Houston Area HIV Services Ryan White Planning Council
Office of Support
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Memorandum

To: Members, Priority and Allocations Committee:

Bobby Cruz, Co-Chair	Josh Mica
Peta-gay Ledbetter, Co-Chair	Paul Richards
Allen Murray	Bruce Turner
Roxane May	Megan Rowe
Ronnie Galley	

Copy:

Crystal R. Starr	Sha'Terra Johnson
Diane Beck	Carin Martin
Mackenzie Hudson	Rodney Goodie
Glenn Urbach	Ann Robison
Mauricia Chatman	Johnetta Evans-Thomas
Tiffany Shepherd	

From: Tori Williams

Date: Thursday, June 15, 2023

Re: Meeting Announcements

You are in the home stretch! This memo is a reminder that there may be two more Priority and Allocations Committee meetings before the end of June. Both of the meetings will be hybrid so you can participate via Zoom or in-person at the old office in the Galleria area. See the top of all meeting agendas for detailed information. Whatever you decide, please be sure to RSVP to Rod for all meetings.

Regularly Scheduled Committee Meeting (see enclosed agenda with Zoom access information)
The Committee will review and again vote on the FY 2024 allocations developed at the special meeting.

- 12 noon, Thursday, June 22, 2023

Final Special Meeting (the agenda for this meeting was included in the packet for all Special Meetings). Please note that the Zoom access information is different.
To review public comment and possibly amend the recommended FY 2024 priorities and allocations before they receive final approval at the July 2023 Steering Committee and Council meetings.

- TENTATIVE: 12noon, Wednesday, June 28, 2023 – look for an email from Rod as this meeting is frequently cancelled due to little to no relevant public comment.

Please let Rod know if you will or will not be in attendance. We appreciate your valuable time and look forward to seeing you next week!

Houston Area HIV Services Ryan White Planning Council DRAFT
Priority & Allocations Committee Meeting

12 noon, Monday, June 22, 2023

Click on this link to join **Zoom Meeting**:
https://us02web.zoom.us/j/89374713843?pwd=UDBqbitGUk14d081eDRUSCtBdGltdz09
Meeting ID: 893 7471 3843 Passcode: 339238 Or call: 346 248-7799
In-Person Meeting will be at the old office at 2223 W. Loop South, Suite 240, Houston, TX 77027

AGENDA

I. Call to Order — Bobby Cruz and Peta-Gay Ledbetter, Co-Chairs
   A. Moment of Reflection
   B. Approval of Agenda
   C. Approval of Minutes
      - May 25, 2023
      - June 12, 2023
   D. Review Meeting Goals — Tori Williams, Director, OoS

II. Public Comment - (NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up in the Chat Box. Or, send a text to: 832 594-1929. No one is required to give his or her name or HIV status. **When signing in, guests are not required to provide their correct or complete names.** All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. 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. Committee members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Review Other Ryan White Planning Committee Recommendations — Tori Williams
   A. Public Comment Related to HIV and Aging
   B. Changes Recommended for the FY 2024 Service Definitions

IV. Allocations for FY 2024 Part A/MAI, Part B & State Services Funding
   A. Any Staff Corrections or Recommendations? — Glenn and Tiffany
   B. Review the FY 2024 Level Funding Scenario
      1) Part A and MAI
      2) Part B and State Services
   C. Review the FY 2024 Increase Funding Scenario
   D. Review the FY 2024 Decrease Funding Scenario
   E. Vote on the 3 Funding Scenarios

V. Announcements
   A. IMPORTANT: June Priority and Allocation Committee Meeting Dates and Times:
      - Tentative: 10 am, Wed., June 28, 2023 – Review public comment

VI. Adjourn

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Houston Area HIV Services Ryan White Planning Council

Priority & Allocations Committee Meeting

12:00 p.m., Thursday, May 25, 2023
Meeting Location: Zoom Teleconference

MINUTES

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Bobby Cruz, Co-Chair	Roxane May, excused	*The Resource Group*
Peta-gay Ledbetter, Co-Chair	Josh Mica	Tiffany Shepherd
Ronnie Galley	Allen Murray, excused	
Paul Richards	Bruce Turner, excused	*Ryan White Grant Admin*
Megan Rowe		Glenn Urbach
Randy Startz		Jason Black
		Mauricia Chatman
	OTHERS PRESENT	
	Crystal Starr, RWPC Chair	*Office of Support*
		Victoria Williams
		Diane Beck

See the attached chart at the end of the minutes for individual voting information.

Call to Order: Peta-gay Ledbetter, Co-Chair, called the meeting to order at 12:04 p.m. and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Galley, Rowe) to approve the agenda.* **Motion carried.**

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Galley, Rowe) to approve the April 27, 2023 minutes.* **Motion carried.** Abstention: Richards.

Determine June Meeting Dates: The committee decided to hold the special meetings from 12:00-4:00 p.m. on June 12-13 and if needed, on June 14. The regular June committee meeting will be at noon on June 22, 2023. The committee co-chairs and others will record the public hearing at 11:00 a.m. on June 16 and if there is significant public comment, the committee will meet again at noon on Wednesday, June 28, 2023.

Public Comment and Announcements: Williams said that the HIV and Aging workgroup has been collecting data that substantiates that older adults living with HIV experience physical aging issues at least 10 years earlier than the general population. They would like to see funding go to pay for aging related testing of Ryan White clients, especially long term survivors, those born with HIV and those over the age of 45. Williams suggested the committee keep this issue on its radar screen during the FY 2024 allocations process and the July reallocation of carryover dollars.

Cruz assumed the position of Chair.

Reports from the Administrative Agencies
Part A/MAI: See attached 2023 Procurement and Service Utilization Reports, which has been adjusted to show the Council's increase scenario. There was concern that Vision Care has had problems spending their funds. Hence, $23,222 was moved to the Health Insurance Assistance Program. The rural primary care contract that used State Services funding is up for renewal. The Purchasing Department mistakenly thought the contract had another year on it so a 6-month extension was created. Final contract awards for FY 2023 should go on the June 6 Commissioner's Court agenda for approval.

Part B and State Services: Williams said no new reports were received. Shepherd said that Part B just came to the end of the funding cycle. Also, they recently lost a staff member; she will make sure the reports are sent in time for the June special meetings.

Training: Houston Council Priority Setting Process: Cruz and Ledbetter presented the attached training slides.

Priority Setting Process
Determine FY 2024 Service Priorities: The committee reviewed the Policy for the FY 2024 Priorities Setting Process. There is no new needs assessment data to justify changes in the priorities. Richards asked if the priorities took into account the loss of continuous Medicaid coverage when COVID ended. Ledbetter said that the needs assessment data was collected prior to COVID so it did not. Ledbetter said that Emergency Financial Assistance has had very high expenditures and she recommends it be moved up to priority 10 or 11. Committee members agreed.

Vote on the FY 2024 Service Priorities: ***Motion #4:*** *it was moved and seconded (Ledbetter, Rowe) to move Emergency Financial Assistance to priority 10 and accept the FY 2024 Ryan White Part A/Minority AIDS Initiative (MAI), Part B, and State Services funded service priorities.* **Motion carried unanimously.** (See page 4 of the minutes for the list of FY 2024 service priorities.)

Public Comment: None.

Vote on the FY 2024 Service Priorities: Since there was no additional public comment, the committee decided they did not need to re-vote on the priorities.

Announcements: None.

Adjournment: ***Motion:*** *it was moved and seconded (Galley, Startz) to adjourn the meeting at 1:07 p.m.* **Motion Carried.**

Submitted by: Approved by:

_____ _____
Tori Williams, Director Date Committee Chair Date

Scribe: Beck
C = chaired the meeting; JA = just arrived; LM = left meeting

2023 Priority & Allocations Committee Voting Record for 05/25/23

	Motion #1 Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Accept the updated service priorities for FY 2024 **Carried**			
MEMBERS	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**
Peta-gay Ledbetter, Co-Chair				C				C		X		
Bobby Cruz, Co-Chair		X				X						C
Ronnie Galley		X				X				X		
Roxane May	X				X				X			
Josh Mica	X				X				X			
Allen Murray	X				X				X			
Paul Richards		X				X				X		
Megan Rowe		X				X				X		
Randy Startz		X				X				X		
Bruce Turner	X				X				X			

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Worksheet for Determining FY 2024 Service Priorities

Core Services	HL Scores	HL Rank	Approved FY 2022 Priorities	Approved FY 2023 Priorities	Proposed FY 2024 Priorities	Justification
Ambulatory/Outpatient Medical Care	HHH	2	1	1	1	No new needs assessment data to justify
Medical Case Management	HHH	2	2	2	2	changes.
Local Pharmacy Assistance Program	HHH	2	3	3	3	
Oral Health Services	HLL	3	4	4	4	
Health Insurance	HLL	3	5	5	5	
Mental Health Services	LLH	7	6	6	6	
~~**Early Intervention Services (jail)**~~	LLL	8	7	---		Program moved to Referral for Healthcare and Support services below
Medical Nutritional Therapy	LLH	7	8	7	7	
~~**Day Treatment**~~	LLH	7	9	8	---	Program no longer funded.
Substance Abuse Treatment	LLH	7	10	9	8	
Hospice*	-	-	11	10	9	

Support Services	HL Scores	HL Rank	Approved FY 2022 Priorities	Approved FY 2023 Priorities	Proposed FY 2024 Priorities	Justification
Emergency Financial Assistance	HLH	4	15	14	10	COVID ending stopped continuous Medicaid coverage; high use/expenditures in 2022
Referral for Health Care & Support Services (AEW and Incarcerated)	HHH	2	12	11	11	
Non-medical case management	HHH	2	13	12	12	
Medical Transportation	HLL	3	14	13	13	
Linguistics Services	LLL	8	16	15	14	
Outreach	LLL	8	17	16	15	

*Hospice does not have HL Score or HL Rank.

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Houston Area HIV Services Ryan White Planning Council

Priority and Allocations Special Committee Meeting

MINUTES

12:00 p.m., Wednesday, June 12, 2023

Meeting Location: 2223 W. Loop South, #240; Houston, TX 77027 and Zoom Teleconference

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MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Bobby Cruz, Co-Chair	Roxane May, excused	*The Resource Group*
Peta-gay Ledbetter, Co-Chair	Bruce Turner, excused	Tiffany Shepherd
Ronnie Galley		Sha'Terra Johnson
Josh Mica		
Allen Murray		*Ryan White Grant Admin*
Paul Richards	**OTHERS PRESENT**	Glenn Urbach
Megan Rowe	Charles Henley	Eric James
Randy Startz	Carin Martin, HHS	
		Office of Support
		Tori Williams
		Diane Beck

See the attached chart for individual voting information.

Call to Order: Bobby Cruz, Co-Chair, called the meeting to order at 12:08 p.m. and asked for a moment of reflection.

Approval of Agenda: ***Motion #1****: it was moved and seconded (Ledbetter, Galley) to approve the agenda.* ***Motion carried.***

Review Meeting Goals: Williams explained that the goal for the meeting was to make recommendations regarding the FY 2024 Level, Increase and Decrease Allocation Scenarios. Recommendations are to be presented at a Public Hearing on June 26, 2023. If no comments are received, the recommendations will move forward to the July Steering Committee and then to the Council for final approval.

Public Comment: See attached public comment regarding recommendations from members of the HIV and Aging Workgroup.

Changes Recommended for the FY 2024 Service Definitions: Williams presented the attached summary of FY 2024 How to Best Meet the Need recommendations from the Quality Improvement Committee, which was approved by the Council on Thursday, June 8th.

Updates from the Administrative Agents:
Ryan White Part A/MAI: See attached FY 2023 procurement report with the increase scenario

applied. Over $1 million in carryover is expected from 2022, primarily due to RWGA staffing vacancies and underspending of the Primary Care targeting Women at the Primary Clinic. It looks like those visits were billed to untargeted. Urbach said cardiology is provided with a referral and asked if the public comment suggested funding Meals on Wheels. Williams said that it was an allowable service category that is currently unfunded and would need to be brought back to do so. Urbach said that there is an ADAP waiting list which has resulted in an increase in waivers for Emergency Financial Assistance-Pharmacy. Galley asked if hearing aids were allowable. Martin said they were provided as durable medical equipment under primary care. Henley said he did not see where hearing aids were mentioned under any service category in the HRSA guidance. Williams said data can be gathered to look at this need during How to Best Meet the Need.

Ryan White Part B/State Services: Shepherd said they expect level funding next year. The Council has already approved eliminating Home and Community Based Health Services and reallocating the funds to Oral Health.

Draft Allocations for FY 2024 Part A/MAI, Part B & State Services Funding
See attached Guiding Principles and Decision Making Criteria. Urbach said that Emergency Financial Assistance-Pharmacy always seems to need more funds and targeting medical case managers to geriatric clients was a good idea. Clinical case managers would be good for the mental health continuum of care. Williams said that the Quality Improvement Committee will also review the public comment to make service recommendations. Henley said that it was not feasible to bundle mental health services with primary care. Williams suggested it could be a subcategory. The committee reviewed the current allocations and made adjustments to fund five medical case managers targeted to geriatrics.

FY 2024 Level Funding Scenario
Part A/MAI, Part B and State Services:
Motion #2*: it was moved and seconded (Ledbetter, Rowe) to approve the attached Ryan White Part A, Minority AIDS Initiative (MAI), Part B, and State Services (SS) Level Funding Scenario for FY 2024.* **Motion carried**. See chart for justification.

FY 2024 Increase/Decrease Funding Scenarios for MAI:
Motion #3*: it was moved and seconded* (*Ledbetter, Galley) to approve the attached increase and decrease funding scenarios for Minority AIDS Initiative (MAI) for FY 2024.* **Motion carried.**

FY 2024 Increase/Decrease Funding Scenarios for Part A:
Motion #4*: it was moved and seconded* (*Ledbetter, Rowe) to approve the attached increase and decrease funding scenarios with the following changes: in the decrease scenario delete 1.g. Primary Care-Pediatric and change 2.h. Medical Case Management-Pediatric to Geriatric; in the increase scenario under Step 1 add 'except 1.h. Vision Care and 1.j. Pay for Performance'.* **Motion carried.**

FY 2024 Increase/Decrease Funding Scenarios Part B and State Services:
Motion #5*: it was moved and seconded* (*Ledbetter, Galley) to approve the attached increase and decrease funding scenarios Ryan White Part B and State Services for FY 2024.* **Motion carried.**

Motion #6: *it was moved and seconded (Ledbetter, Startz) to create a stand alone mental health subcategory. If approved, $200,000 would be allocated to Mental Health-A and $100,000 would be allocated to Mental Health-Special Populations.* **Motion carried.**

Announcements: Williams reminded committee members of the following important meetings:

- The Special Priority & Allocations Committee meeting scheduled for tomorrow is cancelled.
- 12noon, Thursday, June 22, 2023 – The Committee reviews and votes on FY 2024 Allocations
- Tentative: 12noon, Wednesday, June 28, 2023 – Review public comment

Adjournment: ***Motion:*** *it was moved and seconded (Ledbetter, Mica) to adjourn the meeting at 2:31 p.m.* **Motion carried unanimously**.

Submitted by: Approved by:

Tori Williams, Director Date Committee Chair Date

Scribe: Beck
C = chaired the meeting; JA = just arrived; LM = left meeting

2023 Priority & Allocations Committee Voting Record for 06/12/23

	Motion #1 Agenda **Carried**				**Motion #2** FY24 Level funding scenario **Carried**				**Motion #3** FY24 MAI Increase decrease scenarios **Carried**				**Motion #4** FY24 Part A Increase decrease scenarios **Carried**				**Motion #5** FY24 Part B/SS Increase decrease scenarios **Carried**				**Motion #6** Suggest creation of Mental Health-Special Pops subcategory to QI Committee **Carried**			
MEMBERS	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**
Peta-gay Ledbetter, Co-Chair				C					C			C				C				C				C
Bobby Cruz, Co-Chair		X				X				X				X				X				X		
Ronnie Galley		X				X				X				X				X				X		
Roxane May	X				X				X				X				X				X			
Josh Mica	X					X				X				X				X				X		
Allen Murray		X				X				X				X				X				X		
Paul Richards		X				X				X				X				X				X		
Megan Rowe	X					X				X				X				X				X		
Randy Startz		X				X				X				X				X				X		
Bruce Turner	X				X				X				X				X				X			

CLINICAL GUIDELINES PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV · HCV · SUBSTANCE USE · LGBT HEALTH

Guidance: Addressing the Needs of Older Patients in HIV Care

Reviewed and updated: Eugenia L. Siegler, MD; May 5, 2023
Writing group: Steven M. Fine, MD, PhD; Rona M. Vail, MD; Joseph P. McGowan, MD, FACP, FIDSA; Samuel T. Merrick, MD; Asa E. Radix, MD, MPH, PhD; Jessica Rodrigues; Christopher J. Hoffmann, MD, MPH; Charles J. Gonzalez, MD
Committee: Medical Care Criteria Committee
Date of original publication: July 31, 2020

Contents

Purpose of This Guidance

Purpose: Because published evidence to support clinical recommendations is not currently available, this guidance on addressing the needs of older patients in HIV care was developed by the New York State Department of Health AIDS Institute (NYSDOH AI) to present good practices to help clinicians recognize and address the needs of older patients with HIV.

The goals of this guidance are to:

- Raise clinicians' awareness of the needs and concerns of patients with HIV who are ≥50 years old.
- Inform clinicians about an aging-related approach to older patients with HIV.
- Highlight good practices to help clinicians provide optimal care for this population.
- Provide resources about aging with HIV for healthcare providers and their patients.
- Suggest steps to guide medical settings in implementing geriatric care into HIV clinical practice.

Demographics: At the end of 2020, according to the Centers for Disease Control and Prevention, more than 52% of people with HIV in the United States were ≥50 years old [CDC 2023]. As of the end of 2020 in New York State, 60% of people with HIV were ≥50 years old, and nearly 30% were ≥60 years old [NYCDHMH 2021]. That same year, almost 19% of new HIV diagnoses in New York State occurred in people ≥50 years old, and one-third of them had progressed to AIDS at the time of diagnosis [NYCDHMH 2021]. In light of these New York State demographics, the NYSDOH AI has developed this guidance to help care providers expand services for older people with HIV.

Ensuring appropriate care delivery: Although the effects of HIV on aging have been studied for years, HIV care has been acknowledged only recently as a domain of geriatrics [Guaraldi and Rockwood 2017]. Geriatric assessment provides a complete view of a patient's function, cognition, and health, and improves prognostication and treatment decisions [Singh, et al. 2017]. As the population with HIV grows older, the application of the principles of geriatrics can enhance the quality of care.

Definition of terms:

- **"Older":** Published studies differ in their definitions of older patients with HIV (e.g., ≥50 years old, ≥55 years old, ≥60 years old), and the needs of individuals within different age groups may differ markedly. This guidance defines older patients as those ≥50 years old, which is the same definition used by the U.S. Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV [DHHS 2023]. Nonetheless, clinical programs may wish to distinguish different strata within this population, as their needs may differ; a local needs assessment is key to determining how best to care for this population as its age distribution continues to change.
- **"Long-term survivor":** The term long-term survivor has different meanings. Some have defined it as having been diagnosed with HIV before the era of effective antiretroviral therapy; others have defined it in terms of the length of time an individual has lived with HIV, e.g., for at least 1 or 2 decades. Long-term survivors can be any age. For example, older teens and adults who were perinatally infected are long-term survivors. It is useful to ask patients if they self-identify as long-term survivors and what that term means to them.

Effects of Aging

Long-term survivors appear to have physiologic changes consistent with advanced or accentuated aging [Akusjarvi and Neogi 2023], even at the level of gene expression and modification [Esteban-Cantos, et al. 2021; De Francesco, et al. 2019]. When compared with age-matched controls who do not have HIV, older patients with HIV have more comorbidities [Verheij, et al. 2023] and polypharmacy [Kong, et al. 2019; Guaraldi, et al. 2018]; poorer bone health [Erlandson, et al. 2016]; and higher rates of cognitive decline [Goodkin, et al. 2017; Vance, et al. 2016], depression [Do, et al. 2014], and aging-related syndromes, such as gait impairment and frailty [Falutz 2020]. Mental health can also be affected in many ways; in 1 study of individuals with HIV ≥50 years old in San Francisco, the majority of participants reported loneliness, poor social support, and/or depression, and nearly half reported anxiety [John, et al. 2016]. Older individuals may also experience negative effects due to the stigma of ageism, which may be compounded by other kinds of stigma, such as racial, gender, or HIV-related stigma [Johnson Shen, et al. 2019]. In addition, long-term survivors, who may have expected to die at a young age like so many of their peers, may feel survivor's guilt [Machado 2012].

These age-related concerns are not limited to long-term survivors. Although individuals who are ≥50 years old with newly diagnosed HIV are not likely to exhibit the same degree of age advancement as those who have lived a long time with HIV, they may have a delayed diagnosis, low CD4 cell counts, and AIDS at the time of diagnosis [Tavoschi, et al. 2017]. Late initiation of antiretroviral therapy increases the long-term risk of complications [Molina, et al. 2018].

Sex differences in the effect of HIV on aging remain an area of controversy. Studies in several countries have found that women with HIV have life expectancies closer to their HIV-negative counterparts than do men with HIV, but this finding has not been supported by studies in North America [Pellegrino, et al. 2023; Wandeler, et al. 2016; Samji, et al. 2013]. A Canadian study showed shorter life expectancy among women with HIV than men with HIV [Hogg, et al. 2017]. Women with HIV in resource-rich countries appear to have a heightened risk of comorbidities [Palella, et al. 2019], including cardiovascular disease [Kovacs, et al. 2022; Stone, et al. 2017], cognitive loss [Maki, et al. 2018], and more rapid declines in bone mineral density [Erlandson, et al. 2018].

Approach to Aging in HIV Care

→ GOOD PRACTICES

Approach to Aging in HIV Care

- Discussing the effects of aging with patients who have HIV and are ≥50 years old can help identify medical priorities and evaluate physical function. Such conversations may also prompt consideration of advance directives and help patients recognize the effects of age-associated stigma.
- Taking a proactive approach to aging to help prevent or slow functional and social decline.
- Becoming familiar with the many available screening tools and local and national services will help meet the needs of older patients with HIV.

→ GOOD PRACTICES

- Screening for frailty or functional decline can enable early identification of at-risk patients.
- Including nonpharmacologic measures, such as exercise, nutrition, and socialization is essential to a patient's physical and emotional health.
- Using a framework such as the geriatric 5Ms—mind, mobility, medications, multimorbidity, and matters most—can help inform the choice of screening tests or communicate geriatric concepts, but it is important that screening and assessment be performed with established tools that assess specific domains.
- Prioritizing treatment plans may help reduce the potential for polypharmacy in older patients with HIV who are being treated for multiple comorbidities.
- Evaluating medication lists at every clinical visit to eliminate unnecessary or toxic medications and to identify and mitigate potentially harmful drug-drug interactions will help minimize the effects of polypharmacy in older patients with HIV.
- Facilitating and simplifying access to care (e.g., arranging for a cardiologist to see a patient in the HIV primary care setting) and services as patients' care needs increase can improve overall adherence to and satisfaction with treatment.
- Having familiarity with the benefits and local sources of palliative care will help clinicians recognize and meet the needs of older patients who have HIV and other serious illnesses.
- Referring to a social worker or care coordinator can help older patients with HIV to transition from commercial insurance or Special Needs Plans (SNPs) to Medicare without experiencing a loss of services or medication coverage.

Discuss aging-related concerns: It is essential to discuss aging-related concerns with patients with HIV who are ≥50 years old. Some HIV healthcare providers and their patients have enduring relationships. Such longstanding ties promote high levels of trust, but they can also inhibit exploration of new concerns and promote too tight a focus on keeping viral load undetectable and treating common comorbidities. As a consequence, older individuals with HIV may not recognize concerns as aging-related or may feel it is unnecessary or inappropriate to discuss aging.

Care of older patients with HIV begins with recognizing that aging-related issues are a fundamental part of primary care. Geriatric concerns do not supplant other medical conditions; they reframe them in light of a multiplicity of problems and a finite lifespan. A geriatric approach, even for people in their 50s, can improve the quality of care. Older people with HIV may range from 50 to 80 years old and beyond and are a heterogeneous group. Providing care for older patients requires balance to avoid ageism and neglect of essential care *while at the same* prevent excessive, dangerous, or unnecessary treatments. Determining what is appropriate for patients begins with an assessment of their health and their priorities.

Asking questions such as, "Have you thought about aging?" or "What would you like to know about aging with HIV?" creates opportunities to learn about patient's concerns about the future and to discuss survivorship, guilt, ageism, financial worries, and other issues [Del Carmen, et al. 2019]. This is an opportunity to discuss healthy aging through lifestyle modifications that include exercise, diet, and socialization.

Sexual health: Older age does not preclude discussions of topics that are essential to health. For example, sexuality should be considered an essential part of health at any age. There is no age limit at which clinicians should stop taking a sexual history or discussing HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for partners (see the NYSDOH AI guidelines PrEP to Prevent HIV and Promote Sexual Health and PEP to Prevent HIV Infection). Initiating discussions of sexual health, including topics such as erectile dysfunction and loss of libido in men, menopause and postmenopausal sex in women, and screening for sexually transmitted infections as needed, may also provide insights into relationships and the strength of a patient's social network. For more information, see the Centers for Disease Control and Prevention Sexually Transmitted Infections Treatment Guidelines, 2021 > Screening Recommendations.

Cancer screening: Overall, patient health and priorities, rather than age, direct the frequency of cancer screening in individuals with HIV. The literature on adherence to cancer screening guidelines among individuals with HIV is mixed, with most [Corrigan, et al. 2019] but not all [Barnes, et al. 2018] studies failing to find that older individuals were screened less frequently. In patients with a good prognosis, clinicians should continue to follow screening guidelines (see the NYSDOH AI guideline Comprehensive Primary Care for Adults With HIV > Routine Screening and Primary Prevention). Screening can be re-evaluated when it conflicts with a patient's priorities or when a patient's prognosis is poor.

Aging-related syndromes and comorbidities: Some health concerns take on greater relevance as individuals with HIV age. Geriatric or aging-related syndromes, such as frailty, have received special attention. Frailty, which can be measured as a physical construct or as an "accumulation of deficits," is a measure of vulnerability [Kehler, et al. 2022]. Frailty has been

associated with increases in falls [Erlandson, et al. 2019] and mortality [Piggott, et al. 2020; Kelly, et al. 2019], and multiple comorbidities [Masters, et al. 2021; Kelly, et al. 2019] have been linked to its development. However, it is possible to reverse frailty. Early identification may enable increased resources for those at highest risk and may also draw attention to associated comorbidities.

Comorbidities in older individuals with HIV are highly prevalent and require added vigilance (see the NYSDOH AI guideline Comprehensive Primary Care for Adults With HIV). In particular, cardiovascular risk is increased in people with HIV, as is osteoporosis. Guidelines for bone mineral density testing, in particular, are often not followed [Birabaharan, et al. 2021], despite the higher rates of osteoporosis and fractures in people with HIV compared with age-matched controls [Starup-Linde, et al. 2020].

Insurance and long-term care needs: Addressing aging-related concerns directly can help older patients with HIV discuss financial worries and prepare for the future when more personal assistance may be needed. Discussing insurance coverage with patients with HIV when they are in their 60s provides an opportunity to help them prepare for the transition from commercial insurance or SNPs to Medicare-based plans. Planning is essential because commercial insurance plans or SNPs often offer more comprehensive care coordination, medication coverage, and health-maintenance services than Medicare-based plans. People with HIV may need long-term care at an earlier age than those without HIV [Justice and Akgun 2019]. Open discussion about support systems can help patients begin to plan for their long-term care needs.

The 5Ms-an effective communication tool: The geriatric approach can be described as attention to the 5Ms: mind, mobility, multimorbidity, medications, and matters most [Tinetti, et al. 2017]. The 5Ms are a useful way to communicate geriatric principles or choose an area for screening. However, some aging-related syndromes (e.g., dizziness, incontinence) or activities of daily living may not easily fit into one of these categories. Nor do the 5Ms offer a structure for a comprehensive geriatric assessment. The following discussion addresses how the 5Ms can be used to understand and explain geriatric priorities and broaden the focus beyond specific comorbidities. The 5Ms are best viewed as an explanatory framework; it is important that screening and assessment be performed with formally recognized instruments (see Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources).

1. **Mind:** This category includes all domains of behavioral health, including cognition, mood, and other disorders. General assessment questions about instrumental activities of daily living (e.g., using transportation, managing medications, and handling finances) can provide information about practical concerns and offer clues about cognitive or emotional barriers to self-care. Healthcare providers can also use specific tools (see Table 1) to screen patients for disorders such as depression or cognitive impairment, which may be caused by factors both related to and independent of HIV [Winston and Spudich 2020]. Even as the prevalence of HIV-associated neurocognitive disorder has decreased among individuals with HIV, having multiple comorbidities can increase the risk of cognitive impairment [Heaton, et al. 2023]. Identifying factors that can be addressed to prevent or slow cognitive deterioration is a fundamental part of assessment in this category.
2. **Mobility:** Healthcare providers can begin to address mobility with a general assessment of activities of daily living to determine whether patients have difficulty dressing or bathing. Discussion of a patient's fall risk can begin with a question such as, "Have you fallen in the past year?" or healthcare providers can use a comprehensive fall-risk screening tool.
3. **Multimorbidity and multicomplexity:** Care for older patients with HIV usually involves the management of multiple comorbidities, each of which may require treatment with multiple medications. Nonpharmacologic management (e.g., smoking cessation, dietary modification, exercise) can also improve symptoms associated with multiple comorbidities [Fitch 2019].

   A geriatric perspective recognizes that, in patients with multimorbidity, strict adherence to multiple disease-based treatment guidelines may not be possible or may jeopardize a patient's health. Simultaneous management of multiple chronic conditions necessitates establishing treatment priorities [Yarnall, et al. 2017], which requires understanding a patient's priorities [Tinetti, et al. 2019].
4. **Medications:** While older individuals with HIV are taking antiretroviral medications to suppress the virus, they may also be taking other medications to treat comorbidities, which can make medication management especially challenging. Polypharmacy is common, and women appear to be at higher risk than men, likely because of a higher prevalence of comorbidities [Livio, et al. 2021]. Medication evaluation should include a review of all medications, potential drug-drug interactions [Livio and Marzolini 2019], and short- and long-term toxic effects. It may be beneficial to simplify antiretroviral and other medication regimens to ensure that harms from drug-drug interactions and other adverse effects of treatment are avoided [Del Carmen, et al. 2019]. Caution is required when adjusting or simplifying

antiretroviral regimens if changes involve either initiating or discontinuing a medication with pharmacologic inhibitive or induction actions; these changes may affect levels of coadministered medications.

Consultation with a pharmacist can reduce drug-drug interactions and polypharmacy and help clinicians navigate the complexities of medication management in older patients [Ahmed, et al. 2023]. The University of Liverpool HIV Drug Interactions Checker is a useful tool for checking drug-drug interactions; also see NYSDOH AI ART Drug-Drug Interactions.

5. **Matters most:** This is the broadest category and includes medical and social priorities, sexual health, and advance directives. This category may also include discussion of palliative care and frank discussion of long-term care needs and end-of-life plans. Advance directives should be addressed and, if an advance directive is in place, revisited. It is preferable for the patient to designate a specific agent or agents who can speak for them when they are incapacitated. Patients who cannot or will not identify a trusted individual to be their agent can complete the NYSDOH Medical Orders for Life-Sustaining Treatment (MOLST) to describe their wishes regarding medical treatment. The MOLST can now also be documented electronically in the eMOLST registry.

Geriatric Screening and Assessment

General Screening Tools

Screening identifies individuals who are at risk for medical problems. Although care providers may order screening tests for specific diseases such as cancer, they may not be as familiar with screening tools designed to identify functional impairment or geriatric syndromes. In all cases, the same principles apply: brief, sensitive geriatric screening instruments such as those included in Box 1, below, can be used to identify patients who may need more intensive evaluation.

For those programs that are just starting to identify the needs of their older patients, a general screening questionnaire is an excellent place to start. General screening questionnaires are usually appropriate for all older patients and long-term survivors and often are performed annually around a patient's birthday. Such screenings can be completed before a clinic visit; some questionnaires are completed by the patient and others are administered by a staff member. The modified World Health Organization integrated care for older people (ICOPE) screening tool has been tested for people with HIV in a New York State-wide pilot and can be administered by staff in person or over the phone; sites can also use other surveys based on workflows.

Why perform general geriatric screening? Not every patient requires a formal geriatric assessment. Tools for general geriatric screening are simple and cover a wide variety of domains; if the results indicate that more extensive assessment is warranted, then a more formal and comprehensive evaluation can be performed. Use of general screening tools can improve case-finding and, when coupled with referral, can enable targeted interventions but has not yet been shown to reduce hospitalizations or improve function [Rubenstein, et al. 2007].

Box 1: General Geriatric Screening Tools for Older Adults With HIV

- World Health Organization (WHO): Integrated care for older people (ICOPE): guidance on person-centered assessment and pathways in primary care
- NYSDOH HIV Quality of Care Program: Modified WHO ICOPE screening tool
- Vulnerable Elders Survey-13 (VES 13) [Saliba, et al. 2001]
- Medicare annual wellness visit:
  - Centers for Disease Control and Prevention: A Framework for Patient-Centered Health Risk Assessments
  - American College of Physicians: A Checklist for Your Medicare Wellness Annual Visit

Comprehensive Geriatric Assessment

When a patient has a positive result on a general geriatric screening test, the clinician may consider a more comprehensive assessment using validated tools. Formal assessment is more effective than clinical judgment at uncovering problems [Elam, et al. 1991; Pinholt, et al. 1987].

The Comprehensive Geriatric Assessment: The gold standard for geriatric evaluation is the Comprehensive Geriatric Assessment (CGA), which assesses multiple domains of health and function [Singh, et al. 2017]. Because it is comprehensive, the CGA is lengthy, and its use may not be feasible in many clinical settings. In the general geriatric outpatient setting, the CGA has not been shown to reduce mortality or nursing home placement, although it may reduce hospital admissions [Briggs, et al. 2022]. The CGA is a complicated process, requiring both expert assessors and clear care plans to manage areas of deficit, and its mixed success in the community likely stems at least in part from the complexity of creating a system that effectively responds to the assessment and includes patient buy-in.

Consulting experts in geriatric care: Some academic centers have tested models of collaboration with geriatricians [Davis, et al. 2022], including referral to geriatric consultants outside the practice, multidisciplinary geriatric care within the practice, and dual training of clinicians in geriatrics and HIV medicine. More models are being studied.

Choosing domains for focused assessment: Given the limitations in both the HIV care and geriatrics workforces [Armstrong 2021; AGS 2017], access to geriatricians may not be feasible. Community-based programs wishing to assess specific domains in the absence of available expert clinicians may choose from among many options.

Recommendations from community advisory boards and patient surveys can advise sites about patient priorities, and results from general screenings can prompt more broad assessments to identify high-prevalence problems. It may be difficult to implement needed aging-related assessments when access to expertise or funding is limited, but every attempt should be made to assess aging-related issues to the degree possible. Table 1 lists domains of geriatric assessment and selected resources for older patients with HIV.

Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources

Area for Assessment	Tools and Resources
Functional Deficits and Geriatric Syndromes	
Basic activities of daily living (general)	Katz Index of Independence in Activities of Daily Living: bathing, dressing, toileting, grooming, transferring, locomotion
Instrumental activities of daily living	The Lawton Instrumental Activities of Daily Living (IADL) Scale: telephone, transportation, housekeeping, medication management, financial management, meal preparation
Continence	• National Association for Continence • Urinary incontinence in women: evaluation and management [Hu and Pierre 2019] (provides links to 3 different brief screening tools)
Exercise prescription	• ACSM Exercise is Medicine® Health Care Providers' Action Guide • Evidence-informed practical recommendations for increasing physical activity among persons living with HIV [Montoya, et al. 2019]
Frailty	CGA Toolkit Plus: Frailty
Mental Health	
Cognition	• MoCA Test (Registration and training are required) • Alzheimer's Association Alzheimer's Disease Pocketcard app (available for download through the Apple App Store or Google Play) • Mini-Cog© Quick Screening for Early Dementia Detection
Social isolation, loneliness	Multiple screening tools and interventions are available through: • Campaign to End Loneliness • UCSF Stress Measurement Network
Other areas (e.g., depression, anxiety, stigma)	• Patient Health Questionnaire-4 (PHQ-4): Ultra-Brief Screening for Anxiety and Depression • SAMHSA Growing Older: Providing Integrated Care for an Aging Population • CDC HIV Stigma and Discrimination

Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources	
Area for Assessment	**Tools and Resources**
Comorbidities and Medications	
Managing multiple chronic conditions	Decision making for older adults with multiple chronic conditions: executive summary for the American Geriatrics Society Guiding Principles on the Care of Older Adults with Multimorbidity [Boyd, et al. 2019]
Primary care of specific comorbidities	NYSDOH AI guideline Comprehensive Primary Care for Adults With HIV
ART choices and drug-drug interactions	• University of Liverpool HIV Drug Interactions Checker • NYSDOH AI guidelines: - ART Drug-Drug Interactions - Selecting an Initial ART Regimen > ARV Dose Adjustments for Hepatic or Renal Impairment
Medication choices and polypharmacy	• STOPP/START criteria for potentially inappropriate prescribing in older people: version 2 [O'Mahony, et al. 2015] • American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults [AGS 2019]
Bone health	Management algorithms: • Recommendations for evaluation and management of bone disease in HIV [Brown, et al. 2015] • Diagnosis, prevention, and treatment of bone fragility in people living with HIV: a position statement from the Swiss Association against Osteoporosis [Biver, et al. 2019] • Management of osteoporosis in patients living with HIV: a systematic review and meta-analysis [Starup-Linde, et al. 2020]
Nutrition (food insecurity, obesity, undernutrition)	• USDA Food Security in the U.S. > Survey Tools • HIV and antiretroviral therapy-related fat alterations [Koethe, et al. 2020]
Quality of Life	
Advance directives	NYSDOH: • Health Care Proxy: Appointing Your Health Care Agent in New York State (includes fillable form) • Medical Orders for Life-Sustaining Treatment (MOLST) and eMOLST
Caregiving (requiring and providing)	Next Step in Care Toolkits, Guides, and More for Health Care Providers
Elder mistreatment	• New York State Coalition on Elder Abuse • National Center on Elder Abuse > Elder Abuse Screening Tools for Healthcare Professionals
Overall health, pain management	• CDC HRQOL-14 "Healthy Days Measure" • 2017 HIVMA of IDSA Clinical practice guideline for the management of chronic pain in patients living with HIV [Bruce, et al. 2017]
Palliative care, prognosis, and end-of-life plans	• Palliative care as an essential component of the HIV care continuum [Harding 2018] • Prognostic tools: - VACS Index Calculator - UCSF ePrognosis Calculators - Prognostic indices for older adults: a systematic review [Yourman, et al. 2012]

Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources	
Area for Assessment	**Tools and Resources**
Sexual health and menopause	• NYSDOH AI GOALS Framework for Sexual History Taking • NYSDOH AI Guidance: Adopting a Patient-Centered Approach to Sexual Health • Clinical considerations for menopause and associated symptoms in women with HIV [Looby 2023] • Sexual health history: techniques and tips [Savoy, et al. 2020]

Abbreviations: ACSM, American College of Sports Medicine; AGS, American Geriatrics Society; ART, antiretroviral therapy; ARV, antiretroviral medication; CDC, Centers for Disease Control and Prevention; CGA, Comprehensive Geriatric Assessment; GOALS, Give Offer Ask Listen Suggest; HIVMA, HIV Medicine Association; HRQOL, Health-Related Quality of Life; IDSA, Infectious Diseases Society of America; MoCA, Montreal Cognitive Assessment; NIH, National Institutes of Health; NYSDOH AI, New York State Department of Health AIDS Institute; SAMHSA, Substance Abuse and Mental Health Services Administration; UCSF, University of California San Francisco; VACS, Veterans Aging Cohort Study.

Integrating the Needs of Older Patients Into Medical Care

This guidance is designed to foster a shift in the practitioner's perspective when caring for older patients with HIV. However, the clinician cannot provide optimal care in the absence of support. Clinical practices can also begin to address HIV-related aging issues by taking the steps outlined in Box 2, below.

Box 2: Six Steps to Integrating Needs of Older Patients Into HIV Medical Care

1. Assess the clinic's ability to meet the needs of older patients with HIV:

- Review the demographics of the patient population to identify the number of patients in need of aging-related services at present and in the near- and long-term.
- Track patient requests for aging-related services and identify options for responding to those requests.
- Identify resources needed to address any aging-related priorities identified by a community or clinic advisory board.
- Identify clinic care providers who are experienced in geriatrics or the care of older patients.
- If the clinic is not able to provide multidisciplinary, comprehensive services, identify how the clinic can assist patients in accessing needed services.
- Anticipate problems with finances and insurance coverage for those approaching age 65 (earlier for those on disability) who are transitioning to Medicare.

2. Engage older patients with HIV in program planning:

- Provide ample opportunities for patients and clinical care providers and staff to identify needs to be addressed. This is an essential step for programs of any size. The University of California San Francisco used extensive patient input to develop its Golden Compass program for older individuals with HIV [Greene, et al. 2015].
- Provide opportunities for discussion of ageism and stigma, so patients and clinical care providers and staff can understand and identify its effects and how to address them.
- Develop a wish list of services and be realistic about what is possible. Set goals and a timeline for program development.

3. Consider options and develop protocols for identifying patients in need of aging-related care and services. For example, patients may be identified based on:

- Age: At base, a clinic can implement a policy that all patients with HIV who are ≥50 years old should undergo general screening; the clinic might also create a protocol that would add more focused and detailed screening (e.g., for memory or gait) to be initiated at an older age.
- Prognosis, such that a prognostic threshold for referral is established based on measures such as the Veterans Aging Cohort Study (VACS) Index Calculator
- Clinical criteria, such as a recent history of falls, deteriorating memory, polypharmacy, or frailty
- Patient request

Box 2: Six Steps to Integrating Needs of Older Patients Into HIV Medical Care

4. Develop an assessment strategy:

- Identify who will perform assessments and how results will be communicated to patients and other care providers involved with the patient.
- Determine the scope of assessment: Will it focus on one particular problem (e.g., gait disorders, cognition), or will assessment address a broad array of problems? Examples of assessment types include the following:
  - **Global simple geriatric screening tools:** Global geriatric screening tools are available for administration by clinical staff or patient self-administration, at home or in the clinic. Dedicated time for assessment may be scheduled as part of primary care, following a model such as the Medicare Annual Wellness Visit [CMS 2022].
  - **Comprehensive assessment:** Some clinics may collaborate with aging specialists, such as geriatricians or nurse practitioners who specialize in gerontology and can perform a more detailed geriatric assessment as a consultation.
  - **Specific screening tools:** If a clinic has decided to focus on specific assessments, these can be built into the workflow. For example, a clinic may determine that all patients ≥55 years old will be screened for fall risk and cognitive impairment. In this case, patients could be asked to complete a fall-risk evaluation, such as the Centers for Disease Control and Prevention STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention, before the visit, or a nurse could administer a timed walk test while the patient is walking from the waiting room to the exam room.
  - Any of the domains listed in Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources would be appropriate for inclusion in a program to enhance the care of older individuals with HIV.

5. Develop protocols for referral:

- Identify aging-related care and services that can be provided on-site and care and services that require referral to an external source. Referral protocols can be problem-specific. For example, if a patient is assessed as being at high risk for falls, the clinic should take a standard approach to address that risk, which could include referral to physical therapy, podiatry, or neurology; medication review; home safety assessment; and/or an exercise program.
- Identify local specialty care providers to whom patients can be referred.

6. Link to the Aging Network for services:

- Connect individuals with HIV who are ≥60 years old to the Aging Network, an interconnected group of agencies that assists older adults in living independently. The Aging Network was initiated through the Older Americans Act of 1965 [National Health Policy Forum 2012].
- Become familiar with locally offered services and assist clients in preparing for the transition to Medicare when medication benefits and care coordination change.

◊ ONLINE RESOURCES FOR AGING AND GERIATRIC CARE

Clinical Resources:

- Care of People Aging with HIV: Northeast/Caribbean AETC Toolkit
- American Geriatrics Society Publications and Tools
- American Geriatrics Society Geriatrics Workforce Enhancement Program (GWEP):
  - GWEP Coordinating Center
  - Finger Lakes Geriatric Education Center (Rochester, Ithaca)
  - Johns Hopkins Medicine GWEP
- Hartford Institute for Geriatric Nursing

Services and Entitlements:

- New York State Office for Aging (provides links to local agencies on aging and other resources like the state *Aging and Disability Resource Center*)
- USAging (from the Association of Area Agencies on Aging)
- Eldercare Locator
- EngAGED: The National Resource Center for Engaging Older Adults
- National Council on Aging *BenefitsCheckUp*
- National Aging and Disability Transportation Center
- Administration for Community Living > Aging and Disability Resource Centers
- Medicare Rights Center
- SAGE > Advocacy for LGBTQ+ Elders

References

AGS. Projected future need for geriatricians. 2017 Feb. https://www.americangeriatrics.org/sites/default/files/inline-files/Projected-Future-Need-for-Geriatricians_1.pdf [accessed 2023 Mar 27]

AGS. American Geriatrics Society 2019 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatr Soc* 2019;67(4):674-694. [PMID: 30693946] https://pubmed.ncbi.nlm.nih.gov/30693946

Ahmed A, Tanveer M, Dujaili JA, et al. Pharmacist-involved antiretroviral stewardship programs in people living with HIV/AIDS: a systematic review. *AIDS Patient Care STDS* 2023;37(1):31-52. [PMID: 36626156] https://pubmed.ncbi.nlm.nih.gov/36626156

Akusjarvi SS, Neogi U. Biological aging in people living with HIV on successful antiretroviral therapy: do they age faster? *Curr HIV/AIDS Rep* 2023. [PMID: 36695947] https://pubmed.ncbi.nlm.nih.gov/36695947

Armstrong WS. The human immunodeficiency virus workforce in crisis: an urgent need to build the foundation required to end the epidemic. *Clin Infect Dis* 2021;72(9):1627-1630. [PMID: 32211784] https://pubmed.ncbi.nlm.nih.gov/32211784

Barnes A, Betts AC, Borton EK, et al. Cervical cancer screening among HIV-infected women in an urban, United States safety-net healthcare system. *AIDS* 2018;32(13):1861-1870. [PMID: 29762164] https://pubmed.ncbi.nlm.nih.gov/29762164

Birabaharan M, Kaelber DC, Karris MY. Bone mineral density screening among people with HIV: a population-based analysis in the United States. *Open Forum Infect Dis* 2021;8(3):ofab081. [PMID: 33796595] https://pubmed.ncbi.nlm.nih.gov/33796595

Biver E, Calmy A, Aubry-Rozier B, et al. Diagnosis, prevention, and treatment of bone fragility in people living with HIV: a position statement from the Swiss Association against Osteoporosis. *Osteoporos Int* 2019;30(5):1125-1135. [PMID: 30603840] https://pubmed.ncbi.nlm.nih.gov/30603840

Boyd C, Smith CD, Masoudi FA, et al. Decision making for older adults with multiple chronic conditions: executive summary for the American Geriatrics Society Guiding Principles on the Care of Older Adults With Multimorbidity. *J Am Geriatr Soc* 2019;67(4):665-673. [PMID: 30663782] https://pubmed.ncbi.nlm.nih.gov/30663782

Briggs R, McDonough A, Ellis G, et al. Comprehensive Geriatric Assessment for community-dwelling, high-risk, frail, older people. *Cochrane Database Syst Rev* 2022;5(5):CD012705. [PMID: 35521829] https://pubmed.ncbi.nlm.nih.gov/35521829

Brown TT, Hoy J, Borderi M, et al. Recommendations for evaluation and management of bone disease in HIV. *Clin Infect Dis* 2015;60(8):1242-1251. [PMID: 25609682] https://pubmed.ncbi.nlm.nih.gov/25609682

Bruce RD, Merlin J, Lum PJ, et al. 2017 HIVMA of IDSA clinical practice guideline for the management of chronic pain in patients living with HIV. *Clin Infect Dis* 2017;65(10):e1-e37. [PMID: 29020263] https://pubmed.ncbi.nlm.nih.gov/29020263

CDC. HIV surveillance reports. 2023 Mar 9. https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html [accessed 2023 Mar 27]

CMS. Medicare wellness visits. 2022 Aug. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html [accessed 2023 Mar 27]

Corrigan KL, Wall KC, Bartlett JA, et al. Cancer disparities in people with HIV: a systematic review of screening for non-AIDS-defining malignancies. *Cancer* 2019;125(6):843-853. [PMID: 30645766] https://pubmed.ncbi.nlm.nih.gov/30645766

Davis AJ, Greene M, Siegler E, et al. Strengths and challenges of various models of geriatric consultation for older adults living with human immunodeficiency virus. *Clin Infect Dis* 2022;74(6):1101-1106. [PMID: 34358303] https://pubmed.ncbi.nlm.nih.gov/34358303

De Francesco D, Wit FW, Bürkle A, et al. Do people living with HIV experience greater age advancement than their HIV-negative counterparts? *AIDS* 2019;33(2):259-268. [PMID: 30325781] https://pubmed.ncbi.nlm.nih.gov/30325781

Del Carmen T, Johnston C, Burchett C, et al. Special topics in the care of older people with HIV. *Curr Treat Options Infect Dis* 2019;11(4):388-400. [PMID: 33343235] https://pubmed.ncbi.nlm.nih.gov/33343235

DHHS. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. 2023 Mar 23. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines [accessed 2023 Mar 27]

Do AN, Rosenberg ES, Sullivan PS, et al. Excess burden of depression among HIV-infected persons receiving medical care in the united states: data from the medical monitoring project and the behavioral risk factor surveillance system. *PLoS One* 2014;9(3):e92842. [PMID: 24663122] https://pubmed.ncbi.nlm.nih.gov/24663122

Elam JT, Graney MJ, Beaver T, et al. Comparison of subjective ratings of function with observed functional ability of frail older persons. *Am J Public Health* 1991;81(9):1127-1130. [PMID: 1951822] https://pubmed.ncbi.nlm.nih.gov/1951822

Erlandson KM, Guaraldi G, Falutz J. More than osteoporosis: age-specific issues in bone health. *Curr Opin HIV AIDS* 2016;11(3):343-350. [PMID: 26882460] https://pubmed.ncbi.nlm.nih.gov/26882460

Erlandson KM, Lake JE, Sim M, et al. Bone mineral density declines twice as quickly among HIV-infected women compared with men. *J Acquir Immune Defic Syndr* 2018;77(3):288-294. [PMID: 29140875] https://pubmed.ncbi.nlm.nih.gov/29140875

Erlandson KM, Perez J, Abdo M, et al. Frailty, neurocognitive impairment, or both in predicting poor health outcomes among adults living with human immunodeficiency virus. *Clin Infect Dis* 2019;68(1):131-138. [PMID: 29788039] https://pubmed.ncbi.nlm.nih.gov/29788039

Esteban-Cantos A, Rodriguez-Centeno J, Barruz P, et al. Epigenetic age acceleration changes 2 years after antiretroviral therapy initiation in adults with HIV: a substudy of the NEAT001/ANRS143 randomised trial. *Lancet HIV* 2021;8(4):e197-e205. [PMID: 33794182] https://pubmed.ncbi.nlm.nih.gov/33794182

Falutz J. Frailty in people living with HIV. *Curr HIV/AIDS Rep* 2020;17(3):226-236. [PMID: 32394155] https://pubmed.ncbi.nlm.nih.gov/32394155

Fitch KV. Contemporary lifestyle modification interventions to improve metabolic comorbidities in HIV. *Curr HIV/AIDS Rep* 2019;16(6):482-491. [PMID: 31776973] https://pubmed.ncbi.nlm.nih.gov/31776973

Goodkin K, Miller EN, Cox C, et al. Effect of ageing on neurocognitive function by stage of HIV infection: evidence from the Multicenter AIDS Cohort Study. *Lancet HIV* 2017;4(9):e411-e422. [PMID: 28716545] https://pubmed.ncbi.nlm.nih.gov/28716545

Greene M, Covinsky KE, Valcour V, et al. Geriatric syndromes in older HIV-infected adults. *J Acquir Immune Defic Syndr* 2015;69(2):161-167. [PMID: 26009828] https://pubmed.ncbi.nlm.nih.gov/26009828

Guaraldi G, Malagoli A, Calcagno A, et al. The increasing burden and complexity of multi-morbidity and polypharmacy in geriatric HIV patients: a cross sectional study of people aged 65 - 74 years and more than 75 years. *BMC Geriatr* 2018;18(1):99. [PMID: 29678160] https://pubmed.ncbi.nlm.nih.gov/29678160

Guaraldi G, Rockwood K. Geriatric-HIV medicine is born. *Clin Infect Dis* 2017;65(3):507-509. [PMID: 28387817] https://pubmed.ncbi.nlm.nih.gov/28387817

Harding R. Palliative care as an essential component of the HIV care continuum. *Lancet HIV* 2018;5(9):e524-e530. [PMID: 30025682] https://pubmed.ncbi.nlm.nih.gov/30025682

Heaton RK, Ellis RJ, Tang B, et al. Twelve-year neurocognitive decline in HIV is associated with comorbidities, not age: a CHARTER study. *Brain* 2023;146(3):1121-1131. [PMID: 36477867] https://pubmed.ncbi.nlm.nih.gov/36477867

Hogg RS, Eyawo O, Collins AB, et al. Health-adjusted life expectancy in HIV-positive and HIV-negative men and women in British Columbia, Canada: a population-based observational cohort study. *Lancet HIV* 2017;4(6):e270-e276. [PMID: 28262574] https://pubmed.ncbi.nlm.nih.gov/28262574

Hu JS, Pierre EF. Urinary incontinence in women: evaluation and management. *Am Fam Physician* 2019;100(6):339-348. [PMID: 31524367] https://pubmed.ncbi.nlm.nih.gov/31524367

John MD, Greene M, Hessol NA, et al. Geriatric assessments and association with VACS Index among HIV-infected older adults in San Francisco. *J Acquir Immune Defic Syndr* 2016;72(5):534-541. [PMID: 27028497] https://pubmed.ncbi.nlm.nih.gov/27028497

Johnson Shen M, Freeman R, Karpiak S, et al. The intersectionality of stigmas among key populations of older adults affected by HIV: a thematic analysis. *Clin Gerontol* 2019;42(2):137-149. [PMID: 29617194] https://pubmed.ncbi.nlm.nih.gov/29617194

Justice AC, Akgun KM. What does aging with HIV mean for nursing homes? *J Am Geriatr Soc* 2019;67(7):1327-1329. [PMID: 31063666] https://pubmed.ncbi.nlm.nih.gov/31063666

Kehler DS, Milic J, Guaraldi G, et al. Frailty in older people living with HIV: current status and clinical management. *BMC Geriatr* 2022;22(1):919. [PMID: 36447144] https://pubmed.ncbi.nlm.nih.gov/36447144

Kelly SG, Wu K, Tassiopoulos K, et al. Frailty is an independent risk factor for mortality, cardiovascular disease, bone disease, and diabetes among aging adults with human immunodeficiency virus. *Clin Infect Dis* 2019;69(8):1370-1376. [PMID: 30590451] https://pubmed.ncbi.nlm.nih.gov/30590451

Koethe JR, Lagathu C, Lake JE, et al. HIV and antiretroviral therapy-related fat alterations. *Nat Rev Dis Primers* 2020;6(1):48. [PMID: 32555389] https://pubmed.ncbi.nlm.nih.gov/32555389

Kong AM, Pozen A, Anastos K, et al. Non-HIV comorbid conditions and polypharmacy among people living with HIV age 65 or older compared with HIV-negative individuals age 65 or older in the United States: a retrospective claims-based analysis. *AIDS Patient Care STDS* 2019;33(3):93-103. [PMID: 30844304] https://pubmed.ncbi.nlm.nih.gov/30844304

Kovacs L, Kress TC, Belin de Chantemele EJ. HIV, combination antiretroviral therapy, and vascular diseases in men and women. *JACC Basic Transl Sci* 2022;7(4):410-421. [PMID: 35540101] https://pubmed.ncbi.nlm.nih.gov/35540101

Livio F, Deutschmann E, Moffa G, et al. Analysis of inappropriate prescribing in elderly patients of the Swiss HIV Cohort Study reveals gender inequity. *J Antimicrob Chemother* 2021;76(3):758-764. [PMID: 33279997] https://pubmed.ncbi.nlm.nih.gov/33279997

Livio F, Marzolini C. Prescribing issues in older adults living with HIV: thinking beyond drug-drug interactions with antiretroviral drugs. *Ther Adv Drug Saf* 2019;10:2042098619880122. [PMID: 31620274] https://pubmed.ncbi.nlm.nih.gov/31620274

Looby SE. Clinical considerations for menopause and associated symptoms in women with HIV. *Menopause* 2023;30(3):329-331. [PMID: 36811963] https://pubmed.ncbi.nlm.nih.gov/36811963

Machado S. Existential dimensions of surviving HIV: the experience of gay long-term survivors. *J Hum Psychol* 2012;52(1):6-29. [PMID:

Maki PM, Rubin LH, Springer G, et al. Differences in cognitive function between women and men with HIV. *J Acquir Immune Defic Syndr* 2018;79(1):101-107. [PMID: 29847476] https://pubmed.ncbi.nlm.nih.gov/29847476

Masters MC, Perez J, Wu K, et al. Baseline neurocognitive impairment (NCI) is associated with incident frailty but baseline frailty does not predict incident NCI in older persons with human immunodeficiency virus (HIV). *Clin Infect Dis* 2021;73(4):680-688. [PMID: 34398957] https://pubmed.ncbi.nlm.nih.gov/34398957

Molina JM, Grund B, Gordin F, et al. Which HIV-infected adults with high CD4 T-cell counts benefit most from immediate initiation of antiretroviral therapy? A post-hoc subgroup analysis of the START trial. *Lancet HIV* 2018;5(4):e172-e180. [PMID: 29352723] https://pubmed.ncbi.nlm.nih.gov/29352723

Montoya JL, Jankowski CM, O'Brien KK, et al. Evidence-informed practical recommendations for increasing physical activity among persons living with HIV. *AIDS* 2019;33(6):931-939. [PMID: 30946147] https://pubmed.ncbi.nlm.nih.gov/30946147

National Health Policy Forum. Older Americans Act of 1965: programs and funding. 2012 Feb 23. https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1252&context=sphhs_centers_nhpf [accessed 2023 Mar 27]

NYCDHMH. HIV surveillance annual report, 2020. 2021 Dec. https://www.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2020.pdf [accessed 2023 Mar 27]

O'Mahony D, O'Sullivan D, Byrne S, et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age Ageing* 2015;44(2):213-218. [PMID: 25324330] https://pubmed.ncbi.nlm.nih.gov/25324330

Palella FJ, Hart R, Armon C, et al. Non-AIDS comorbidity burden differs by sex, race, and insurance type in aging adults in HIV care. *AIDS* 2019;33(15):2327-2335. [PMID: 31764098] https://pubmed.ncbi.nlm.nih.gov/31764098

Pellegrino RA, Rebeiro PF, Turner M, et al. Sex and race disparities in mortality and years of potential life lost among people with HIV: a 21-year observational cohort study. *Open Forum Infect Dis* 2023;10(1):ofac678. [PMID: 36726547] https://pubmed.ncbi.nlm.nih.gov/36726547

Piggott DA, Bandeen-Roche K, Mehta SH, et al. Frailty transitions, inflammation, and mortality among persons aging with HIV infection and injection drug use. *AIDS* 2020;34(8):1217-1225. [PMID: 32287069] https://pubmed.ncbi.nlm.nih.gov/32287069

Pinholt EM, Kroenke K, Hanley JF, et al. Functional assessment of the elderly. A comparison of standard instruments with clinical judgment. *Arch Intern Med* 1987;147(3):484-488. [PMID: 3827424] https://pubmed.ncbi.nlm.nih.gov/3827424

Rubenstein LZ, Alessi CA, Josephson KR, et al. A randomized trial of a screening, case finding, and referral system for older veterans in primary care. *J Am Geriatr Soc* 2007;55(2):166-174. [PMID: 17302651] https://pubmed.ncbi.nlm.nih.gov/17302651

Saliba D, Elliott M, Rubenstein LZ, et al. The Vulnerable Elders Survey: a tool for identifying vulnerable older people in the community. *J Am Geriatr Soc* 2001;49(12):1691-1699. [PMID: 11844005] https://pubmed.ncbi.nlm.nih.gov/11844005

Samji H, Cescon A, Hogg RS, et al. Closing the gap: increases in life expectancy among treated HIV-positive individuals in the United States and Canada. *PLoS One* 2013;8(12):e81355. [PMID: 24367482] https://pubmed.ncbi.nlm.nih.gov/24367482

Savoy M, O'Gurek D, Brown-James A. Sexual health history: techniques and tips. *Am Fam Physician* 2020;101(5):286-293. [PMID: 32109033] https://pubmed.ncbi.nlm.nih.gov/32109033

Singh HK, Del Carmen T, Freeman R, et al. From one syndrome to many: incorporating geriatric consultation into HIV care. *Clin Infect Dis* 2017;65(3):501-506. [PMID: 28387803] https://pubmed.ncbi.nlm.nih.gov/28387803

Starup-Linde J, Rosendahl SB, Storgaard M, et al. Management of osteoporosis in patients living with HIV-a systematic review and meta-analysis. *J Acquir Immune Defic Syndr* 2020;83(1):1-8. [PMID: 31809356] https://pubmed.ncbi.nlm.nih.gov/31809356

Stone L, Looby SE, Zanni MV. Cardiovascular disease risk among women living with HIV in North America and Europe. *Curr Opin HIV AIDS* 2017;12(6):585-593. [PMID: 28832367] https://pubmed.ncbi.nlm.nih.gov/28832367

Tavoschi L, Gomes Dias J, Pharris A. New HIV diagnoses among adults aged 50 years or older in 31 European countries, 2004-15: an analysis of surveillance data. *Lancet HIV* 2017;4(11):e514-e521. [PMID: 28967582] https://pubmed.ncbi.nlm.nih.gov/28967582

Tinetti M, Huang A, Molnar F. The geriatrics 5M's: A new way of communicating what we do. *J Am Geriatr Soc* 2017;65(9):2115. [PMID: 28586122] https://pubmed.ncbi.nlm.nih.gov/28586122

Tinetti M, Naik AD, Dindo L, et al. Association of patient priorities-aligned decision-making with patient outcomes and ambulatory health care burden among older adults with multiple chronic conditions: a nonrandomized clinical trial. *JAMA Intern Med* 2019;179(12):1688-1697. [PMID: 31589281] https://pubmed.ncbi.nlm.nih.gov/31589281

Vance DE, Rubin LH, Valcour V, et al. Aging and neurocognitive functioning in HIV-infected women: a review of the literature involving the Women's Interagency HIV Study. *Curr HIV/AIDS Rep* 2016;13(6):399-411. [PMID: 27730446] https://pubmed.ncbi.nlm.nih.gov/27730446

Verheij E, Boyd A, Wit FW, et al. Long-term evolution of comorbidities and their disease burden in individuals with and without HIV as they age: analysis of the prospective AGE(h)IV cohort study. *Lancet HIV* 2023;10(3):e164-e174. [PMID: 36774943] https://pubmed.ncbi.nlm.nih.gov/36774943

Wandeler G, Johnson LF, Egger M. Trends in life expectancy of HIV-positive adults on antiretroviral therapy across the globe: comparisons with general population. *Curr Opin HIV AIDS* 2016;11(5):492-500. [PMID: 27254748] https://pubmed.ncbi.nlm.nih.gov/27254748

Winston A, Spudich S. Cognitive disorders in people living with HIV. *Lancet HIV* 2020;7(7):e504-e513. [PMID: 32621876] https://pubmed.ncbi.nlm.nih.gov/32621876

Yarnall AJ, Sayer AA, Clegg A, et al. New horizons in multimorbidity in older adults. *Age Ageing* 2017;46(6):882-888. [PMID: 28985248] https://pubmed.ncbi.nlm.nih.gov/28985248

Yourman LC, Lee SJ, Schonberg MA, et al. Prognostic indices for older adults: a systematic review. *JAMA* 2012;307(2):182-192. [PMID: 22235089] https://pubmed.ncbi.nlm.nih.gov/22235089

FY 2024 - Increase Scenario Part A, MAI, Part B and State Services **Priorities and Allocations Committee PC approved 06/12/2023**

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2024 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
		Part A	**MAI**	**Part B**	**State Services**	**State Rebate**	**Total**	**FY 2024 Allocations & Justification**
1	**Ambulatory/Outpatient Primary Care**	**$11,169,413**	**$2,068,055**	**$0**	**$0**	**$0**	**$13,237,468**	**Level fund since EHE Rapid Start Program brings new clients into the system.**
1.a	PC-Public Clinic	$4,109,697					$4,109,697	**Are hearing aides durable medical equipment in this service category?**
1.b	PC-AA	$1,114,019	$1,045,669				$2,159,688	
1.c	PC-Hisp - see 1.b above	$952,840	$1,022,386				$1,975,226	
1.d	PC-White - see 1.b above	$1,201,238					$1,201,238	
1.e	PC-Rural	$1,151,088					$1,151,088	
1.f	PC-Women	$2,090,531					**$2,090,531**	**FY24 Pt A: Reduce by $107,000 due to FY22 Expend Report**
1.g	PC-Pedi							
1.h	Vision Care	$500,000					**$500,000**	**FY24 Pt A: Reduce by $23,222 due to FY22 Expend Report**
1.j	PC-Pay for Performance Pilot Project	$50,000					$50,000	**FY24 Pt. A: Reduce by $150,000 due to FY22 Expend Report**
2	**Medical Case Management**	**$2,183,040**	**$314,061**	**$0**	**$0**	**$0**	**$2,497,101**	
2.a	CCM-Mental/Substance	$531,025					$531,025	
2.b	MCM-Public Clinic	$301,129					$301,129	
2.c	MCM-AA	$183,663	$157,030				$340,693	
2.d	MCM-Hisp	$183,665	$157,031				$340,696	
2.e	MCM-White	$66,491					$66,491	
2.f	MCM-Rural	$297,496					$297,496	
2.g	MCM-Women	$81,841					$81,841	
2.h	**MCM-Geriatrics**	$400,899					$400,899	**FY24 Pt A: Add 5 Geriatric MCM. 5 FTEs x $80k = $400,000**
2.i	MCM-Veterans	$86,964					$86,964	
2.j	MCM-Youth	$49,867					$49,867	
3	**Local Pharmacy Assistance Program**	**$2,067,104**	**$0**	**$0**	**$0**	**$0**	**$2,067,104**	
3.a	LPAP-Public Clinic	$367,104					$367,104	
3.b	LPAP-Untargeted	$1,700,000					$1,700,000	
4	**Oral Health**	**$166,404**	**$0**	**$2,332,193**	**$0**		**$2,498,597**	
4.a	General Oral Health			$1,815,536				
4.b	Prosthodontics			$516,657				
4.c	Rural Dental	$166,404					$166,404	
5	**Health Insurance Co-Pays & Co-Ins**	**$1,583,137**	**$0**	**$1,028,433**	**$864,506**	**$0**	**$3,476,076**	
6	**Mental Health Services**		**$0**	**$0**	**$300,000**	**$0**	**$300,000**	
6.a.	Mental Health - General				**$200,000**		$200,000	
6.b.	**Mental Health - Other**		**$0**	**$0**	**$100,000**	**$0**	$100,000	**FY24 SS: Pending approval by the Quality Improve Committee**
7	**Medical Nutritional Therapy**	**$341,395**	**$0**	**$0**	**$0**	**$0**	**$341,395**	
8	**Substance Abuse Treatment - Outpatient**	$25,000	**$0**	**$0**	**$0**	**$0**	$25,000	**FY24 Pt A: Using alternative funds 1st. Reduce by $20,677 due to FY22 Expend Report**

FY 2024 - Increase Scenario Part A, MAI, Part B and State Services **Priorities and Allocations Committee PC approved 06/12/2023**

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2024 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
9	**Hospice**	**$0**	**$0**	**$0**	**$259,832**	**$0**	**$259,832**	
10	**Emergency Financial Assistance**	**$2,139,136**	**$0**	**$0**	**$0**	**$0**	**$2,139,136**	
10.a.	EFA - Pharmacy Assistance	$2,039,136					$2,039,136	**FY24 Pt. A: Keep as is due to former ADAP issues & funds can be added later in year if needed**
10.b	EFA - Other	$100,000					$100,000	

FY 2024 - Increase Scenario Part A, MAI, Part B and State Services **Priorities and Allocations Committee PC approved 06/12/2023**

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2024 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
11	**Referral for Health Care & Support Services**	**$0**	**$0**	**$0**	**$175,000**		**$175,000**	**FY22 - This service was Early Interv Services**
12	**Non-Medical Case Management**	**$1,267,002**	**$0**	**$0**	**$350,000**	**$0**	**$1,617,002**	
12.a	SLW-Youth	$110,793					$110,793	
12.a	SLW-Testing	$100,000					$100,000	
12.b	SLW-Public	$370,000					$370,000	
12.c	SLW-CBO, includes some Rural	$686,209					$686,209	
12.d	SLW-Substance Use	$0			$350,000		$350,000	
13	**Transportation**	**$424,911**	**$0**	**$0**	**$0**	**$0**	**$424,911**	
13.a	Van Based - Urban	$252,680					$252,680	
13.b	Van Based - Rural	$97,185		$0			$97,185	
13.c	Bus Passes & Gas Vouchers	$75,046					$75,046	
14	**Linguistic Services**	**$0**	**$0**	**$0**	**$68,000**	**$0**	**$68,000**	
15	**Outreach Services**	**$320,000**	**$0**	**$0**	**$0**	**$0**	**$320,000**	**FY24 Pt A: Reduce by $100,000 due to FY22 Expend Report**
	Total Service Allocation	**$21,686,542**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$29,446,622**	
NA	Quality Management	$428,695					$428,695	
NA	Administration - RWGA + RWPC Support	$2,226,914					$2,226,914	**Indirect costs are now included in RWGA Admin Budget; The PC's full adjusted FY24 budget is included.**
NA	**Total Non-Service Allocation**	**$2,655,609**	**$0**	**$0**	**$0**	**$0**	**$2,655,609**	
	Total Grant Funds	**$24,342,151**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$32,102,231**	

Remaining Funds to Allocate (exact same as the yellow row on top)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Tips:

* Do not make changes to any cells that are underlined. These cells represent running totals. If you make a change to these cells, then the formulas throughout the sheet will become "broken" and the totals will be incorrect.
* It is useful to keep a running track of the changes made to any service allocation. For example, if you want to change an allocation from $42,000 to $40,000, don't just delete the cell contents and type in a new number. Instead, type in "=42000-2000". This shows that you subtracted

Core medical **$17,535,493** **81%**

[For Staff Only]

If needed, use this space to enter base amounts to be used for calculations

	RW/A Amount Actual	MAI Amount Actual	Part B actual	State Service est.	State Rebate est.	
Total Grant Funds	**$24,342,151**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$32,102,231**

DRAFT

Houston Ryan White Planning Council
Priority and Allocations Committee

Proposed Ryan White Part A, MAI, Part B and State Services Funding FY 2024 Allocations

(Priority and Allocations Committee approved 06-12-23)

MOTION A: All Funding Streams – Level Funding Scenario

Level Funding Scenario for Ryan White Part A, MAI, Part B and State Services Funding.

Approve the attached Ryan White Part A, Minority AIDS Initiative (MAI), Part B, and State Services (SS) Level Funding Scenario for FY 2024.

MOTION B: MAI Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Minority AIDS Initiative (MAI).

Primary care subcategories will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Minority AIDS Initiative (MAI).

Primary care subcategories will be increased by the same percent. This applies to the total amount of service dollars available.

MOTION C: Part A Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Part A Funding.

All service categories except subcategories 2.h. Medical Case Management-Geriatric, 2.i. Medical Case Management-Veterans, 2.j. Medical Case Management-Youth, 10. Substance Abuse Services-Outpatient, 13.a. Service Linkage-Youth, and 13.b. Service Linkage-Newly Diagnosed/Not in Care will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Part A Funding.

Step 1: Allocate the first $500,000 to Primary Ambulatory/Outpatient Medical Care (category 1) to be allocated proportionately to all Primary Care subcategories by the Administrative Agent except 1.h. Vision Care and 1.j. Pay for Performance Pilot Project.

Step 2: Allocate the next $200,000 to Health Insurance Assistance Program (category 5).

Step 3: Any remaining funds following the application of Steps 1 and 2 will be allocated by the Ryan White Planning Council.

MOTION D: Part B and State Services Increase/Decrease Scenario

Decrease Funding Scenario for Ryan White Part B and State Services Funding.

A decrease in funds of any amount will be allocated by the Ryan White Planning Council after the notice of grant award is received.

Increase Funding Scenario for Ryan White Part B and State Services Funding.

Step 1: Allocate the first $200,000 to be divided evenly between Oral Health – General Oral Health (category 4.a.) and Oral Health – Prosthodontics (category 4.b.).

Step 2: Allocate the next $200,000 to Health Insurance Assistance Program (category 5).

Step 3: Any remaining increase in funds following application of Steps 1 and 2 will be allocated by the Ryan White Planning Council after the notice of grant award is received.

Houston Area HIV Services Ryan White Planning Council

FY 2024 How to Best Meet the Need Quality Improvement Committee Service Category Recommendation Summary (as of 05/10/23)

Those services for which no change is recommended include:

Case Management (Medical, Clinical, Non-Medical Service Linkage, and Non-Medical Targeting Substance Use Disorders)

Hospice Services

Local Pharmacy Assistance Program (LPAP)

Medical Nutritional Therapy/Supplements

Mental Health Services

Oral Health (Untargeted and Targeting the Northern Rural Area)

Outreach

Referral for Health Care (ADAP Enrollment Workers and Incarcerated)

Substance Abuse Treatment

Vision Care

Services <u>with</u> recommended changes include the following:

Ambulatory Outpatient Medical Care (which includes Emergency Financial Assistance - Pharmacy Assistance)

- Add text to the service definition for EFA-Pharmacy stating that, within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30 day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Keep the financial eligibility the same: Primary Care = 300%, EFA-Pharmacy = 500%

Emergency Financial Assistance – Other

- Keep the service definition and financial eligibility the same at 400%, with the understanding that the Planning Council may add additional services based upon additional information, which is to be provided soon.

Health Insurance Premium and Cost Sharing Assistance

- Keep the service definition and financial eligibility the same: 0 - 400%, ACA plans must have a subsidy, and also request that the Integrated Plan's HIV Education Council increase awareness of this service among private physicians.

Linguistic Services

- Keep the service definition the same and increase the financial eligibility to 500%. Also, explore ways to use virtual technology as much as possible to make this service more accessible and easier for consumers to use. And, ask the Quality Improvement Committee to explore language justice principles in order to make all Ryan White funded services inclusive of people from all cultures.

Transportation

- Add ride sharing to the service definition and keep the financial eligibility the same at 400%.

Table of Contents

FY 2024 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

REVISED – 05-23-23

MEMO

To: Houston Ryan White Planning Council

From: Members, Operations Committee

Date: Tuesday, May 15, 2023

Re: Proposed FY 2024 Council Support Budget

Attached you will find the proposed FY 2024 Council Support Budget, which is higher than the FY 2023 budget by $~~65,327~~ $22,664.

FY 2024 proposed budget	$562,919
FY 2023 budget	- 540,255
Difference	$ 22,664

The reason for the increase in FY 2024 is because of the following additional activities in FY 2024:

New HIV Resource Guide/Blue Book	$ 31,000
National HRSA Conference (hybrid format), August 2024	8,000
Rental fees at Bering Church for 6 months	12,000

Houston Ryan White Planning Council
FY 2024 Council Support Budget
March 1, 2024 - February 28, 2025
(As of 05-23-23)

		Subtotal	Total
PERSONNEL		**$274,474**	
RWPC Manager (V. Williams) ($6930/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$83,158		
RWPC Health Planner (M. Hudson) ($6493/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$77,918		
RWPC Coordinator (D. Beck) ($4938/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$59,259		
Consumer Engagment (R. Avila) ($4512/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$54,139		
FRINGE		**$133,616**	
Social Security @ 7.38%	$20,256		
Health Insurance (4 x $17,252/FTE)	$69,008		
Retirement @ 14.25%	$39,113		
Workers Compensation @ 0.88%	$2,415		
Unemployment Insurance @ 0.10%	$274		
Incentives/allowances	$2,550		
EQUIPMENT			
Replace obsolete computers and tablets and purchase equipment needed to allow Ryan White volunteers and students access to virtual meetings	$4,000	**$4,000**	

Houston Ryan White Planning Council
FY 2024 Council Support Budget
March 1, 2024 - February 28, 2025
(As of 05-23-23)

		Subtotal	Total
TRAVEL		**$8,800**	
Local Travel: $0.655/mile for Planning Council Support Staff	$800		
Out of EMA travel: Two out of town trips for either Office of Support staff and/or Ryan White volunteers to attend HIV related conferences.	$8,000		
SUPPLIES General consumable office supplies including materials for Council members & public meetings.	$6,000	**$6,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$136,029**	
Rental Fees for Office & Meeting Rooms Short-term rental agreement for office and meeting space for RW volunteers & staff while County building is being remodeled. ($2,000/mos. X 12 mos. = $24,000)	$12,000		
Moving Costs	$2,500		
Resource Guide	$31,000		
Reimbursement for Volunteer Expenses: Reimbursement for meals, childcare, travel, gift cards/incentives & other eligible expenses resulting from participation in Council approved/HRSA grant required activities.	$19,000		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$5,000		
Communications (telephone and computer): For local and long distance phone expenses, equipment and internet charges.	$3,500		
Council Education: For speakers & training costs for ongoing training to insure that key decision-makers receive necessary information. This includes a January Orientation and a mid-year Council meeting to be held off-site in Harris County.	$4,500		

Houston Ryan White Planning Council
FY 2024 Council Support Budget
March 1, 2024 - February 28, 2025
(As of 05-23-23)

	Subtotal	Total
Project LEAP Student Reimbursement: 45 participants for 17-week & 16-week courses including travel, childcare, gift card/incentives & other expenses resulting from participation in required consumer training activities in English and Spanish related to the Ryan White grant.	$7,592	
Project LEAP Education: Training costs for 17 weeks & 16 weeks including facilitation & speaker fees, translators & educational materials in English and Spanish.	$15,000	
Consumer Education: Training costs for up to 5 seminars including speaker fees, translators and educational materials.	$2,500	
Interpreter Services: For Spanish-speaking & sign-language interpretation services during Council meetings, public hearings, focus groups and more.	$10,000	
Fees and Dues: Registration costs for attending meetings, trainings & conferences related to HIV/AIDS health planning.	$500	
English/Spanish Translation (written): For professional translation of Council, Project LEAP & other educational materials into Spanish.	$5,000	
Storage Unit for HIV Resource Directories: Storage for 30,000 directories @ $250/month	$3,000	
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$6,000	
Copier Rental: For rental, service agreement of high-use Xerox machine used by Council staff.	$9,000	
TOTAL		**$562,919**

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2023 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
		Part A	**MAI**	**Part B**	**State Services**	**State Rebate**	**Total**	**FY 2023 Allocations & Justification**
1	**Ambulatory/Outpatient Primary Care**	**$11,449,635**	**$2,068,055**	**$0**	**$0**	**$0**	**$13,517,690**	**$500,000 added to all subcategories except Pilot Project**
1.a	PC-Public Clinic	$4,109,697					$4,109,697	
1.b	PC-AA	$1,114,019	$1,045,669				$2,159,688	
1.c	PC-Hisp - see 1.b above	$952,840	$1,022,386				$1,975,226	
1.d	PC-White - see 1.b above	$1,201,238					$1,201,238	
1.e	PC-Rural	$1,151,088					$1,151,088	
1.f	PC-Women	$2,197,531					$2,197,531	
1.g	PC-Pedi	$0					$0	**Must zero out for FY24 (-$16,153) Done (RWPC 5/12/23)**
1.h	Vision Care	$523,222					$523,222	
1.j	PC-Pay for Performance Pilot Project	$200,000					$200,000	
2	**Medical Case Management**	**$1,782,141**	**$314,061**	**$0**	**$0**	**$0**	**$2,096,202**	
2.a	CCM-Mental/Substance	$531,025					$531,025	$150,000 overall increase redistributed amoung all subcategories. **Done.**
2.b	MCM-Public Clinic	$301,129					$301,129	
2.c	MCM-AA	$183,663	$157,030				$340,693	
2.d	MCM-Hisp	$183,665	$157,031				$340,696	
2.e	MCM-White	$66,491					$66,491	
2.f	MCM-Rural	$297,496					$297,496	
2.g	MCM-Women	$81,841					$81,841	
2.h	MCM-Pedi	$0					$0	**Must zero out for FY24 (-$97,859) Done (RWPC 5/12/23)**
2.i	MCM-Veterans	$86,964					$86,964	
2.j	MCM-Youth	$49,867					$49,867	
3	**Local Pharmacy Assistance Program**	**$2,067,104**	**$0**	**$0**	**$0**	**$0**	**$2,067,104**	
3.a	LPAP-Public Clinic	$367,104					$367,104	**FY23 Part A: Increase by $56,744 to address ADAP issues. Done.**
3.b	LPAP-Untargeted	$1,700,000					$1,700,000	
4	**Oral Health**	**$166,404**	**$0**	**$2,218,878**	**$0**		**$2,385,282**	
4.a	General Oral Health			$1,758,878				
4.b	Prosthodontics			$460,000				
4.c	Rural Dental	$166,404					$166,404	
5	**Health Insurance Co-Pays & Co-Ins**	**$1,583,137**	**$0**	**$1,028,433**	**$864,506**	**$0**	**$3,476,076**	**$200,000 added.**
6	**Mental Health Services**	**$0**	**$0**	**$0**	**$300,000**	**$0**	**$300,000**	
7	**Early Intervention Services**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**FY23 SS: Move $175,000 to Referral for Healthcare and Services (RHSS) since the service fits better within RHSS.**

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2023 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
8	**Medical Nutritional Therapy**	**$341,395**	**$0**	**$0**	**$0**	**$0**	**$341,395**	
9	**Home & Community Based Health Services**	**$0**	**$0**	**$113,315**	**$0**	**$0**	**$113,315**	
9.a	In-Home (skilled nursing & health aide)						$0	
9.b	Facility-based (adult day care)			$113,315			$113,315	
10	**Substance Abuse Treatment - Outpatient**	**$45,677**	**$0**	**$0**	**$0**	**$0**	**$45,677**	
11	**Hospice**	**$0**	**$0**	**$0**	**$259,832**	**$0**	**$259,832**	
12	**Referral for Health Care & Support Services**	**$0**	**$0**	**$0**	**$175,000**		**$175,000**	**FY23 SS: Move $175,000 from EIS to Referral to Healthcare & Support Services (RHSS) since service fits better within RHSS.**
13	**Non-Medical Case Management**	**$1,267,002**	**$0**	**$0**	**$350,000**	**$0**	**$1,617,002**	**FY23 Pt A: Per a request from Quality Improvement Committee, increase the average allocation per FTE in order to encourage higher case management salaries and address high turnover. Due to underspending in FY21, Priority & Alloc. Committee feels that level funding will be enough to allow all SLW FTE positions to be increased if agencies wish to make this change.**
13.a	SLW-Youth	$110,793					$110,793	
13.b	SLW-Testing	$100,000					$100,000	
13.c	SLW-Public	$370,000					$370,000	
13.d	SLW-CBO, includes some Rural	$686,209					$686,209	
13.e	SLW-Substance Use	$0			$350,000		$350,000	
14	**Transportation**	**$424,911**	**$0**	**$0**	**$0**	**$0**	**$424,911**	
14.a	Van Based - Urban	$252,680					$252,680	
14.b	Van Based - Rural	$97,185		$0			$97,185	
14.c	Bus Passes & Gas Vouchers	$75,046					$75,046	

Priorities and Allocations Committee PC approved

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2023 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
15	**Emergency Financial Assistance**	**$2,139,136**	**$0**	**$0**	**$0**	**$0**	**$2,139,136**	
15.a	EFA - Pharmacy Assistance	$2,039,136					$2,039,136	**FY23: Increase by $240,000 to address ADAP issues. April reallocation = $485,889; $7,808 added under 10% rule to reconcille allocations against available funds (RWGA).**
15.b	EFA - Other	$100,000					$100,000	**FY23 Part A: Decreased by $140,000 due to underspending in FY21.**
16	**Linguistic Services**	**$0**	**$0**	**$0**	**$68,000**	**$0**	**$68,000**	
17	**Outreach Services**	**$420,000**	**$0**	**$0**	**$0**	**$0**	**$420,000**	
	Total Service Allocation	**$21,686,542**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$29,446,622**	
NA	Quality Management	$428,695					$428,695	
NA	Administration - RWGA + RWPC Support	$2,226,914					$2,226,914	**Indirect costs are now included in RWGA Admin Budget; April: added $18,000 to PC Support (rent at Bering)**
	Total Non-Service Allocation	**$2,655,609**	**$0**	**$0**	**$0**	**$0**	**$2,655,609**	
	Total Grant Funds	**$24,342,151**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$32,102,231**	

Remaining Funds to Allocate (exact same as the yellow row on top)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Tips:

* Do not make changes to any cells that are underlined. These cells represent running totals. If you make a change to these cells, then the formulas throughout the sheet will become "broken" and the totals will be incorrect.
* It is useful to keep a running track of the changes made to any service allocation. For example, if you want to change an allocation from $42,000 to $40,000, don't just delete the cell contents and type in a new number. Instead, type in "=42000-2000". This shows that you

Core medical **$17,435,493** **80%**

[For Staff Only]

If needed, use this space to enter base amounts to be used for calculations

	RW/A Amount Actual	MAI Amount Actual	Part B actual	State Service est.	State Rebate est.	
Total Grant Funds	**$24,342,151**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$32,102,231**

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Harris County Public Health
Building a Healthy Community

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DATE: 06/12/2023

TO: RWPC Priorities & Allocations Committee

FR: Ryan White Grant Administration

RE: FY 2022 Part A/MAI Procurement Report

Please note the following regarding the ***FY 2022 Part A/MAI Procurement Report dated 06/06/2023***:

FY 2022-as of 6/6/23	Total Award	Expense	%	Unspent
Part A Services[1]	$21,708,243	$21,051,463	97%	$656,780
MAI Services[2]	$2,704,223	$2,685,100	99.3%	$19,123
Administration[3]	$1,440,965	$1,030,811	71.6%	$410,154
RWPC Support	$524,908	$525,193	100.1%	-$285
CQM	$412,940	$339,969	82.4%	$72,971
Total*	**$26,791,279**	**$25,632,536**	**95.7%**	**$1,158,743**

*Final numbers are certified when Harris County submits its Federal Financial Report (FFR) due July 30, 2023

- The Houston EMA will be required submit a *retrospective* **Core Services Waiver** for FY22 because final Core Services expenditures were less than 75% of total service expenditures (this is the first time Houston has been under 75% Core services expenditures)
    - Core Services expenditures: 74.03% (primarily underspending in Primary Care)
    - Support Services expenditures: 25.97% (primarily due to higher than originally allocated expenditures in EFA-Pharmacy and Non-MCM**)**

- 97.2% of all procured RW/A & MAI service dollars were expended ($24,409,611 allocated; $23,736,563 expended)

- Of the total of $1,158,743 in unspent funds in Outpatient Primary Care, $437,926 (39%) is attributed to Primary Care Targeted to Women at Public Clinic (service priority 1.f) while $483,125 is attributed to unspent RWGA Admin and CQM funds. Taken together, these two amounts represent 80% of all FY22 unspent funds.

- $888,285 in FY21 carryover funds were allocated to Health Insurance Assistance ($138,285) and EFA-Pharmacy ($750,000) and these funds were fully expended

[1] Part A Services includes carryover funds of $888,285

[2] MAI Services includes carryover funds of $276,305

[3] PHS did not take indirect costs of $169,915 in FY22, but will charge indirect costs for FY 2023, which will be included in the admin budget

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- Most of the Final Quarter Adjustments were reallocated to LPAP, Non-Medical Case Management (SLW), and EFA-Pharmacy

- Vision (service category 1.h): only $404,505 (81%) was expended in FY22 out of the $500,000 allocated
    - One Vision care provider did not accept their full award in FY22. For FY23, the other Vision care provider have accepted those additional funds

- The Primary Care Pay for Performance (P4P) pilot project awarded only $29,070 to agencies in FY22 despite an allocation of $200,000
    - Only two out of the five outpatient primary care providers billed for P4P services. This is historically an underspent category. RWGA is waiting to hear back from agencies to gauge interest in continuing the pilot project
    - The RWPC may consider reallocating this $200,000 to other service categories in FY24. If needed, RWGA can usually identify unspent funds in the final quarter of the grant year to cover potential P4P costs

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Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments (to avoid UOB penalty)	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**	**10,965,788**	**-15,437**	**0**	**84,657**	**-239,401**	**10,795,607**	**44.82%**	**10,795,607**	**0**	3/1/2022	**9,447,043**	**88%**	**100%**
1.a	Primary Care - Public Clinic (a)	3,927,300				-249,250	3,678,050	15.27%	3,678,050	0	3/1/2022	$3,488,935	95%	100%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576			90,574	9,849	1,164,999	4.84%	1,164,999	0	3/1/2022	$1,383,157	119%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551			75,774		986,325	4.09%	986,325	0	3/1/2022	$1,295,725	131%	100%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924			16,300		1,164,224	4.83%	1,164,224	0	3/1/2022	$731,455	63%	100%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000			-97,990		1,002,010	4.16%	1,002,010	0	3/1/2022	$866,195	86%	100%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000					2,100,000	8.72%	2,100,000	0	3/1/2022	$1,248,001	59%	100%
1.g	Primary Care - Pediatric (a.1)	15,437	-15,437				0	0.00%	0	0	3/1/2022	$0	0%	0%
1.h	Vision	500,000					500,000	2.08%	500,000	0	3/1/2022	$404,505	81%	100%
1.x	Primary Care Health Outcome Pilot	200,000					200,000	0.83%	200,000	0	3/1/2022	$29,070	15%	100%
2	**Medical Case Management**	**1,730,000**	**-90,051**	**0**	**-15,000**	**-51,045**	**1,573,904**	**6.53%**	**1,573,904**	**0**	3/1/2022	**1,810,623**	**115%**	**100%**
2.a	Clinical Case Management	488,656					488,656	2.03%	488,656	0	3/1/2022	$557,172	114%	100%
2.b	Med CM - Public Clinic (a)	277,103				53,200	330,303	1.37%	330,303	0	3/1/2022	$432,591	131%	100%
2.c	Med CM - Targeted to AA (a) (e)	169,009				-52,123	116,886	0.49%	116,886	0	3/1/2022	$237,123	203%	100%
2.d	Med CM - Targeted to H/L (a) (e)	169,011				-52,123	116,888	0.49%	116,888	0	3/1/2022	$95,821	82%	100%
2.e	Med CM - Targeted to W/MSM (a) (e)	61,186					61,186	0.25%	61,186	0	3/1/2022	$90,077	147%	100%
2.f	Med CM - Targeted to Rural (a)	273,760					273,760	1.14%	273,760	0	3/1/2022	$120,320	44%	100%
2.g	Med CM - Women at Public Clinic (a)	75,311					75,311	0.31%	75,311	0	3/1/2022	$154,384	205%	100%
2.h	Med CM - Targeted to Pedi (a.1)	90,051	-90,051			0	0	0.00%	0	0	3/1/2022	$0	0%	0%
2.i	Med CM - Targeted to Veterans	80,025			-15,000	0	65,025	0.27%	65,025	0	3/1/2022	$40,737	63%	100%
2.j	Med CM - Targeted to Youth	45,888					45,888	0.19%	45,888	0	3/1/2022	$82,398	180%	100%
3	**Local Pharmacy Assistance Program**	**1,810,360**	**200,000**	**0**	**0**	**177,476**	**2,187,836**	**9.08%**	**2,187,836**	**0**	3/1/2022	**$1,862,173**	**85%**	**100%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	310,360				196,050	506,410	2.10%	506,410	0	3/1/2022	$393,778	78%	100%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,500,000	200,000			-18,574	1,681,426	6.98%	1,681,426	0	3/1/2022	$1,468,395	87%	100%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.69%**	**166,404**	**0**	3/1/2022	**166,400**	**100%**	**100%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	**0%**
4.b	Oral Health - Targeted to Rural	166,404				0	166,404	0.69%	166,404	0	3/1/2022	$166,400	100%	100%
5	**Health Insurance (c)**	**1,383,137**	**431,299**	**138,285**		**0**	**1,952,721**	**8.11%**	**1,952,721**	**0**	3/1/2022	**$1,952,386**	**100%**	**100%**
6	**Mental Health Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
7	**Early Intervention Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Medical Nutritional Therapy (supplements)**	**341,395**					**341,395**	**1.42%**	**341,395**	**0**	**3/1/2022**	**$339,519**	**99%**	**100%**
9	**Home and Community-Based Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9.a	In-Home	0					0		0	0	N/A	$0	0%	0%
9.b	Facility Based	0					0		0	0	N/A	$0	0%	0%
10	**Substance Abuse Services - Outpatient (c)**	**45,677**			**-20,667**		**25,010**	**0.10%**	**25,010**	**0**	3/1/2022	**$6,788**	**27%**	**100%**
11	**Hospice Services**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Referral for Health Care and Support Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
13	**Non-Medical Case Management**	**1,267,002**	**0**	**0**	**43,000**	**112,783**	**1,422,785**	**5.91%**	**1,422,785**	**0**	**3/1/2022**	**$1,401,421**	**98%**	**100%**
13.a	Service Linkage targeted to Youth	110,793					110,793	**0.46%**	110,793	0	3/1/2022	$114,507	103%	100%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			**-7,000**		93,000	**0.39%**	93,000	0	3/1/2022	$95,171	102%	100%
13.c	Service Linkage at Public Clinic (a)	370,000				69,960	439,960	**1.83%**	439,960	0	3/1/2022	$508,524	116%	100%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209			50,000	42,823	779,032	**3.23%**	779,032	0	3/1/2022	$683,219	88%	100%
13.e	SLW-Substance Use	0					0	**0.00%**	0	0	NA	$0	0%	0%
14	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.76%**	**424,911**	**0**		**424,383**	**100%**	**100%**
14.a	Medical Transportation services targeted to Urban	252,680					252,680	1.05%	252,680	0	3/1/2022	$269,988	107%	100%
14.b	Medical Transportation services targeted to Rural	97,185					97,185	0.40%	97,185	0	3/1/2022	$79,874	82%	100%
14.c	Transportation vouchering (bus passes & gas cards)	75,046					75,046	0.31%	75,046	0	3/1/2022	$74,521	99%	100%
15	**Emergency Financial Assistance**	**1,545,439**	**189,168**	**750,000**	**-120,000**	**121,903**	**2,486,510**	**10.32%**	**2,486,510**	**0**		**3,344,026**	**134%**	**100%**
15.a	EFA - Pharmacy Assistance	1,305,439	189,168	750,000		121,903	2,366,510	9.82%	2,366,510	0	3/1/2022	$3,267,696	138%	100%
15.b	EFA - Other	240,000			-120,000		120,000	0.50%	120,000	0	3/1/2022	$76,331	64%	100%
16	**Linguistic Services (c)**	**0**	**0**				**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
17	**Outreach**	**420,000**			**30,030**	**-121,717**	**328,313**	**1.36%**	**328,313**	**0**	**3/1/2022**	**$296,700**	**90%**	**100%**
BEU27516	**Total Service Dollars**	**20,100,113**	**714,979**	**888,285**	**2,020**	**-1**	**21,705,396**	**90.11%**	**21,705,396**	**0**		**21,051,463**	**97%**	**100%**

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments (to avoid UOB penalty)	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
	Grant Administration	**1,795,958**	**169,915**	**0**	**0**	**0**	**1,965,873**	**8.16%**	**1,965,873**	0	**N/A**	**1,556,004**	**79%**	**100%**
BEU27517	HCPH/RWGA Section	1,271,050	169,915	0		0	1,440,965	5.98%	1,440,965	0	N/A	$1,030,811	72%	100%
PC	RWPC Support*	524,908			0	0	524,908	2.18%	524,908	0	N/A	525,193	100%	100%
BEU27521	**Quality Management**	**412,940**		**0**	**0**	**0**	**412,940**	**1.71%**	**412,940**	**0**	**N/A**	**$339,969**	**82%**	**100%**
		22,309,011	**884,894**	**888,285**	**2,020**	**-1**	**24,084,209**	**99.99%**	**24,084,209**	**0**		**22,947,436**	**95.28%**	**100%**
								Unallocated	**Unobligated**			**Unspent**		100%
	Part A Grant Award:	**23,198,771**	***Carry Over:***	**888,285**		***Total Part A:***	**24,087,056**	**2,847**	**0**			**1,139,620**	**4.73%**	100%

		Original Allocation	Award Reconcilation	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent				
	Core (must not be less than 75% of total service dollars)	**16,442,761**	**525,811**	**138,285**	**48,990**	**-112,970**	**17,155,847**	**79.04%**	**15,584,932**	**74.03%**	**Core Service Waiver needed for FY22**			
	Non-Core (may not exceed 25% of total service dollars)	**3,657,352**	**189,168**	**750,000**	**-46,970**	**112,969**	**4,549,550**	**20.96%**	**5,466,531**	**25.97%**	Reasons: Underspent Pcare (Public Clinic); Underspent			
	Total Service Dollars (does not include Admin and QM)	**20,100,113**	**714,979**	**888,285**	**2,020**	**0**	**21,705,397**		**21,051,463**		MCM; EFA & SLW higher expenditures than Level alloc			
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,795,958**	**169,915**	**0**	**0**	**0**	**1,965,873**	**7.34%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**412,940**	**0**	**0**	**0**	**0**	**412,940**	**1.54%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	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**	**2,002,860**	**104,950**	**0**	**0**	**68,030**	**2,175,840**	**80.46%**	**2,175,840**	**0**		**2,173,325**	**100%**	**100%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,012,700	53,065			34,015	1,099,780	40.67%	1,099,780	0	3/1/2022	$1,143,450	104%	100%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	990,160	51,884			34,015	1,076,059	39.79%	1,076,059	0	3/1/2022	$1,029,875	96%	100%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**-68,030**	**252,070**	**9.32%**	**252,070**	**0**		**$236,811**	**94%**	100%
2.c (MAI)	MCM - Targeted to African American	160,050				-34,015	126,035	4.66%	126,035	0	3/1/2022	$146,495	116%	100%
2.d (MAI)	MCM - Targeted to Hispanic	160,050				-34,015	126,035	4.66%	126,035	0	3/1/2022	$90,316	72%	100%
3	**DSHS ADAP**	**0**	**0**	**276,305**	**0**	**0**	**276,305**	**10.22%**	**276,305**	**0**	**3/1/2022**	**$274,964**	**100%**	**100%**
	Total MAI Service Funds	**2,322,960**	**104,950**	**276,305**	**0**	**0**	**2,704,215**	**100.00%**	**2,704,215**	**0**		**2,685,100**	**99%**	100%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
	Total MAI Funds	**2,322,960**	**104,950**	**276,305**	**0**	**0**	**2,704,215**	**100.00%**	**2,704,215**	**0**		**2,685,100**	**99%**	**100%**
								Unallocated	**Unobligated**					
	MAI Grant Award	**2,427,918**	***Carry Over:***	**276,305**		***Total MAI:***	**2,704,223**	***8***	0			**Unspent**		100%
												19,124		100%
	Combined Part A and MAI Orginial Allocation Total	**24,631,971**												

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

Prepared by: Ryan White Grant Administration

FY 2022 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 4th Quarter (3/1-2/28)																		
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 plus**
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**7,946**	**76%**	**22%**	**2%**	**44%**	**12%**	**2%**	**41%**	**0%**	**0%**	**5%**	**28%**	**28%**	**11%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,607	72%	26%	1%	42%	9%	2%	47%	0%	0%	3%	17%	27%	14%	36%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	2,267	71%	27%	3%	98%	0%	1%	0%	0%	0%	7%	37%	27%	10%	18%	2%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,908	82%	14%	4%	0%	0%	0%	100%	0%	0%	6%	32%	30%	11%	19%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	759	87%	11%	2%	0%	85%	15%	0%	0%	0%	2%	29%	26%	8%	32%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	614	71%	28%	1%	43%	21%	2%	34%	0%	0%	2%	30%	28%	11%	26%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	697	0%	99%	1%	52%	5%	1%	42%	0%	0%	2%	10%	27%	18%	38%	5%
1.g	Primary Care - Pediatric (a)	7	0															
1.h	Vision	1,600	2,251	74%	24%	2%	46%	13%	2%	38%	0%	0%	4%	23%	24%	12%	31%	6%
2	**Medical Case Management (f)**	**3,075**	**4,567**															
2.a	Clinical Case Management	600	753	71%	27%	2%	53%	13%	1%	33%	0%	0%	3%	23%	25%	12%	31%	6%
2.b	Med CM - Targeted to Public Clinic (a)	280	480	91%	7%	2%	50%	13%	1%	35%	0%	0%	1%	23%	28%	10%	32%	5%
2.c	Med CM - Targeted to AA (a)	550	1,404	67%	30%	3%	99%	0%	1%	0%	0%	0%	4%	30%	26%	10%	26%	4%
2.d	Med CM - Targeted to H/L(a)	550	678	79%	15%	6%	0%	0%	0%	100%	0%	0%	6%	29%	30%	11%	22%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	449	86%	12%	2%	0%	89%	11%	0%	0%	0%	2%	20%	25%	10%	35%	8%
2.f	Med CM - Targeted to Rural (a)	150	462	66%	33%	1%	44%	30%	3%	24%	0%	0%	3%	24%	26%	10%	32%	6%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	199	0%	99%	1%	65%	10%	3%	23%	0%	0%	4%	22%	32%	12%	25%	5%
2.h	Med CM - Targeted to Pedi (a)	125	0															
2.i	Med CM - Targeted to Veterans	200	135	97%	3%	0%	70%	20%	1%	10%	0%	0%	0%	0%	3%	4%	44%	49%
2.j	Med CM - Targeted to Youth	120	7	86%	14%	0%	29%	29%	0%	43%	0%	14%	86%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**5,505**	**75%**	**21%**	**3%**	**46%**	**12%**	**2%**	**40%**	**0%**	**0%**	**4%**	**28%**	**28%**	**12%**	**26%**	**2%**
4	**Oral Health**	**200**	**285**	**68%**	**31%**	**1%**	**39%**	**28%**	**1%**	**31%**	**0%**	**0%**	**3%**	**20%**	**24%**	**15%**	**31%**	**7%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	285	68%	31%	**1%**	39%	28%	1%	31%	0%	0%	3%	20%	24%	15%	31%	7%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,698**	**79%**	**19%**	**2%**	**43%**	**25%**	**3%**	**29%**	**0%**	**0%**	**1%**	**15%**	**19%**	**10%**	**41%**	**15%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**9**	**100%**	**0%**	**0%**	**11%**	**44%**	**11%**	**33%**	**0%**	**11%**	**0%**	**44%**	**22%**	**0%**	**22%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**452**	**75%**	**23%**	**2%**	**43%**	**19%**	**3%**	**35%**	**0%**	**0%**	**1%**	**8%**	**17%**	**8%**	**50%**	**15%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**843**	**77%**	**20%**	**3%**	**58%**	**14%**	**2%**	**26%**	**0%**	**0%**	**5%**	**32%**	**28%**	**9%**	**22%**	**5%**
13	**Non-Medical Case Management**	**7,045**	**7,619**															
13.a	Service Linkage Targeted to Youth	320	165	77%	23%	0%	51%	6%	2%	41%	0%	13%	87%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	83	73%	24%	2%	54%	6%	4%	36%	0%	0%	0%	46%	33%	10%	12%	0%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	3,085	68%	30%	1%	50%	9%	1%	39%	0%	0%	0%	18%	25%	13%	38%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	4,286	75%	23%	3%	53%	12%	2%	33%	0%	0%	4%	29%	24%	10%	27%	5%
14	**Transportation**	**2,850**	**2,032**															
14.a	Transportation Services - Urban	170	659	69%	30%	2%	59%	7%	3%	31%	0%	0%	5%	26%	24%	10%	30%	6%
14.b	Transportation Services - Rural	130	161	66%	32%	1%	29%	29%	1%	41%	0%	0%	4%	19%	19%	18%	30%	9%
14.c	Transportation vouchering	2,550	1,212															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**1,786**	**76%**	**22%**	**2%**	**46%**	**9%**	**2%**	**43%**	**0%**	**0%**	**4%**	**26%**	**28%**	**12%**	**27%**	**3%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**13,745**	**75%**	**23%**	**2%**	**49%**	**14%**	**2%**	**35%**	**0%**	**0%**	**4%**	**25%**	**25%**	**11%**	**29%**	**6%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		**NA**	**30,198**	**75%**	**25%**		**48%**	**17%**	**5%**	**30%**	**0%**	**4%**		**21%**	**23%**	**25%**	**20%**	**7%**

Available Data As Of: 4/10/2023

Prepared by: Ryan White Grant Administration

FY 2022 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 4th Quarter (03/01 - 02/28)																		
Priority	**Service Category MAI unduplicated served includes clients also served under Part A**	**Goal**	**Unduplicated MAI 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**	**45-49**	**50-64**	**65 plus**
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,819	**71%**	**25%**	**3%**	**99%**	**0%**	**1%**	**0%**	**0%**	**0%**	**6%**	**35%**	**27%**	**10%**	**19%**	**2%**
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,627	**82%**	**14%**	**4%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**5%**	**31%**	**29%**	**13%**	**20%**	**1%**
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	885	**80%**	**17%**	**4%**	**47%**	**13%**	**2%**	**38%**	**0%**	**0%**	**7%**	**37%**	**27%**	**9%**	**17%**	**1%**
2.d	Med CM - Targeted to H/L(a)	960	662	**64%**	**33%**	**3%**	**63%**	**12%**	**1%**	**24%**	**0%**	**1%**	**6%**	**24%**	**28%**	**10%**	**24%**	**6%**

RW Part A New Client Service Utilization Report - 4th Quarter (03/01-02/28) Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/22-2/28/23)																		
Priority	**Service Category**	**Goal**	**Unduplicated New 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**	**45-49**	**50-64**	**65 plus**
1	**Primary Medical Care**	**2,100**	**1,755**	**81%**	**17%**	**2%**	**47%**	**13%**	**2%**	**38%**	**0%**	**1%**	**9%**	**37%**	**26%**	**9%**	**2%**	**17%**
2	**LPAP**	**1,200**	**791**	**80%**	**17%**	**4%**	**47%**	**13%**	**2%**	**38%**	**0%**	**0%**	**7%**	**37%**	**27%**	**9%**	**1%**	**17%**
3.a	Clinical Case Management	400	67	64%	33%	3%	63%	12%	1%	24%	0%	1%	6%	24%	**28%**	**10%**	6%	**24%**
3.b-3.h	Medical Case Management	1,600	1003	77%	21%	2%	49%	15%	2%	34%	0%	0%	7%	33%	**26%**	**8%**	3%	**21%**
3.i	Medical Case Manangement - Targeted to Veterans	60	20	95%	5%	0%	55%	20%	5%	20%	0%	0%	0%	0%	**5%**	**15%**	35%	**45%**
4	**Oral Health**	**40**	**34**	**76%**	**24%**	0%	**44%**	**26%**	**6%**	**24%**	**0%**	**0%**	**9%**	**32%**	**18%**	**9%**	**6%**	**26%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**1,753**	**75%**	**23%**	**2%**	**52%**	**13%**	**2%**	**33%**	**0%**	**1%**	**7%**	**30%**	**25%**	**9%**	**23%**	**4%**
12.b	**Service Linkage at Testing Sites**	**260**	**74**	**76%**	**22%**	**3%**	**57%**	**7%**	**3%**	**34%**	**0%**	**4%**	**23%**	**30%**	**27%**	**9%**	**7%**	**0%**
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																	

Available Data As Of: 4/10/2023

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2223 Ryan White Part B

Procurement Report

April 1, 2022 - March 31, 2023

Reflects spending through March 2023 (FINAL)

Spending Target: 100%

Revised 6/1/23

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	$1,658,878	48%	$0	$1,658,878	-$35,000	$1,623,878	4/1/2022	$1,582,979	97%
4	Oral Health Service -Prosthodontics	$560,000	16%	$0	$560,000	$75,000	$635,000	4/1/2022	$662,235	104%
5	Health Insurance Premiums and Cost Sharing (1)	$1,107,702	32%	$0	$1,107,702	$0	$1,107,702	4/1/2022	$1,367,261	123%
9	Home and Community Based Health Services	$113,315	3%	$0	$113,315	-$54,000	$59,315	4/1/2022	$58,960	99%
		$0	0%	$0	$0					
	Total Houston HSDA	3,439,895	100%	0	3,439,895	-$14,000	$3,425,895		3,671,436	107%

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.

*Note TRG reallocated funds to avoid lapse in funds including reallocated funds from rural HSDAs.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2223 DSHS State Services

Procurement Report

September 1, 2022 - August 31, 2023

Chart reflects spending through April 2023

Spending Target: 67%

Revised 6/1/2023

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)**	$864,506	47%	**$0**	$864,506	$0	$864,506	9/1/2022	$771,355	89%
6	**Mental Health Services (2)**	$300,000	16%	**$0**	$300,000	$0	$300,000	9/1/2022	$69,629	23%
11	**Hospice (3)**	$259,832	14%	**$0**	$259,832	$0	$259,832	9/1/2022	$234,080	90%
13	**Non Medical Case Management (4)**	$350,000	19%	**$0**	$350,000	$0	$350,000	9/1/2022	$115,595	33%
16	**Linguistic Services (5)**	$68,000	4%	**$0**	$68,000	$0	$68,000	9/1/2022	$36,180	53%
	Total Houston HSDA	**1,842,338**	**100%**	**$0**	$1,842,338	$0	$1,842,338		1,226,839	67%

Note

(1) HIP- Funded by Part A, B and State Services/. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31.
(2) Demand for services has been lower than expected
(3) Service utilization has increased. TRG will reallocate funds to support care delivery
(4) Staff vacancy has resulted in underspending
(5) Slight decrease in utilization

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2022-4/30/2023

Revised: 5/24/2023

	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	611	$71,336.66	278	*0*	*$0.00*	*0*
Medical Deductible	210	$177,222.18	159	*0*	*$0.00*	*0*
Medical Premium	4952	$1,735,534.41	864	*0*	*$0.00*	*0*
Pharmacy Co-Payment	4351	$1,462,509.24	1708	*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	14	$1,137.06	12	*NA*	*NA*	*NA*
Totals:	10138	$3,445,465.43	3021	0	$0.00	

Comments: This report represents services provided under all grants.

DRAFT

Priority and Allocations

FY 2024 Guiding Principles and Decision Making Criteria

(Priority and Allocations Committee approved 02-23-23)

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)

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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 Comprehensive 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

Houston Ryan White Planning Council
Priority and Allocations Committee

Proposed Ryan White Part A, MAI, Part B and State Services Funding FY 2023 Allocations

(Priority and Allocations Committee approved 06-06-22)

MOTION A: All Funding Streams – Level Funding Scenario

Level Funding Scenario for Ryan White Part A, MAI, Part B and State Services Funding.

Approve the attached Ryan White Part A, Minority AIDS Initiative (MAI), Part B, and State Services (SS) Level Funding Scenario for FY 2023.

MOTION B: MAI Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Minority AIDS Initiative (MAI).

Primary care subcategories will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Minority AIDS Initiative (MAI).

Primary care subcategories will be increased by the same percent. This applies to the total amount of service dollars available.

MOTION C: Part A Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Part A Funding.

All service categories except subcategories 1.g. Primary Care-Pediatric, 2.h. Medical Case Management-Pediatric, 2.i. Medical Case Management-Veterans, 2.j. Medical Case Management-Youth, 10. Substance Abuse Services-Outpatient, 13.a. Service Linkage-Youth, and 13.b. Service Linkage-Newly Diagnosed/Not in Care will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Part A Funding.

Step 1: Allocate the first $500,000 to Primary Ambulatory/Outpatient Medical Care (category 1) to be allocated proportionatly to all Primary Care subcategories by the Administrative Agent.

Step 2: Allocate the next $200,000 to Health Insurance Assistance Program (category 5).

Step 3: Any remaining funds following the application of Steps 1 and 2 will be allocated by the Ryan White Planning Council.

MOTION D: Part B and State Services Increase/Decrease Scenario

Decrease Funding Scenario for Ryan White Part B and State Services Funding.

A decrease in funds of any amount will be allocated by the Ryan White Planning Council after the notice of grant award is received.

Increase Funding Scenario for Ryan White Part B and State Services Funding.

Step 1: Allocate the first $200,000 to be divided evenly between Oral Health – General Oral Health (category 4.a.) and Oral Health – Prosthodontics (category 4.b.).

Step 2: Allocate the next $200,000 to Health Insurance Assistance Program (category 5).

Step 3: Any remaining increase in funds following application of Steps 1 and 2 will be allocated by the Ryan White Planning Council after the notice of grant award is received.

UPDATED:
06/05/23

All meetings subject to change. Please call in advance to confirm:
832 927-7926

Unless otherwise noted, all meetings will be hybrid

June 2023

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1 12 noon Steering Committee	**2**	**3**
4	**5** National Long Term Survivors Awareness Day	**6**	**7**	**8** Nat'l Caribbean American HIV Awareness Day 12 noon **hybrid** Planning Council 2:00 pm **hybrid** Comp HIV Planning	**9**	**10**
11	**12** 12noon – 4pm Special P&A meeting: Allocations	**13** 11:00 a.m. Operations 12noon – 4pm Special P&A meeting: Allocations CANCELLED Quality Improvement	**14** TENTATIVE Special P&A meeting: Allocations	**15**	**16**	**17**
18	**19** **Juneteenth Office Closed**	**20** 12 noon Affected Community	**21**	**22** 12 noon Priority & Allocations	**23**	**24**
25	**26** 7:00 p.m. Public Hearing	**27** Nat'l HIV Testing Day	**28** 9:30 a.m. SIRR Meeting *GoToMeeting* *TENTATIVE* 12noon Priority & Allocations	**29**	**30**	