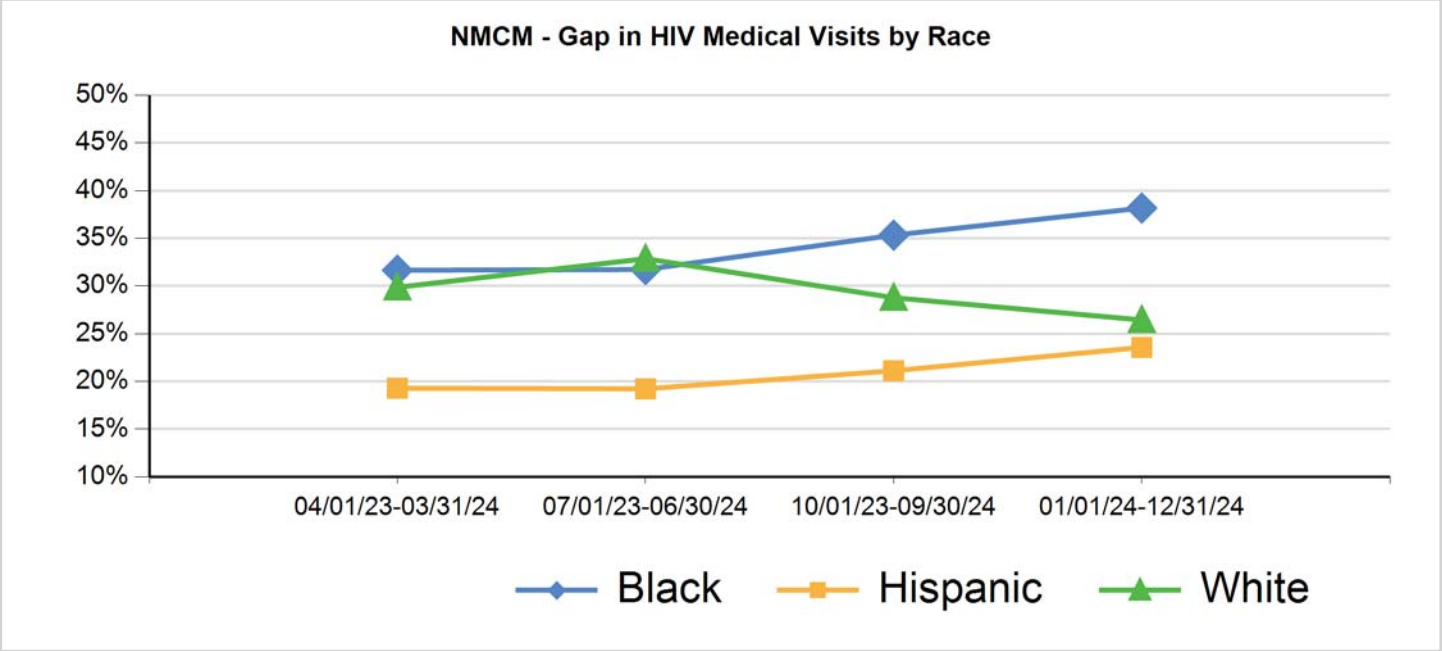
| MCM - Gap in HIV Medical Visits by Agency | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10/01/23 - 09/30/24 | | | | | | | 01/01/24 - 12/31/24 | | | | | | |
| | A | B | C | D | E | F | G | A | B | C | D | E | F | G |
| Number of clients in the denominator 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% |



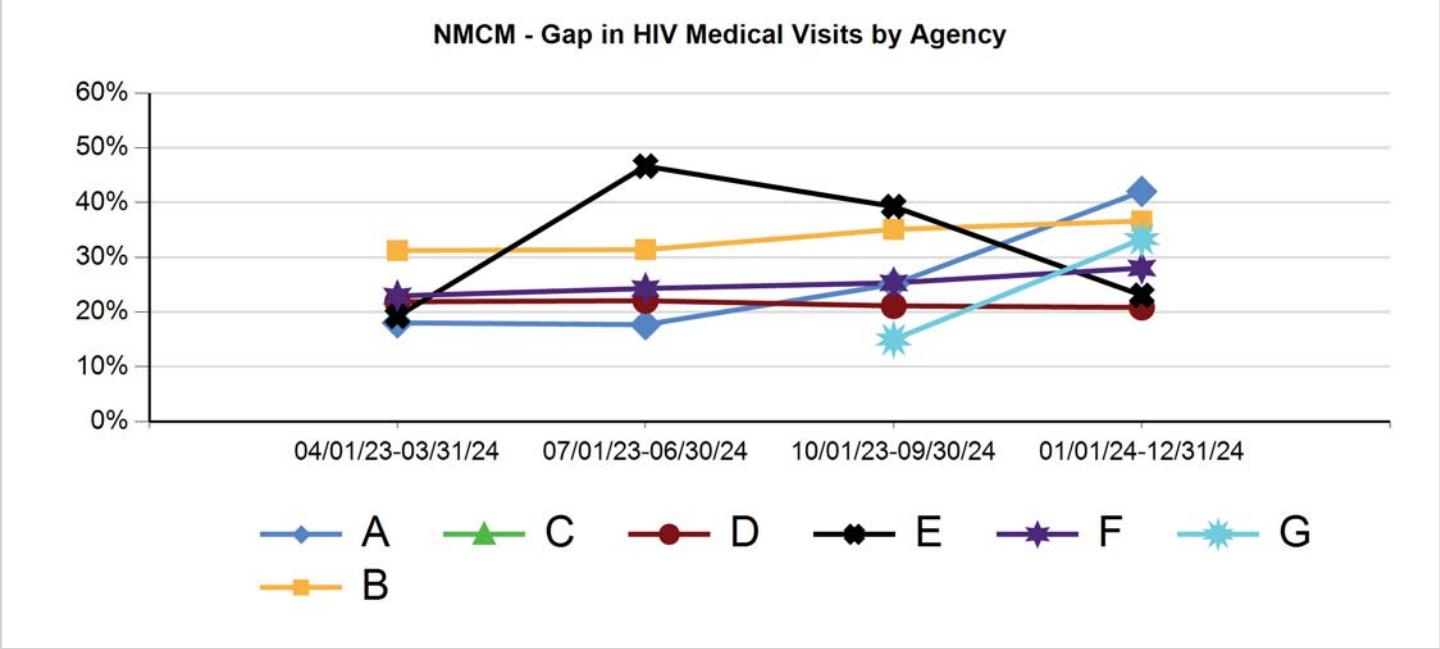
| NMCM - Gap in HIV Medical Visits | | | | |
|---|---|---|---|---|
| | 04/01/23 - 03/31/24 | 07/01/23 - 06/30/24 | 10/01/23 - 09/30/24 | 01/01/24 - 12/31/24 |
| Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year | 903 | 899 | 991 | 1,020 |
| 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% |



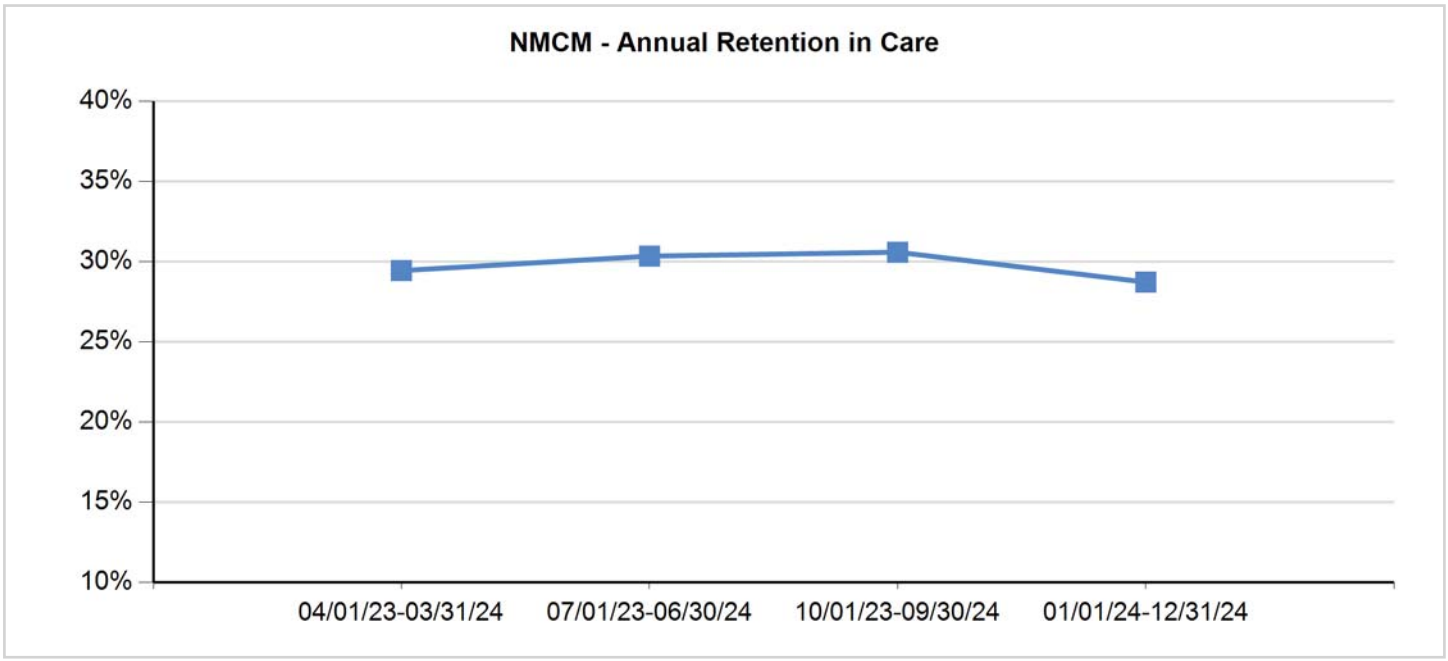
| NMCM - Gap in HIV Medical Visits by Race/Ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 07/01/23 - 06/30/24 | | | 10/01/23 - 09/30/24 | | | 01/01/24 - 12/31/24 | | |
| | Black | Hisp | White | Black | Hisp | White | Black | Hisp | White |
| Number of clients in the denominator 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% |



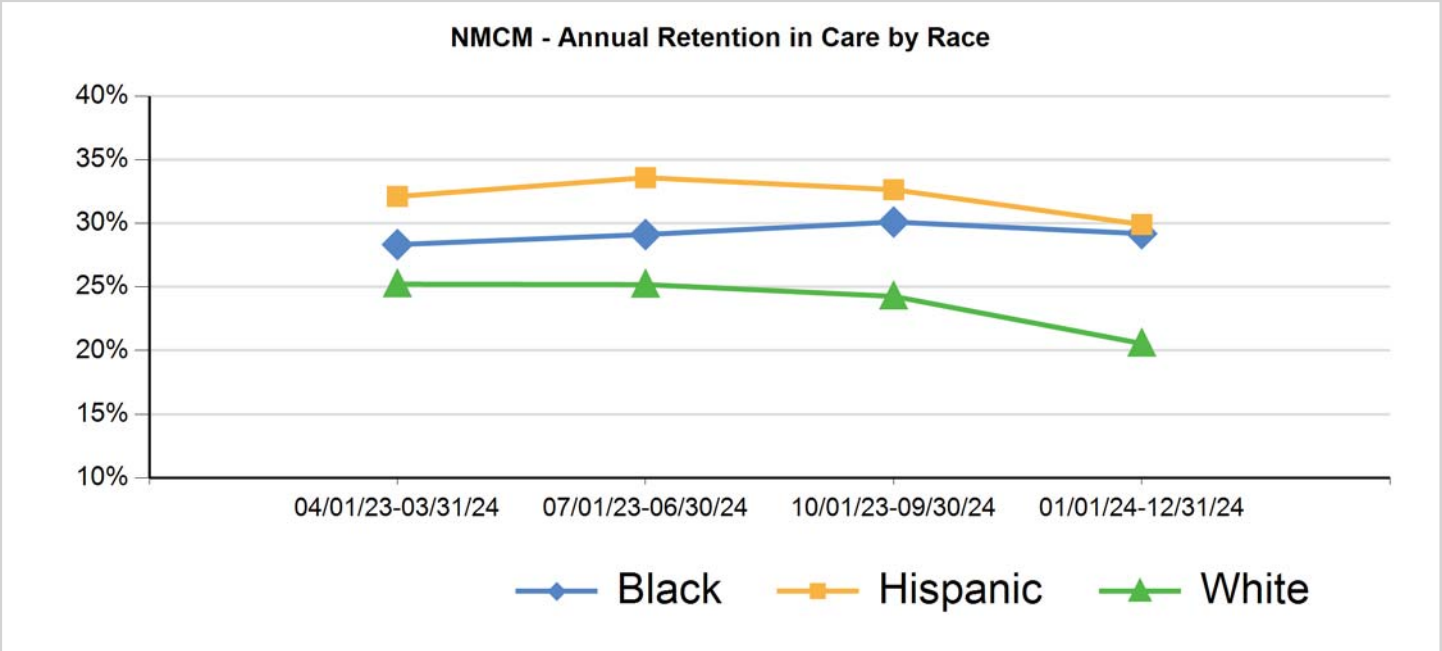
| NMCM - Gap in HIV Medical Visits by Agency | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10/01/23 - 09/30/24 | | | | | | | 01/01/24 - 12/31/24 | | | | | | |
| | A | B | C | D | E | F | G | A | B | C | D | E | F | G |
| Number of clients in the denominator 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% |



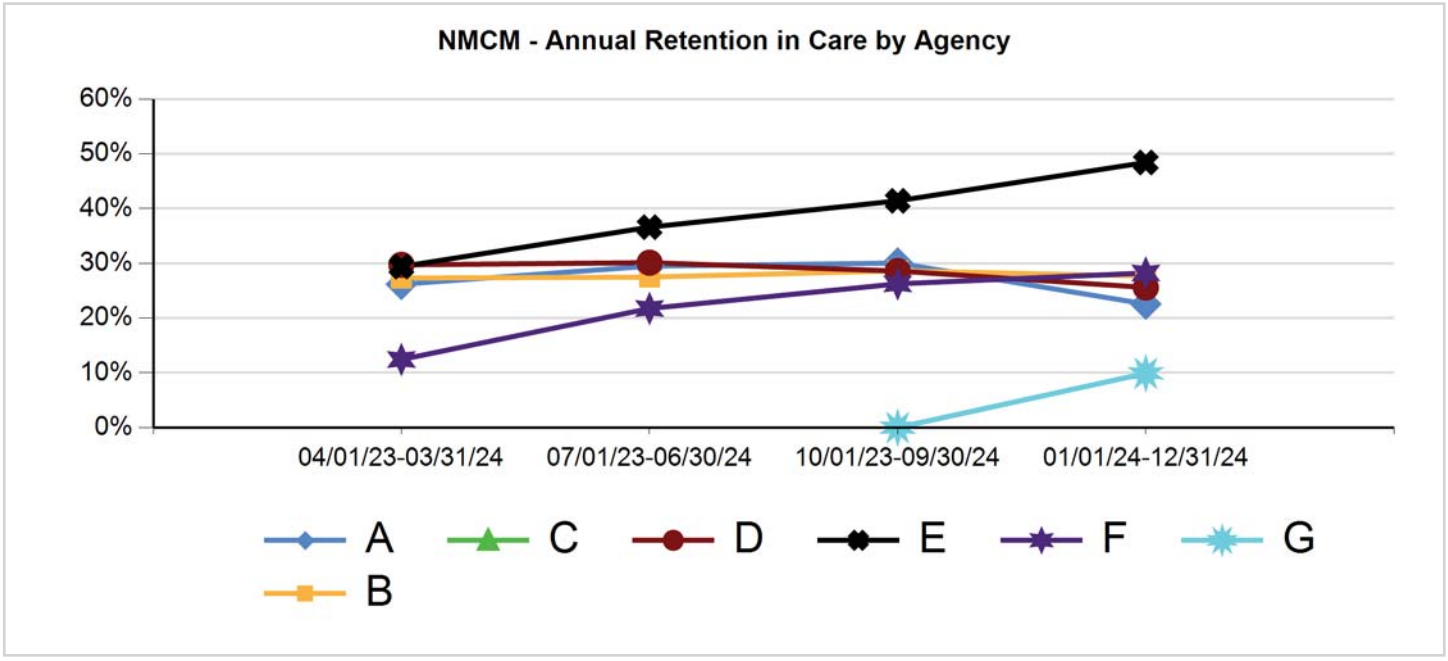
| NMCM - Annual Retention in Care | | | | |
|---|---|---|---|---|
| | 04/01/23 - 03/31/24 | 07/01/23 - 06/30/24 | 10/01/23 - 09/30/24 | 01/01/24 - 12/31/24 |
| Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year. | 2,184 | 2,228 | 2,186 | 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% |



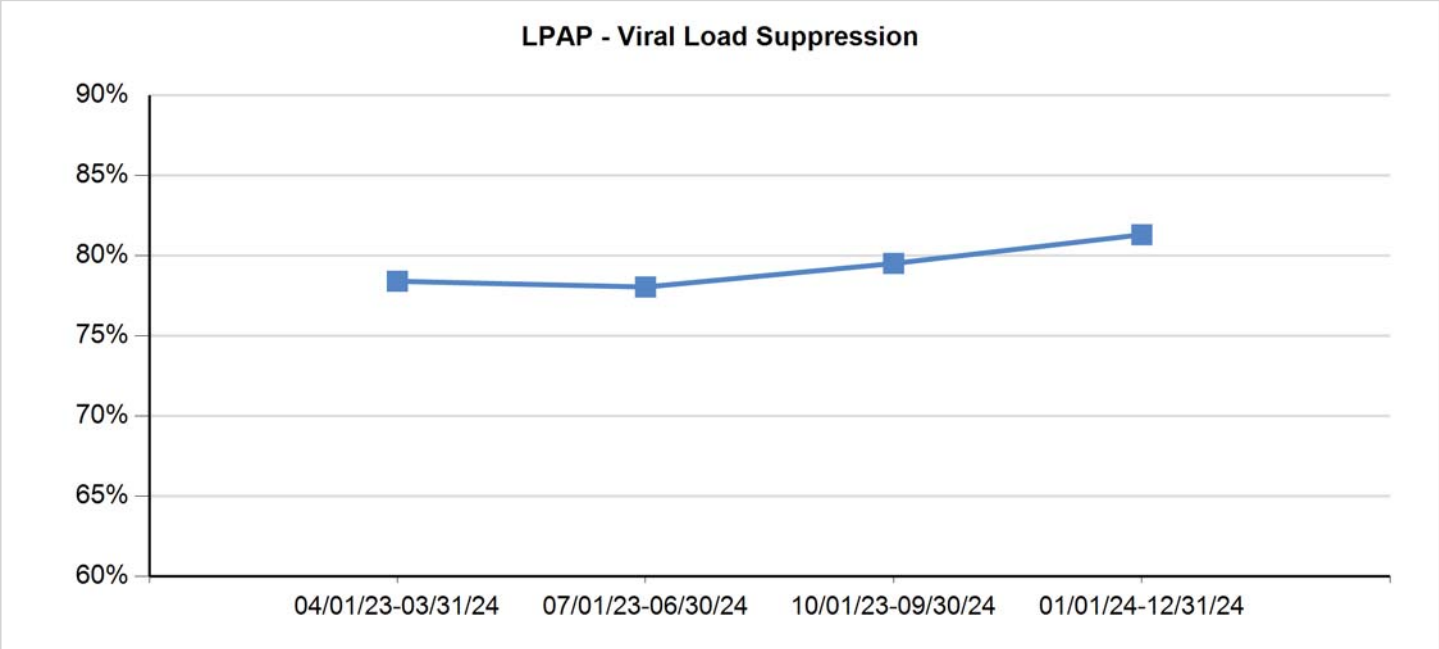
| NMCM - Annual Retention in Care by Race/Ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 07/01/23 - 06/30/24 | | | 10/01/23 - 09/30/24 | | | 01/01/24 - 12/31/24 | | |
| | Black | Hisp | White | Black | Hisp | White | Black | Hisp | White |
| Number of clients in the denominator 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% |



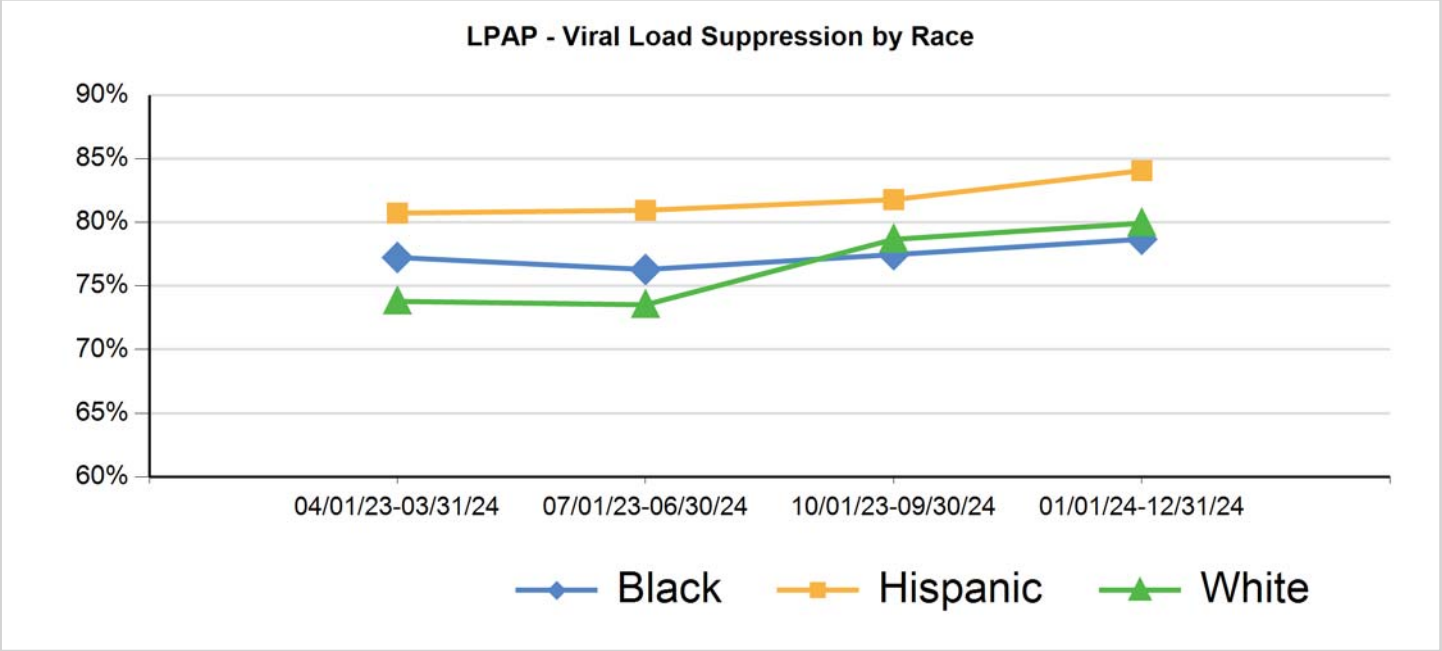
| NMCM - Annual Retention in Care by Agency | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10/01/23 - 09/30/24 | | | | | | | 01/01/24 - 12/31/24 | | | | | | |
| | A | B | C | D | E | F | G | A | B | C | D | E | F | G |
| Number of clients in the denominator 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% |

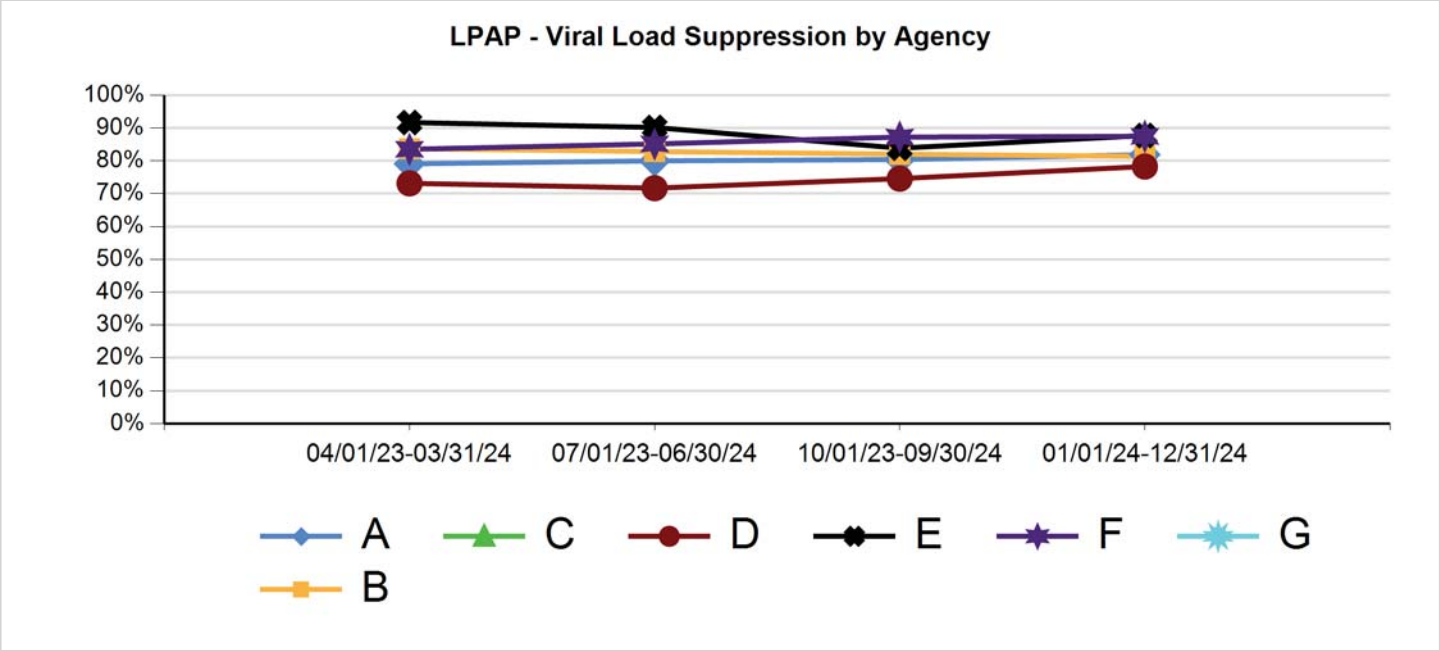


| LPAP - Viral Load Suppression by Race/Ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 07/01/23-06/30/24 | | | 10/01/23-09/30/24 | | | 01/01/24-12/31/24 | | |
| | Black | Hisp | White | Black | Hisp | White | Black | Hisp | White |
| Number of clients in the denominator with 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 |



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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 | Accountability<br>There is a system in place to document staff work time. | Accountability<br>There is a system in place to document staff time and effort commensurate to appropriate funding source. |
| General Standard 4.7b | | Client Eligibility (EHE Only)<br>In order to be eligible for services, individuals must meet the following:<br>• HIV+<br>• Payor of last resort |
| General Standard 4.9c | | Charges for Services (EHE Only)<br>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 | | **EHE Only:** Points of Entry (Primary Medical Care, Health Insurance Premium & Cost Sharing Assistance, Psychiatry, and Mental Health services only).<br>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 | -IS-200.C: Basic Incident Command System for Initial Response<br>-IS-700.B: An Introduction to the National Incident Management System | -IS-200.C: ICS for Single Resources and Initial Action Incidents<br>-IS-700.B: National Incident Management System, An Introduction |
| Case Management All 1.6 | Warm Handoff Procedure<br>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. | Warm Handoff Procedure<br>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. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| | **Non-Medical Case Management Services (Service Linkage Worker)** | **Non-Medical Case Management Services (Service Linkage Worker) (Part A & EHE Grants)** |
| SLW 1.1 | Minimum Qualifications<br>Service Linkage Worker – unlicensed community case manager<br>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.<br>Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish.<br>Agency will provide Service Linkage Worker a written job description upon hiring. | Minimum Qualifications<br>Service Linkage Worker – unlicensed community case manager:<br>Service linkage workers must have a minimum of 1-year work experience with PLWH, or a community health worker/patient navigator.<br>Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish.<br>Agency will provide Service Linkage Worker a written job description upon hire. |
| SLW 2.1b | | **EHE Only**: Client Eligibility – Service Linkage Workers targeted to Re-engagement in care and Newly Diagnosed<br><br>In addition to EHE criteria, individuals must meet the following in order to be eligible for non-medical case management services:<br>• 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.<br>• Newly diagnosed (within the last twelve (12) months) and not currently receiving outpatient HIV primary medical care services as documented in the CPCDMS<br>• Client retained-in-care but who are not virally suppressed as documented in the CPCDMS. |
| SLW 2.4b | | **(EHE Only):** Transfer of Not-in-Care and Newly Diagnosed Clients<br><br>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). |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | 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 | | **Geriatric Medical Case Management** |
| 4.1 | | **Criteria for Geriatric Medical Case Management**<br>Clients living with HIV/AIDS, ages 60 and older. |
| 4.2 | | Service Provisions Oriented to Geriatric Clients<br>• Provide support, education, and established goal-directed medical interventions to achieve optimal treatment outcomes and improve quality of life.<br>• Conduct comprehensive assessments to determine each client's level of need for medical case management and health literacy.<br>• Develop and implement a service plan for each client and provide an ongoing assessment of its efficacy.<br>• Monitor the service plan to ensure its implementation.<br>• Maintain regular contact with each client to monitor response to treatment and identify new needs.<br>• Coordinate access to medically appropriate levels of health and support services, including facilitating and coordinating services from one service provider to another.<br>• Coordinate and track referrals to internal and external services and programs.<br>• Provide or refer to a licensed medical provider assessment involving ADL abilities, cognitive functioning, vision, hearing, nutrition, fall prevention, incontinence, Osteoporosis, and medication contraindications.<br>• Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues.<br>• Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues.<br>• Provide benefits counseling by assisting clients in obtaining access to other public and private programs for which they may be eligible.<br>• Provide advocacy on behalf of clients.<br>• Provide emotional support on behalf of clients.<br>Provide liaison services with medical providers on behalf of the client. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| Emergency Financial Assistance (Prescriptions) – (Part A & EHE Grants) 1.1b | | EHE Only: Client Eligibility<br>• HIV+ |
| EFA 1.2b | | EHE ONLY: Timeliness of Service Provision<br>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.<br><br>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 | Medication Formulary<br>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. | Medication Formulary<br>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. |
| **Emergency Financial Assistance (Rental Assistance (EHE Grant Only)**<br><br>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 | | EFA-RA funds may be used on the following essential services:<br>• One-Time Rental Assistance, or<br>• Short-Term Rental Assistance for up to six (6) consecutive or non-consecutive months within a twelve (12) month period, or<br>• Payment of security deposits, utility deposits, |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | and application fees |
| 1.2 | | Client Eligibility<br>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:<br>• A significant increase in rent or bills<br>• A recent decrease in income<br>• High unexpected expenses on essential items<br>• The cost of their shelter is more than 30% of the household income<br>• They are unable to obtain credit necessary to provide for basic needs and shelter<br>• A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children<br>• Other emergency needs as deemed appropriate by the agency<br>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. |
| 1.3 | | Client Confidentiality<br>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. |
| 1.4 | | Assessment<br>The service linkage worker will complete RWGA-approved brief assessment tool on all clients and within five (5) working days of the client visit.<br>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.<br>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.<br>Emergent need must be documented each time funds are used. |
| 1.5 | | Documentation<br>Plans are developed jointly with the client and must include an approach to mitigate the need in the future. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | Client's chart contains documented plan for EFA that indicates emergent need, other resources pursued, and outcome of EFA provided. |
| 1.6 | | Timeliness of Service Provision<br>All completed requests for assistance shall be approved or denied within three (3) business days following the completed request. |
| **2.0** | **Agency Requirements** | |
| 2.1 | | Budget Requirements or Restrictions<br>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.<br>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 | Health Insurance Assistance | Health Insurance Premium and Cost Sharing Assistance (Part A & EHE) |
| **New Service** | **Home Delivered Meals (Part A Only** | |
| **1.0** | | **Services are individualized and tailored to client needs.** |
| 1.1 | | Eligibility<br>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 | | Culturally Competent |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | 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.<br><br>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. |
| **2.0** | | **Services adhere to professional standards and regulations.** |
| 2.1 | | Referrals and Consultation<br>The prepared meals should be nutritious and individualized to client's dietary needs, and shall be based on current federal dietary guidelines (Dietary Guidelines for Americans, 2020-2025 and Online Materials \| Dietary Guidelines for Americans).<br><br>All meal plans must be reviewed and approved by a registered dietician.<br><br>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.<br><br>Consultation should be done on an annual basis and must be documented. |
| 2.2 | | Regulations<br>Subrecipient shall comply with local, state, and federal food safety, sanitization, and safety regulations. |
| 2.3 | | Licensure<br>Subrecipient shall comply with the USDA Department of Agriculture food handling guidelines.<br><br>Staff members packaging bulk foods shall have current and valid food handling permits or license. |
| 2.4 | | Inspections<br>Subrecipient shall maintain and show evidence that all required inspections are current and resulted in acceptable findings. |
| 2.5 | | Facility<br>Subrecipient shall provide adequate space and equipment to store food in a sanitary manner. |
| 2.6 | | Procurement |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | Subrecipient shall comply with procedures for purchasing, receiving, sorting, issuing, preparing, and service of safe food and beverage products. |
| 2.7 | | New Staff Training<br>All new staff members shall attend educational seminars regarding food safety within three months of hire and annually thereafter. |
| **3.0** | | **Food Processing & Delivery** |
| 3.1 | | Condition of Food Items<br>• All milk and cheese products shall have the word pasteurized on the label.<br>• Fresh food such as bread shall be free of any mold.<br>• Fruits and vegetables shall be free from insects and mold.<br>• All packaged products shall be labeled properly, and within the expiration period as stated on the product in accordance with FDA regulations.<br>Frozen foods shall be packaged, kept completely frozen and stored in a proper freezer at 0° Fahrenheit or below. |
| 3.2 | | Delivery vehicle and driver<br>• Vehicle will be insured.<br>Driver will be free of past moving violations. |
| 3.3 | | Delivery of meals<br>• Delivered timely at proper temperature.<br>• Delivery must be directly to client or authorized representative. |
| **4.0** | | **Client Eligibility** |
| **5.0** | | Client Screening<br>• Agencies shall ensure that clients have exhausted access through other funding sources prior to issuing a food voucher.<br>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 | | **Discharge** |
| 5.2 | | Clients may be discharged from home delivered meals services when the client:<br>• Has achieved all goals listed in the Nutritional Care Plan<br>• Has become ineligible for services<br>• Has relocated out of the service area<br>• Is incarcerated<br>• Is deceased<br>• Decides to discontinue services<br>• Is found to be improperly utilizing the service and/or is asked to leave the agency. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | 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** | **Legal Assistance - Expungement of Criminal Record (Part A Only)** | |
| **1.0** | | **Services are part of the coordinated continuum of HIV/AIDS services.** |
| 1.1 | | Clients Referral and Tracking<br>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 | | Licensure<br>Attorneys are licensed to practice law in the state of Texas and have a minimum educational level of a doctorate in Jurisprudence. |
| 2.2 | | Non-Licensed Staff<br>Non-licensed staff members are supervised by attorneys. |
| **3.0** | | **Service providers are knowledgeable, accepting and respectful of the needs of people living with HIV/AIDS.** |
| 3.1 | | Ongoing Staff Training<br>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.<br>Agency paid legal staff and contractors must complete two (2) hours of HIV-specific training annually.<br>New agency paid legal staff and contractors must complete two (2) hours of HIV-specific training within 90 days of start date.<br>Volunteer legal staffs are encouraged to complete HIV-specific legal training. |
| **4.0** | | **Client is kept informed and participates in decisions about his/her case.** |
| 4.1 | | Service Agreement<br>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 | | Case Closure<br>Agency will develop case closure criteria and procedures.<br>Cases may be closed when the client's legal record is expunged, or when the client:<br>• is determined to be ineligible for criminal expungement<br>• has had no direct program contact for over six months |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | • is deceased<br>• no longer needs the service<br>• discontinues the service<br>• improperly utilizes the service<br>• has not complied with the client services agreement<br>Agency will attempt to notify clients about case closure. |
| **Local Pharmacy Assistance Program (Part A Grant Only)** | | |
| LPAP 1.3 | LPAP Medication Formulary<br>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. | LPAP Medication Formulary<br>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 | Ongoing Training<br>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. | Ongoing Training<br>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. |
| **Medical Nutritional Therapy/Supplements (Part A Grant Only)** | | |
| 2.1 | Nutritional Supplement Formulary<br>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. | Nutritional Supplement Formulary<br>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** | **Mental Health Services (EHE Grant Only)** | |
| **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 | | Minimum Qualifications<br>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) |
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| | | licensed by the State of Texas. |
| 1.2 | | Licensing, Knowledge, Skills and Experience<br>All staff maintain current organizational licensure (and/or applicable certification) and professional licensure.<br>• 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.<br>• Physician extenders must obtain this experience within six months of hire.<br>• All staff receive professional supervision.<br>Staff show training and/or experience with the medical care of adults living with HIV. |
| 1.3 | | Mental Health Services<br>Outpatient mental health therapy and counseling services provided solely by Mental Health Practitioners licensed in the State of Texas includes:<br>• Mental Health Assessment<br>• Treatment Planning<br>• Treatment Provision<br>• Individual psychotherapy<br>• Psychotropic medication assessment, prescription, and monitoring (physician, midlevel provider, and psychiatrist only)<br>• Psychotropic medication management (physician, midlevel provider, psychiatrist, or Doctor of Pharmacy (PharmD only)<br>• Emergency/Crisis Intervention<br>Mental health services can be delivered via telehealth, subject to federal guidelines, Texas State law, and DSHS policy.<br><br>Individual psychotherapy is defined as 1:1 counseling or family-based crisis intervention provided by a licensed mental health practitioner. |
| 1.4 | | Mental Health Assessment<br>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:<br>• Presenting problem(s)<br>• Completed mental status evaluation<br>• Cognitive assessment<br>• Current risk of danger to self and others<br>• Living situation<br>• Social support and family relationships, including client strengths<br>• and challenges, coping mechanisms, and self-help strategies |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| | | • Medical history<br>• Current medications<br>• Substance use history<br>• Psychosocial history, which may include:<br>o Education and employment history, including military<br>o service<br>o Sexual and relationship history and status<br>o Physical, emotional, or sexual abuse history<br>o Domestic violence assessment<br>o Trauma assessment<br>o Legal history<br>o Leisure and recreational activities<br>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. |
| 1.5 | | Treatment Plan and Services<br>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.<br><br>The treatment plan should include:<br>Diagnosed mental health issue(s)<br>Goals and objectives of treatment<br>Treatment type (individual, group)<br>Start date for mental health services<br>Recommended number of sessions (up to three (3) sessions)<br>Any recommendations for follow up<br><br>Treatment should include counseling regarding the following, as clinically appropriate:<br>Healthy behaviors and health promotion<br>Substance use disorder<br>Treatment adherence<br>Development of social support systems<br>Community resources<br>Maximizing social and adaptive functioning<br>The role of spirituality and religion in a client's life, health, and future goals<br><br>The mental health professional must sign the |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | 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:<br>• Client name<br>• Session date<br>• Focus of the session<br>• Interventions<br>• Progress on treatment goals<br>• Newly identified issues or goals<br>• Counselor signature and authentication (credentials)<br>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. |
| 1.6 | | Psychiatric Referral<br>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. |
| 1.7 | | Psychotropic Medication Management<br>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.<br><br>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.<br><br>Mental health providers with prescriptive authority will follow all regulations required for prescribing psychoactive medications, as outlined by the Texas Administrative Code, Title 25, Part1, Chapter 415, Subchapter A, Rule 415.10 |
| 1.8 | | Coordination of Care<br>Providers should coordinate care across the mental health team. Agencies should ensure the client is involved in all decision-making, including whether |

| Location | 2024-2025 (old) | 2025-2026 (new) |
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| | | 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 | | Referrals<br>As needed, mental health providers should refer clients to a full range of medical and mental health services, including:<br>• Psychiatric evaluation<br>• Pharmacist for psychotropic medication management<br>• Neuropsychological testing<br>• Day treatment programs<br>• In-patient hospitalization<br>Family or couples therapy |
| 1.10 | | Discharge Planning<br>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:<br>• Circumstances of discharge<br>• Summary of needs at admission<br>• Summary of services provided<br>• Goals and objectives completed during counseling<br>• Discharge plan<br>• Signature of provider<br>• Counselor authentication, in accordance with current licensure<br>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) |
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| | | 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. |
| Outreach 1.6 | • Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff. | • Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff.<br>• Documentation of warm handoff in the client record. |
| Outreach 2.2 | Eligibility Criteria for Outreach<br>Eligibility for outreach will vary and is specific to each agency. Criteria can include, but is not limited to clients:<br>Cusp of Falling Out of Care Clients:<br>• Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks.<br>• Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks.<br>• Clients who have not been seen in 4 months by their primary care provider; and/or<br>• Three missed appointments in past 12 months (do not have to be consecutive).<br>Lost-to-Care Clients:<br>• (HRSA) Lost to care definition<br>Newly Diagnosed Clients:<br>• Applies to clients with a diagnosis within the last 12 months but have not engaged in care.<br>• Clients who have not been seen in 4 months by their primary care provider; and/or:<br>• Three missed appointments in the past 12 months(do not have to be consecutive). | Eligibility Criteria for Outreach<br>Eligibility for outreach will vary and is specific to each agency. Criteria must include:<br>Cusp of Falling Out of Care Clients:<br>• Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks.<br>• Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks.<br>• Clients who have not been seen in 4 months by their primary care provider; and/or<br>• Three missed appointments in past 12 months (do not have to be consecutive).<br>Lost-to-Care Clients:<br>• (HRSA) Lost to care definition<br>Newly Diagnosed Clients:<br>• Applies to clients with a diagnosis within the last 12 months but have not engaged in care. |
| **New Service** | **Outreach and Community Engagement Services (EHE Only)** | |
| | 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. | |
| **1.0** | | **Staff Training** |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| 1.1 | | Minimum/Qualifications<br>Minimum Qualifications – High School Diploma or GED.<br>Six months of working with or volunteering with PLWH. |
| 1.2 | | Scope of Services<br>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. |
| 1.3 | | Ongoing Education/Training for Outreach and Community engagement Workers<br>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.<br><br>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. |
| 1.4 | | Outreach Brief Intervention<br>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 ***brief intervention*** with the client.<br><br>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. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| 1.5 | | Documentation and Reporting<br>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 | | Warm Handoff Procedure<br>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** | | **Timeliness of Service/Documentation** |
| 2.1 | | Progress Notes<br>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 | | Eligibility Criteria for Outreach and Community Engagement Activities<br>Eligibility for Outreach and Community Engagement will vary and is specific to each agency. Criteria m u s t include:<br>• 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<br>• Promoting rapid start services and other EHE programs through distribution of promotional materials within the Houston EMA<br>• 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<br>Provide navigation support for those newly diagnosed or identified as a Person living with HIV(PLWH) who is not in care |
| **Primary Medical Care (Part A & EHE Grants)** | | |
| PCARE 1.3 | Peer Review<br>Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e., MD, NP, PA). | Peer Review<br>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 | Adherence Assessment<br>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. | Adherence Assessment<br>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. |
| PCARE 1.19 | Intimate Partner Violence Screening Policy<br>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:<br>Process for ensuring clients are screened for IPV no less than annually<br>Intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management.<br>State reporting requirements associated with IPV.<br>Description of required medical record documentation.<br>Procedures for patient referral including available resources, procedures for follow-up and responsible personnel.<br>Plan for training all appropriate staff (including non-RW funded staff) | Intimate Partner Violence Screening Policy<br>The agency must have in place a written policy and procedure regarding client.<br>Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address:<br>• 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.).<br>• Intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management.<br>• State reporting requirements associated with IPV.<br>• Description of required medical record documentation.<br>• Procedures for patient referral including available resources, procedures for follow-up and responsible personnel.<br>Plan for training all appropriate staff (including non-RW funded staff) |
| **NEW SERVICE** | **Psychiatry (EHE Grant Only)** | |
| | 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. | |
| **1.0** | | **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.** |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| 1.1 | | Minimum Qualifications<br>Psychiatric care for persons living with HIV shall be provided by MD, DO, NP, CNS or PA licensed in the State of Texas. |
| 1.2 | | Licensing, Knowledge, Skills and Experience<br>• All staff maintain current organizational licensure (and/or applicable certification) and professional licensure.<br>• The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc.<br>• Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org):<br>• Clinical management of at least 25 people living with HIV patients within the last year.<br>• 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.<br>• Physician extenders must obtain this experience within six months of hire.<br>• All staff receive professional supervision.<br>Staff show training and/or experience with the medical care of adults living with HIV. |
| 1.3 | | Psychiatric Guidelines<br>Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including:<br>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. |
| 1.4 | | Psychiatric Services<br>• 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.<br>• 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) |
|---|---|---|
| | | • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.<br>• 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.<br>• Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. |
| 1.5 | | Staff Requirements<br>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. |
| 1.6 | | Special Requirements<br>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. |
| | **Ride Share Services (EHE Grant Only)** | |
| | 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 | | Ride Share Guidelines<br>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.<br>This form of transportation can be provided to any HIV-related Core Medical and Support service appointments, specifically:<br>• Rapid Start Appointment<br>• Rapid Start Medication Pick-up<br>• RWA medical appointment<br>• Eligibility appointment<br>• RW Pharmacy (Refills)<br>• Mental health<br>• Case management<br>• Dental Visit<br>• Psychosocial Support<br>• Grocery/Food bank<br>• Job support (Work source etc.)<br>• Job interview<br>• Housing Support<br>• Rehabilitation Services<br>• Other<br>*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. |
| **2.0** | | **Accessibility: Ride Share services are offered in such a way as to overcome barriers to access and utilization.** |
| 2.1 | | Notification of Service Availability<br>Prospective and current clients are informed of service availability, prioritization, and eligibility requirements. |
| 2.2 | | Access<br>Clients must notify their agency's point of contact of their need for ride share to/ from their appointment.<br>Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle.<br>This statement should include the consequences of violating the agreement. |
| 2.3 | | HSDA Accessibility<br>Services are available throughout the Houston/Galveston HSDAs as contractually defined in the RFP. |
| 2.4 | | Service Availability<br>The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| | | coverage must be available for medical and health-related appointments on Saturdays. |
| 2.5 | | Service Capacity<br>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 | | Timeliness<br>There is a maximum waiting time for ride share; appointments are kept<br>• Waiting times longer than 20 minutes will also be documented in the client record<br>• 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 | | Immediate Service Problems<br>Clients are made aware of problems immediately (e.g., vehicle breakdown) and notification documented. |
| 3.3 | | Future Service Delays<br>Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur. |
| 3.4 | | Confirmation of Appointments<br>Agency must allow clients to confirm appointments at least 48 hours in advance. |
| 3.5 | | "No Shows"<br>"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 | | System Abuse<br>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.<br>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.<br>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 | | Client Incidents<br>If an agency is charged a cleaning fee due to an incident resulting from a client's action, the fee is reimbursable. |
| 3.8 | | Documentation of Service Utilization<br>• Transportation Provider must ensure:<br>• Requested via the Lyft platform<br>• Record of service entered into CPCDMS<br>• Scheduling of transportation services by scheduling agency's point of contact<br><br>The content of the proof of service will include:<br>• Requesting agency<br>• Pick-up and drop-off date/time<br>• Pick up and drop off address<br>• CPCDMS client code<br>Name of agency's staff who requested the ride |
| **4.0** | | **Records Administration: Ride Share services are documented consistently and appropriately** |
| 4.1 | | Transportation Consent<br>Prior to receiving transportation services, clients must read and sign the Ride Share Consent. |
| 4.2 | | Ride Share<br>Agency must ensure documentation in Lyft for Business is accurate and includes the clients CPCDMS Client Code |
| **NEW SERVICE** | **Transitional Housing - Temporary Assisted Living** | |
| | 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).<br>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. | |
| **1.0** | | **Service Specific Requirements** |
| 1.1 | | 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:<br>• Room and daily nutritious meals and snacks,<br>• 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) |
|---|---|---|
| | | with attending physician(s) and personal care team<br>• Other Therapeutic Services including physical and occupational therapies. |
| 1.2 | | Patient Medication Education Services must adhere to the following requirements:<br>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. |
| **2.0** | | **Staff Requirements** |
| 2.1 | | Staff must have all required federal, state and local licensure, certifications, permits and must comply with local, state, and federal regulations.<br><br>The contractor is responsible for ensuring that services are provided by State licensed MDs, NPs, PAs, RNs, LVNs, social workers, and pharmacists. |
| 2.2 | | 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. |
| **3.0** | | **Facility Requirements** |
| 3.1 | | Facility must have all required federal, state and local licenses, certifications and permits and must comply with local, state, and federal regulations. |
| **4.0** | | **Client Eligibility and Referral** |
| 4.1 | | Eligibility:<br>• Client must receive referral for service from an MD, NP, or PA.<br>• 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.<br><br>Client must enter the facility within 30 days of discharge from a hospital. |
| | | 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. |
| **5.0** | | **Initial Assessment and Care Plan** |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| 5.1 | | A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care.<br>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. |
| 5.2 | | Comprehensive Assessment<br>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.<br>A comprehensive evaluation of the PLWH's health, psychosocial status, functional status, and home environment should be completed to include:<br>• Assessment of PLWH's access to primary care<br>• adherence to therapies, disease progression, symptom management and prevention<br>• need for skilled nursing or rehabilitation services.<br>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. |
| 5.3 | | Plan of Care<br>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. |
| 5.4 | | Implementation of Care Plan<br>In coordination with the medical care coordination team, professional staff will:<br>• Provide nursing and rehabilitation therapy care under the supervision and orders of the client's referring provider.<br>• 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.<br>• Monitor changes in client's physical health and level of functionality.<br>• 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.<br>• Participate in the development of individualized care plan with members of the care team.<br>• Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| | | • Provide attendant care services which include taking vital signs if medically indicated<br>• Assist with client's self-administration of medication.<br>• Promptly report any problems or questions regarding the client's adherence to medication.<br>• Report any changes in the client's condition and needs.<br>• Current assessment and needs of the client, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities)<br>• Need for home and community-based health services.<br>• Types, quantity and length of time services are to be provided. |
| 5.5 | | <u>Provision of Services/ Progress Notes</u><br>Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of housing – temporary assisted living services.<br>• Progress notes will be kept in the client's primary service record and must be written the day services are rendered.<br>• Progress notes will then be entered into the client record within (5) working days.<br>• The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines.<br>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. |
| **6.0** | | **Billing Requirements** |
| 6.1 | | Agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payers. |
| | | <u>Restrictions</u><br>• Housing activities cannot be in the form of direct cash payments to clients.<br>Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services. |
| **7.0** | | **Discharge** |
| 7.1 | | Services will end when one or more of the following takes place:<br>• Referral period ends or thirty (days) pass without additional referral and approved waiver.<br>• Client acuity indicates self-sufficiency and care plan goals completed.<br>• Client expresses desire to discontinue/transfer services. |

| Location | 2024-2025 (old) | 2025-2026 (new) |
|---|---|---|
| | | • Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility)<br>• Client is unable or unwilling to adhere to Care Plan.<br>• Client is unable or unwilling to adhere to agency policies.<br>• PLWH relocates out of the service delivery area<br>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. |
| 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. |
| | **Transportation Services (Part A Grant Only)** | |
| TRANS 1.1 | • Income no greater than 300% of the Federal Poverty level | • Income no greater than 500% of the Federal Poverty level |
| TRANS 1.2 | Voucher Guidelines (Distribution Sites)<br>• 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.<br>• 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.<br>➢ In order 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 | Voucher Guidelines (Distribution Sites)<br>• Bus Card Voucher (Renewal): 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.<br>• 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.<br>➢ 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<br><br>This has been added to the MEASURE section.<br>• **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.harriscountytx.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-engagment-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

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

| | | |
|---|---|---|
| ___ | Current HIV Comprehensive Plan (Year:_____) | Page(s): ___Paragraph: ___ |
| ___ | Health Outcome Results: Date: _____ | Page(s): ___Paragraph: ___ |
| ___ | Other Ryan White Planning Document: | |
| | Name & Date of Document: _____ | Page(s): ___Paragraph: ___ |

RECOMMENDATION OF QUALITY IMPROVEMENT COMMITTEE:
___ Recommended ___ Not Recommended ___ Sent to How To Best Meet Need

REASON FOR RECOMMENDATION:

(Continue on Page 3 of this application form)

**REVISED DRAFT**

# 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**:

- 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.Aguilles

# Houston Ryan White Health Insurance Assistance Service Utilization Report

**Period Reported:** 09/01/2024-12/31/2024

**Revised:** 1/23/2025

| | Assisted | | | NOT Assisted | | |
|---|---|---|---|---|---|---|
| Request by Type | Number of Requests (UOS) | *Dollar Amount of Requests* | Number of Clients (UDC) | *Number of Requests (UOS)* | *Dollar Amount of Requests* | *Number of Clients (UDC)* |
| Medical Co-Payment | 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.**

# Priority and Allocations
# FY 2026 Guiding Principles and Decision Making Criteria

(Council approved _____)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Texas Department of State Health Services (TDSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort.** Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV. Decisions will address at least one or more of the following principles **and** criteria.

*Principles are the standards* **guiding the discussion** *of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

**Principles**

A. Ensure ongoing client access to a comprehensive system of core services as defined by HRSA
B. Eliminate barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
C. Meet the needs of diverse populations as addressed by the epidemiology of HIV
D. Identify individuals newly aware of their status and link them to care. Address the needs of those that are aware of their status and not in care.

Allocations only

E. Document or demonstrate cost-effectiveness of services and minimization of duplication
F. Consider the availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies
G. Reduce the time period between diagnosis and entry into HIV medical care to facilitate timely linkage.

*Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.*

(Continued)

**DECISION MAKING CRITERIA STEP 1:**

A. Documented service need with consumer perspectives as a primary consideration
B. Documented effectiveness of services with a high level of benefit to people and families living with HIV, including quality, cost, and outcome measures when applicable
C. Documented response to the epidemiology of HIV in the EMA and HSDA
D. Documented response to emerging needs reflecting the changing local epidemiology of HIV while maintaining services to those who have relied upon Ryan White funded services.
E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
F. Documented consistency with the current Houston Area Integrated HIV Prevention and Care Services Plan, the Continuum of Care, the National HIV/AIDS Strategy, the Texas HIV Plan and their underlying principles to the extent allowable under the Ryan White Program to:
    - build public support for HIV services;
    - inform people of their serostatus and, if they test positive, get them into care;
    - help people living with HIV improve their health status and quality of life and prevent the progression of HIV;
    - help reduce the risk of transmission; and
    - help people with advanced HIV improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

**DECISION MAKING CRITERIA STEP 2:**

A. Services have a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
B. Services are accessible to all people living with or affected by HIV, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).
D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
F. Services are available to meet the needs of all people living with HIV and families, as applicable under Part A and B guidelines
G. Services meet or exceed standards of care
H. Services reflect latest medical advances, when appropriate
I. Services meet a documented need that is not fully supported through other funding streams

**PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS. All decisions are expected to address needs of the overall community affected by the epidemic.**

# DRAFT
# FY 2026 Priority Setting Process

(Priority and Allocations Committee approved 02-28-25)

**IMPORTANT: HRSA RW Part A Manual requires that "all RWHAB core medical and support services must be prioritized annually." RWHAP 2023 Part A Manual, page 33.**

1. Agree on the priority-setting process.
2. Agree on the principles to be used in the decision making process.
3. Agree on the criteria to be used in the decision making process.
4. Agree on the process to be used to determine service categories that will be considered for allocations. (This is done at a joint meeting of members of the Quality Improvement, Priority and Allocations and Affected Community Committees and others, or in other manner agreed upon by the Planning Council).
5. Staff creates an information binder containing documents to be used in the Priority and Allocations Committee decision-making processes. The binder will be available at all committee meetings and copies will be made available upon request.
6. Committee members attend a training session to review the documents contained in the information binder and hear presentations from representatives of other funding sources such as HOPWA, Prevention, Medicaid and others.
7. Staff prepares a table that lists services that received an allocation from Part A or B or State Service funding in the current fiscal year. The table lists each service category by HRSA-defined core/non-core category, need, use and accessibility and includes a score for each of these items. The utilization data is obtained from calendar year CPCDMS data. The medians of the scores are used as guides to create midpoints for the need of HRSA-defined core and non-core services. Then, each service is compared against the midpoint and ranked as equal or higher (H) or lower (L) than the midpoint.
8. The committee meets to do the following. This step occurs at a single meeting:
    - Review documentation not included in the binder described above.
    - Review and adjust the midpoint scores.
    - After the midpoint scores have been agreed upon by the committee, **public comment** is received.
    - During this same meeting, the midpoint scores are again reviewed and agreed upon, taking public comment into consideration.
    - Ties are broken by using the first non-tied ranking. If all rankings are tied, use independent data that confirms usage from CPCDMS or TCT (Take Charge Texas).
    - By matching the rankings to the template, a numerical listing of services is established.
    - Justification for ranking categories is denoted by listing principles and criteria.
    - Categories that are not justified are removed from **tier #1 (Ryan White justified core services) and tier #2 (Ryan White justified non-core service) rankings and moved to a third and fourth tier where they are ranked separately.**
    - If a committee member suggests moving a priority more than five places from the previous year's ranking, this automatically prompts discussion and is challenged; any other category that has changed by three places may be challenged; any category that moves less than three places cannot be challenged unless documentation can be shown (not cited) why it should change.
    - The Committee votes upon all challenged categorical rankings.

(Continued on next page)

- At the end of challenges, the entire ranking is approved or rejected by the committee.

9. At a separate meeting, the Priority and Allocations Committee goes through the allocations process.
10. The complete list of recommended priorities is presented at a Public Hearing.
11. The committee meets to review public comment and possibly revise the recommended priorities.
12. At the end of the How To Best Meet the Need, prioritization and allocations processes, staff removes services from the priority list that are not included on the list of services recommended to receive an allocation from Part A or B or State Service funding. The priority numbers are adjusted upward to fill in the gaps left by services removed from the list.
13. Once this is done, the committee recommended single list of priorities is forwarded as the priority list of services for the following year.

# 2025 Policy for Addressing Unobligated and Carryover Funds

(Council approved _____ )

**Background**

The Ryan White Planning Council must address two different types of money: Unobligated and Carryover.

**Unobligated** funds are funds allocated by the Council but, for a variety of reasons, are not put into contracts. Or, the funds are put into a contract but the money is not spent. For example, the Council allocates $700,000 for a particular service category. Three agencies bid for a total of $400,000. The remaining $300,000 becomes unobligated. Or, an agency is awarded a contract for a certain amount of money. Halfway through the grant year, the building where the agency is housed must undergo extensive remodeling prohibiting the agency from providing services for several months. As the agency is unable to deliver services for a portion of the year, it is unable to fully expend all of the funds in the contract. Therefore, these unspent funds become unobligated. The Council is informed of unobligated funds via Procurement Reports provided to the Quality Improvement (QI) and Priority and Allocations (P&A) Committees by the respective Administrative Agencies (AA), HCPH/Ryan White Grant Administration and The Resource Group.

**Carryover** funds are the RW Part A Formula and MAI funds that were unspent in the previous year. Annually, in October, the Part A Administrative Agency will provide the Committee with the estimated total allowable Part A and MAI carryover funds that could be carried over under the Unobligated Balances (UOB) provisions of the Ryan White Treatment Extension Act. The Committee will allocate the estimated amount of possible unspent prior year Part A and MAI funds so the Part A AA can submit a carryover waiver request to HRSA in December.

The Texas Department of State Health Services (TDSHS) does not allow carryover requests for unspent Ryan White Part B and State Services funds.

It is also important to understand the following applicable rules when discussing funds:

1.) **10% Rule:** The Administrative Agencies are allowed to move up to 10% of unobligated funds from one service category to another. The 10% rule applies to the amount being moved from one category and the amount being moved into the other category. For example, 10% of an $800,000 service category is $80,000. If a $500,000 category needs the money, the Administrative Agent is only allowed to move 10%, or $50,000 into the receiving category, leaving $30,000 unobligated.

2.) **Procurement Rules**, it is difficult to RFP funds after the mid-point of any given fiscal year.

In the final quarter of the applicable grant year, after implementing the Council-approved October reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, the AA may reallocate any remaining unspent funds as necessary to ensure the Houston EMA/HSDA has less than 5% unspent Formula funds and no unspent Supplemental funds. The AA for Part B and *State Services* funding may do the same to ensure no funds are returned to the Texas Department of State Health Services (TDSHS). The applicable AA must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting.

**Recommendations for Addressing Unobligated and Carryover Funds:**

1.) **Requests from Currently Funded Agencies Requesting an Increase in Funds in Service Categories where the Agency Currently Has a Contract:** These requests come at designated times during the year.

A.) In response, the AA will provide funded agencies a standard form to document the request (see attached). The AA will state the amount currently allocated to the service category, state the amount being requested, and state if there are eligible entities in the service category. This form is known as a ***Request for Service Category Increase***. The AA will also provide a Summary Sheet listing all requests that are eligible for an increase (e.g. agency is in good standing).

The AA must submit this information to the Office of Support in an appropriate time for document distribution for the April, July and October P&A Committee meetings. The form must be submitted for all requests regardless of the completeness of the request. The AA for Part B and State Services Funding will do the same, but the calendar for the Part B AA to submit the Requests for Service Category Increases to the Office of Support is based upon the current Letter of Agreement. The P&A Committee has the authority to recommend increasing the service category funding allocation, or not. If not, the request "dies" in committee.

2.) **Requests for Proposed Ideas:** These requests can come from any individual or agency at any time of the year. Usually, they are also addressed using unobligated funds. The individual or agency submits the idea and supporting documentation to the Office of Support. The Office of Support will submit the form(s) as an agenda item at the next QI Committee meeting for informational purposes only, the Office of Support will inform the Committee of the number of incomplete or late requests submitted and the service categories referenced in these requests. The Office of Support will also notify the person submitting the Proposed Idea form of the date and time of the first committee meeting where the request will be reviewed. All committees will follow the RWPC bylaws, policies, and procedures in responding to an "emergency" request.

**Response to Requests:** Although requests will be accepted at any time of the year, the Priority and Allocations Committee will Review requests at least three times a year (in April, July, and October). The AA will notify all Part A or B agencies when the P&A Committee is preparing to allocate funds.

3.) **Committee Process:** The Committee will prioritize recommended requests so that the AA can distribute funds according to this prioritized list up until May 31, August 31 and the end of the grant year. After these dates, all requests (recommended or not) become null and void and must be resubmitted to the AA or the Office of Support to be considered in the next funding cycle.

After reviewing requests and studying new trends and needs the committee will review the allocations for the next fiscal year and, after filling identified gaps in the current year, and if appropriate and possible, attempt to make any increase in funding less dramatic by using an incremental allocation in the current fiscal year.

4.) **Projected Unspent Formula Funds:** Annually in October, the Committee will allocate the projected, current year, unspent, Formula funds so that the Administrative Agent for Part A can report this to HRSA in December.

# 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<br>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<br>Election Policy<br>Project LEAP and Proyecto VIDA Presentations | Josh Mica, Chair, Ryan White Planning Council<br>Caleb Brown & Cecilia Ligons, Co-Chairs, Operations Comm.<br>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