Houston Area HIV Services Ryan White Planning Council
Office of Support
832 927-7926 telephone; 713 572-3740 fax

Memorandum

To: Members, Quality Improvement Committee

Tana Pradia, Co-Chair	Faye Robinson
Pete Rodriguez, Co- Chair	*Herman Finley*
Kevin Aloysius	*Denis Kelly*
Caleb Brown	*Gloria Sierra*
Titan Capri	*Deborah Somoye*
Daphne L. Jones	*Denis Kelly*
Oscar Perez	*Christopher Walker*

Copy:

Glenn Urbach	Mackenzie A. Hudson
Mauricia Chatman	Diane Beck
Tiffany Shepherd	Ann Robison
Sha'Terra Johnson	Gary Grier
Patrick Martin	

From: Tori Williams

Date: Wednesday, July 12, 2023

Re: Meeting Notice

We look forward to seeing you at the next Quality Improvement Committee meeting. Details are as follows:

Quality Improvement Committee Meeting
2:00 p.m., Tuesday, July 18, 2023

To participate virtually, click on this link:
https://us02web.zoom.us/j/81144509622?pwd=SFNBM1RScVFabHkzakVpaUZoeHhIdz09
Meeting ID: 811 4450 9622 Passcode: 125672
Or, call in by dialing: 346 248 7799
To attend in person: Bering Church, 1440 Harold St, Houston, Texas 77006

RSVP to Rod, even if you cannot attend the meeting. She can be reached at: Rodriga.Avila@cjo.harriscountytx.gov or by telephone at 832 927-7926. And, if you have questions for your committee mentor, do not hesitate to contact her at:

Tana Pradia, 832 298-4248, tanapradia@gmail.com

DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

2:00 pm, Tuesday, July 18, 2023

Join the meeting via Zoom
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 811 4450 9622 Passcode: 125672

Or, use your cell phone to dial in at: 346 248 7799

Agenda

* = Handout to be distributed at the meeting

I.	Call to Order	Tana Pradia and
	A. Welcoming Remarks and Moment of Reflection	Pete Rodriguez, Co-Chairs
	B. Adoption of Agenda	
	C. Approval of Minutes dated 05/09/23	
II.	Public Comment	

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III.	Reports from the Administrative Agents	
	A. Ryan White Part A	Glenn Urbach
	B. Ryan White Part B and State Services	Tiffany Shepherd
IV.	New Business	
	A. Stand-Alone Mental Health Subcategory Service Definition*	Sha'Terra Johnson
	B. HIV & Aging Public Comment: AETC Information	Tori Williams
	C. Case Manager for people with history of sexual offense	
V.	Announcements	
V.	Adjourn	
Optional: New members meet with committee mentor		Tana Pradia

***Minutes of the 06-12-23 Priority and Allocations Committee Meeting*: 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.**

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, May 9, 2023
Meeting Location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Tana Pradia, Co-Chair	Pete Rodriguez, excused	Glenn Urbach, RWGA
Kevin Aloysius	Faye Robinson	Mauricia Chatman, RWGA
Caleb Brown	Herman Finley	Tionna Cobb, TRG
Titan Capri	Gloria Sierra, excused	Tori Williams, Ofc of Support
Daphne Jones	Christopher Walker	Mackenzie Hudson, Ofc of Support
Oscar Perez		Diane Beck, Ofc of Support
Denis Kelly		
Deborah Somoye		

Call to Order: Tana Pradia, Co-Chair, called the meeting to order at 2:07 p.m. and asked for a moment of reflection for those who are gone.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Jones, Capri) to approve the March 14, 2023 joint committee meeting minutes.* ***Motion carried****.* Abstentions: Kelly. ***Motion #3****: it was moved and seconded (Kelly, Somoye) to approve the March 14, 2023 committee meeting minutes.* ***Motion carried****.* Abstentions: Aloysius, Capri, Jones, Kelly.

Public Comment: None.

Reports from the Administrative Agents
Ryan White Part A/MAI: The committee reviewed the following attached reports:

- FY 2022 Ryan White Part A and MAI Service Utilization Report, dated 04/10/23
- FY 2022 Ryan White Part A and MAI Procurement Report, dated 03/21/23
- FY 2023 Level Funding Scenario - Adjusted to Final Award, dated 04/10/23

Ryan White Part B and State Services: The committee reviewed the following attached reports:

- FY2022 Part B Procurement Report, dated 04/06/23
- FY2022-23 DSHS State Services Procurement Report, dated 04/06/23
- FY2022-23 DSHS State Services Service Utilization Report, dated 04/03/23
- Health Insurance Service Utilization Report, dated 03/30/23

FY 2024 How to Best Meet the Need
Workgroup Recommendations, including Financial Eligibility: See attached summary of workgroup recommendations, FY2024 justification chart and the full packet of service definitions.

Motion #4*: it was moved and seconded (Kelly, Jones) to approve the How to Best Meet the Need workgroup recommendations for services with no recommended changes: Case Management (including Medical, Clinical, Non-Medical Service Linkage, and Non-Medical Targeting Substance Use Disorders), Hospice Services, Local Pharmacy Assistance Program, Medical Nutritional Therapy/Supplements, Mental Health Services, Oral Health (untargeted and targeted to northern rural area), Outreach, Referral for Health Care (ADAP enrollment workers and incarcerated), Outpatient Substance Abuse Treatment, and Vision Care.* **Motion carried**. *Abstentions: Aloysius, Jones, Kelly, Perez.*

Motion #5*: it was moved and seconded (Jones, Kelly) to amend the How to Best Meet the Need workgroup recommendation for Emergency Financial Assistance-Other: change Quality Improvement Committee to Planning Council.* **Motion carried.** Abstentions: Aloysius, Jones.

Motion #6*: it was moved and seconded (Aloysius, Kelly) to approve the How to Best Meet the Need workgroup recommendations for Ambulatory Outpatient Medical Care, Emergency Financial Assistance–Other, Health Insurance Premium and Cost Sharing Assistance, and Transportation.* **Motion carried**. Abstentions: Aloysius, Jones, Kelly.

Motion #7: *it was moved and seconded (Capri, Jones) to approve the How to Best Meet the Need workgroup recommendation for Linguistic Services: accept the service definition as presented and keep the financial eligibility the same. 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.* **Motion failed**. Abstentions: Jones.

Motion #8*: it was moved and seconded (Kelly, Capri) to accept the service definition for Linguistic Services as presented 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.* **Motion carried**. Abstentions: Aloysius, Jones.

HIV Targeting Chart: ***Motion #9****: it was moved and seconded (Kelly, Jones) to approve the attached Targeting Chart for FY 2024 Service Categories for Ryan White Part A, B, MAI and State Services Funding.* **Motion carried**. Abstentions: Aloysius, Jones.

Workgroup re: Strategy to coordinate substance use disorder prevention and care services: Williams said Charles Henley has created the resource inventory for the Integrated Plan. He suggested that the Council host a workgroup to determine a strategy for coordinating substance use disorder prevention and care services, per the instructions for the 2022 Integrated HIV Prevention and Care Services Plan. Soon, she will get back to the committee with more information in hopes that members of the committee participate in the workgroup.

Announcements: The co-chairs will present the How to Best Meet the Need recommendations at a Public Hearing which will be recorded later this week. The video will be posted on YouTube and aired on Houston Access television at 7:00 p.m. on Tuesday, May 23, 2023. If significant public comment is received, there will be a Special Committee Meeting on Wednesday, May 24, 2023 on Zoom.

Adjourn: ***Motion:*** *it was moved and seconded (Kelly, Perez) to adjourn the meeting at 3:04 p.m.* **Motion Carried.**

Submitted by: Approved by:

Tori Williams, Director Date Committee Chair Date

JA = Just arrived at meeting
LM = Left the meeting
C = Chaired the meeting

2023 Quality Improvement Meeting Voting Record for Meeting Date 05/09/23

MEMBERS:	**Motion #1** Agenda				**Motion #2** Joint Committee Meeting Minutes				**Motion #3** Committee Meeting Minutes				**Motion #4** HTBMN wg recommendations for services w/no changes				**Motion #5** Change to HTBMN wg recommendation for EFA-Other			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Tana Pradia, Co-Chair				**C**				**C**				**C**				**C**				**C**
Pete Rodriguez, Co-Chair	**X**				**X**				**X**				**X**				**X**			
Kevin Aloysius		**X**				**X**						**X**				**X**				**X**
Caleb Brown		**X**				**X**				**X**				**X**				**X**		
Titan Capri		**X**				**X**						**X**		**X**				**X**		
Daphne Jones		**X**				**X**						**X**				**X**				**X**
Oscar Perez ja 2:20 pm	**X**				**X**					**X**						**X**	**X**			
Faye Robinson	**X**				**X**				**X**				**X**				**X**			
Herman Finley	**X**				**X**				**X**				**X**				**X**			
Denis Kelly		**X**						**X**				**X**				**X**	**X**			
Gloria Sierra	**X**				**X**				**X**				**X**				**X**			
Deborah Somoye		**X**				**X**				**X**				**X**				**X**		
Christopher Walker	**X**				**X**				**X**				**X**				**X**			

2023 Quality Improvement Meeting Voting Record for Meeting Date 05/09/23 - *continued*

MEMBERS:	**Motion #6** HTBMN wg recommendation for PriCare, EFA-other, HIA, Transportation				**Motion #7** HTBMN wg recommendation for Linguistics				**Motion #8** QI Committee recommendation for Linguistics				**Motion #9** FY 2024 Targeting Chart			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Tana Pradia, Co-Chair				**C**				**C**				**C**				**C**
Pete Rodriguez, Co-Chair	**X**				**X**				**X**				**X**			
Kevin Aloysius				**X**			**X**					**X**				**X**
Caleb Brown		**X**					**X**			**X**				**X**		
Titan Capri		**X**					**X**			**X**				**X**		
Daphne Jones				**X**				**X**				**X**				**X**
Oscar Perez	**X**				**X**					**X**				**X**		
Faye Robinson	**X**				**X**				**X**				**X**			
Herman Finley	**X**				**X**				**X**				**X**			
Denis Kelly				**X**			**X**			**X**				**X**		
Gloria Sierra	**X**				**X**				**X**				**X**			
Deborah Somoye		**X**					**X**			**X**				**X**		
Christopher Walker	**X**				**X**				**X**				**X**			

Public Comment

BCM Houston AETC Proposal for HIV and Aging

The South Central AIDS Education and Training Center (AETC), mission is to provide HIV evidence driven quality education, training, and capacity building technical assistance to organizations and health professionals throughout South Central United States (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas). Our training topics are provided along the continuum of care starting with prevention and testing best practices, therapeutics and other treatments, comorbidities, and service linkage and retention. The BCM Houston AETC (a regional partner of the South Central AETC) initiatives also includes capacity building and implementation science. We are leaders in our regional in partnerships with local organizations and Ryan White funded agencies. We customize programs based on discussion and agreed upon needs and objectives with our partners. Programs can include ECHO program development, a learning curriculum for a lecture series or workshops, clinical consultations, and clinical preceptorships.

Significance:

In 2020, per the Centers for Disease Control and Prevention, more than 52% of people with HIV in the United States were 50 years of age or older. As of the end of 2019 in Houston, Harris County, approximately 45-50% of people with HIV were ≥50 years old, and nearly 30% were ≥55 years old [Houston/Harris County EPI 2021]. That same year, almost 19% of new HIV diagnoses in occurred in people ≥45 years old. In light of these local demographics, we propose to help develop a training initiative to educate and building capacity to address the needs of PWH aging with HIV as well as long term survivors aging with HIV. This proposal will help care providers expand quality services and improve health outcomes for older people with HIV as well as play a role in components of Ending the HIV Epidemic.

The goals of this proposal are to:

• Increase providers' awareness of the needs and concerns of patients with HIV who are 50 years of age or older.
• Inform providers about an aging-related approach to older patients with HIV.
• Highlight good practices to help providers 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

Specifications:

Pilot: Develop of training curriculum for case managers and/or prescribing providers to address the goals above. Start with a small group of case managers and/or prescribing providers

a. Initial in-person meeting to assess baseline understanding and knowledge related to HIV and aging
b. In person half day workshop with experts within HIV care, geriatrics, and organizations that provide care and resources for individuals that are aging.
c. Create a (virtual or in person) learning series that occurs once a month for 6 months after the workshop to reinforce concepts and knowledge, inform about new considerations, and update on best practices or evidence driven care.

Budget:

Item		
Personnel	$50,000	Funding includes development and implementation effort of project coordinator clinical/associate clinical director and experts for workshop and learning program over 9-12 months
Supplies	$500	Supplies needed for initial in person meeting and workshop
Meeting costs	$ 2000	Costs related to in person meetings

Public Comment

Re: HIV and Aging Medical Case Management
June 15, 2023

The following comment was submitted to the Office of Support via email:

I lend support to the Houston Harris County EMA Ryan White Planning Council efforts to create a Medical Case Management category for aging adults 50 years and older. The New York State Department of Health AIDS Institute document that was reviewed by Dr. Eugenia Siegler is a great start. However, Houston should adapt these guidelines for their Ryan White HIV Care System.

The amount of $400,000 is appreciated but falls short to hire 5 FTEs qualified Medical Social Workers to address these issues jointly with Physicians, Nurse Practitioners, or Physician Assistants including Psychiatrist. These Medical Case Managers must play a central role in the integration of services for these older 50+ older adults. Interdisciplinary teams of care must jointly meet with clients to educate and build the health literacy of the client. The focus must be on polypharmacy, multi-morbidities, and cultural risk factors.

Medical Case Managers trained in cultural factors and cultural humility for aging minorities affected by HIV. Long-term stigma and cultural stress associated with living with HIV for more than 10 years and being older than 50 years old. SBIRT and recreational substance use screening with older adults. The issue of Medical Mistrust is most important with an aging population, rapport and trust with the client should be established. Motivational interviewing intervention skills are utilized to find mutual solutions to meet healthier outcomes.

Bone density is important but we must be more vigilant on muscle wasting with aging older adults over the age of 50 with more than 10 years since their HIV diagnosis. Weight management and mobility issues are further items to explore.

Ryan White as a player of last resort has limitations, therefore eligibility and transition of care to Medicare and/or Medicaid should be made seamless. Ryan White should be allowed to fill the gap in services where absent or medication purchases and adherence whenever needed. Medical Case Managers should be trained and be experts to provide the best options to clients.

Providing adequate Monitoring and Evaluation of positive health outcomes for individuals 50 years and older with more than 10 years since their HIV diagnosis. Measurable outcomes addressing Diabetes, Cholesterol management, Hypertension, and maintaining HIV viral suppression.

The term Geriatric in the literature refers to older adults over the age of 65. The Geriatric term does not really take into account the earlier onset of aging symptoms that affect HIV-positive individuals over the age of 50 and with more than 10 years since their HIV diagnosis.

Evelio Salinas Escamilla

MEMO

To: Members, Ryan White Priority and Allocations Committee

From: D. Kelly, A. Murray & Bruce Turner, Members, Ryan White HIV & Aging Workgroup

Date: Monday, June 12, 2023

Re: FY 2022 Carryover and FY 2024 Funds

According to the attached *Guidance: Addressing the Needs of Older Adults in AIDS Care*, from the New York State Department of Health AIDS Institute (updated on May 5, 2023):

> "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 the population with HIV grows older, the application of the principles of geriatrics can enhance the quality of care.
>
> Because published evidence to support clinical recommendations is not currently available, (the attached) guidance on addressing the needs of older patients in HIV care was developed.... to present good practices to help clinicians recognize and address the needs of older patients with HIV. The goals of this guidance are several, including.... suggesting steps to guide medical settings in implementing geriatric care into HIV clinical practice."

It is recommended by the three individuals listed above, that the members of the HIV & Aging Workgroup, along with members of the Quality Improvement and Priority and Allocations Committees, set resources aside that will enable the following activities to take place starting in FY 2023, using FY 2022 carryover funds, and continuing into FY 2024:

1. Establish a partnership with AETC to provide training on the needs of older adults in HIV care for private physicians, as well as physicians and physician assistants at Houston EMA/HSDA Ryan white funded clinics.

2. Use Ryan White or State Services funding to pay for bone density tests and screenings for frailty for all RW clients who are ≥50 years old.

3. Use Ryan White or State Services funding to allow agencies to provide part time employment to individuals who are ≥50 years old so that they can educate Ryan White consumers on the importance of the above mentioned test and screening.

4. Develop a partnership with Meals on Wheels to better assist clients with nutritional needs and also lessen social isolation of older adults in HIV care.

5. Develop partnerships with local agencies who have volunteer companionship programs that would address issues of isolation and loneliness among older adults in HIV care.

Thank you for your thoughtful consideration. Feel free to contact us if you have questions or need additional information.

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

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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

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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%**
BEU27519	**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 2023 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 1st Quarter (3/1-5/31)

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)**	8,643	3,674	75%	22%	2%	40%	13%	3%	44%	0%	0%	4%	26%	27%	12%	28%	3%
1.a	Primary Care - Public Clinic (a)	2,959	1,530	74%	25%	2%	39%	9%	2%	50%	0%	0%	2%	17%	26%	15%	36%	4%
1.b	Primary Care - CBO Targeted to AA (a)	2,417	823	69%	27%	4%	98%	0%	1%	0%	0%	0%	5%	36%	26%	9%	22%	2%
1.c	Primary Care - CBO Targeted to Hispanic (a)	1,916	699	82%	14%	4%	0%	0%	0%	100%	0%	0%	5%	32%	30%	12%	19%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	774	430	83%	15%	3%	5%	63%	13%	18%	0%	0%	6%	32%	25%	7%	28%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	683	232	73%	27%	0%	28%	27%	2%	43%	0%	0%	5%	25%	25%	10%	30%	4%
1.f	Primary Care - Women at Public Clinic (a)	793	384	0%	99%	1%	43%	6%	1%	50%	0%	0%	1%	10%	27%	20%	38%	5%
1.g	Primary Care - Pediatric (a)	5	0															
1.h	Vision	2,815	492	76%	23%	1%	37%	14%	1%	47%	0%	0%	2%	18%	24%	10%	40%	5%
2	**Medical Case Management (f)**	5,429	1,299															
2.a	Clinical Case Management	936	279	66%	32%	3%	56%	16%	2%	26%	0%	0%	2%	20%	21%	13%	36%	7%
2.b	Med CM - Targeted to Public Clinic (a)	569	278	93%	4%	3%	53%	10%	2%	35%	0%	0%	1%	24%	24%	12%	34%	5%
2.c	Med CM - Targeted to AA (a)	1,625	277	73%	22%	4%	99%	0%	1%	0%	0%	1%	5%	28%	29%	8%	23%	5%
2.d	Med CM - Targeted to H/L(a)	813	129	78%	19%	4%	0%	1%	1%	98%	0%	0%	3%	36%	27%	8%	21%	5%
2.e	Med CM - Targeted to White and/or MSM (a)	504	113	89%	8%	3%	1%	94%	5%	0%	0%	0%	1%	19%	27%	6%	36%	12%
2.f	Med CM - Targeted to Rural (a)	548	75	63%	37%	0%	51%	32%	3%	15%	0%	0%	1%	16%	17%	8%	47%	11%
2.g	Med CM - Targeted to Women at Public Clinic (a)	246	115	0%	100%	0%	70%	6%	2%	23%	0%	0%	2%	16%	37%	13%	28%	5%
2.h	Med CM - Targeted to Pedi (a)	0	0															
2.i	Med CM - Targeted to Veterans	172	31	94%	6%	0%	74%	19%	0%	6%	0%	0%	0%	0%	0%	3%	45%	52%
2.j	Med CM - Targeted to Youth	15	2	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	5,775	2,253	76%	20%	4%	39%	14%	2%	45%	0%	0%	3%	22%	27%	12%	33%	3%
4	**Oral Health**	356	170	65%	34%	1%	35%	28%	1%	36%	0%	0%	2%	14%	25%	18%	33%	9%
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	356	170	65%	34%	1%	35%	28%	1%	36%	0%	0%	2%	14%	25%	18%	33%	9%
5	**Mental Health Services (d)**	0	NA															
6	**Health Insurance**	1,918	962	79%	19%	1%	37%	29%	4%	30%	0%	0%	1%	11%	16%	9%	44%	18%
7	**Home and Community Based Services (d)**	NA	NA															
8	**Substance Abuse Treatment - Outpatient**	17	6	100%	0%	0%	0%	50%	17%	33%	0%	0%	0%	50%	17%	17%	17%	0%
9	**Early Medical Intervention Services (d)**	NA	NA															
10	**Medical Nutritional Therapy/Nutritional Supplements**	546	265	77%	22%	2%	43%	17%	4%	37%	0%	0%	2%	6%	13%	8%	53%	18%
11	**Hospice Services (d)**	NA	NA															
12	**Outreach**	1,042	206	72%	26%	2%	64%	14%	1%	21%	0%	0%	6%	30%	25%	9%	25%	5%
13	**Non-Medical Case Management**	8,657	2,552															
13.a	Service Linkage Targeted to Youth	175	85	69%	29%	1%	53%	7%	4%	36%	0%	9%	91%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	100	40	80%	20%	0%	45%	3%	0%	53%	0%	0%	0%	48%	33%	10%	5%	5%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,546	1,209	69%	29%	2%	51%	9%	2%	38%	0%	0%	0%	20%	24%	13%	38%	5%
13.d	Service Linkage at CBO Primary Care Programs (a)	4,537	1,218	75%	21%	3%	45%	13%	1%	41%	0%	0%	4%	29%	24%	12%	27%	4%
14	**Transportation**	2,366	502															
14.a	Transportation Services - Urban	796	129	62%	37%	1%	50%	8%	2%	40%	0%	0%	5%	20%	25%	9%	29%	13%
14.b	Transportation Services - Rural	237	42	62%	38%	0%	36%	31%	0%	33%	0%	0%	5%	17%	14%	14%	36%	14%
14.c	Transportation vouchering	1,333	331	75%	23%	2%	64%	10%	2%	24%	0%	0%	2%	12%	18%	11%	51%	6%
15	**Linguistic Services (d)**	NA	NA															
16	**Emergency Financial Assistance (e)**	1,830	264	72%	25%	3%	63%	7%	2%	29%	0%	0%	5%	25%	25%	8%	35%	2%
17	**Referral for Health Care - Non Core Service (d)**	NA	NA															
*Net unduplicated clients served - all categories**		12,941	7,988	74%	23%	2%	44%	14%	2%	39%	0%	0%	4%	23%	24%	11%	32%	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: 6/21/2023

FY 2023 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 1st Quarter (03/01 -05/31)

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)	1,664	464	72%	25%	4%	99%	0%	1%	0%	0%	0%	5%	34%	29%	9%	20%	2%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	1,380	551	83%	13%	4%	0%	0%	0%	100%	0%	0%	5%	32%	27%	12%	23%	1%
2	**Medical Case Management (f)**	0																
2.c	Med CM - Targeted to AA (a)	967	225	83%	14%	3%	44%	13%	1%	41%	1%	1%	5%	39%	27%	9%	18%	1%
2.d	Med CM - Targeted to H/L(a)	735	132	80%	20%	0%	73%	7%	0%	20%	0%	0%	0%	7%	33%	13%	47%	0%

RW Part A New Client Service Utilization Report - 1st Quarter (03/01-05/31)

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/22 - 5/31/22)

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**	1,871	444	78%	19%	3%	46%	11%	2%	41%	0%	1%	8%	41%	25%	8%	2%	14%
2	**LPAP**	954	135	83%	14%	3%	44%	13%	1%	41%	1%	1%	5%	39%	27%	9%	1%	18%
3.a	Clinical Case Management	95	15	80%	20%	0%	73%	7%	0%	20%	0%	0%	0%	7%	33%	13%	0%	47%
3.b-3.h	Medical Case Management	1,097	210	74%	24%	1%	51%	10%	1%	37%	0%	1%	4%	34%	24%	11%	6%	19%
3.i	Medical Case Manangement - Targeted to Veterans	33	3	67%	33%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	33%	67%	0%
4	**Oral Health**	50	10	60%	40%	0%	30%	30%	0%	40%	0%	0%	0%	10%	30%	10%	0%	50%
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	1,870	504	72%	26%	2%	51%	13%	1%	34%	0%	1%	5%	27%	25%	12%	24%	7%
12.b	**Service Linkage at Testing Sites**	92	34	71%	26%	3%	38%	3%	3%	56%	0%	6%	9%	29%	32%	12%	6%	6%

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: 6/21/2023

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

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 2324 Ryan White Part B

Procurement Report

April 1, 2023 - March 31, 2024

Reflects spending through May 2023

Spending Target: 17%

Revised 6/27/23

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-General	$1,833,318	53%	$0	$1,833,318	$0	$1,833,318	4/1/2023	$272,390	15%
4	Oral Health Service -Prosthodontics	$576,750	17%	$0	$576,750	$0	$576,750	4/1/2023	$95,833	17%
5	Health Insurance Premiums and Cost Sharing (1)	$1,028,433	30%	$0	$1,028,433	$0	$1,028,433	4/1/2023	$260,420	25%
		$0	0%	$0	$0					
	Total Houston HSDA	3,438,501	100%	0	3,438,501	$0	$3,438,501		628,643	18%

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.

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 May 2023

Spending Target: 75%

Revised 6/27/2023

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	$769,352	89%
6	**Mental Health Services (2)**	$300,000	16%	**$0**	$300,000	$0	$300,000	9/1/2022	$83,850	28%
11	**Hospice (3)**	$259,832	14%	**$0**	$259,832	$0	$259,832	9/1/2022	$260,040	100%
13	**Non Medical Case Management (4)**	$350,000	19%	**$0**	$350,000	$0	$350,000	9/1/2022	$120,573	34%
16	**Linguistic Services (5)**	$68,000	4%	**$0**	$68,000	$0	$68,000	9/1/2022	$40,854	60%
	Total Houston HSDA	**1,842,338**	**100%**	**$0**	$1,842,338	$0	$1,842,338		1,274,669	69%

Note

(1) TRG will reallocate as needed to support service delivery

(2) Demand for serviecs 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

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2324 Ryan White Part B

Procurement Report

April 1, 2023 - March 31, 2024

Reflects spending through May 2023

Spending Target: 17%

Revised 6/27/23

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-General	$1,833,318	53%	$0	$1,833,318	$0	$1,833,318	4/1/2023	$272,390	15%
4	Oral Health Service -Prosthodontics	$576,750	17%	$0	$576,750	$0	$576,750	4/1/2023	$95,833	17%
5	Health Insurance Premiums and Cost Sharing (1)	$1,028,433	30%	$0	$1,028,433	$0	$1,028,433	4/1/2023	$260,420	25%
		$0	0%	$0	$0					
	Total Houston HSDA	3,438,501	100%	0	3,438,501	$0	$3,438,501		628,643	18%

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.

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 May 2023

Spending Target: 75%

Revised 6/27/2023

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Final Adjustments	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$864,506	47%	**$0**	$864,506	$0	$0	$864,506	9/1/2022	$769,352	89%
6	**Mental Health Services (2)**	$300,000	16%	**$0**	$300,000	$0	$0	$300,000	9/1/2022	$83,850	28%
11	**Hospice (3)**	$259,832	14%	**$0**	$259,832	$0	$0	$259,832	9/1/2022	$260,040	100%
13	**Non Medical Case Management (4)**	$350,000	19%	**$0**	$350,000	$0	$0	$350,000	9/1/2022	$120,573	34%
16	**Linguistic Services (5)**	$68,000	4%	**$0**	$68,000	$0	$0	$68,000	9/1/2022	$40,854	60%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	**$0**							
	Total Houston HSDA	**1,842,338**	**100%**	**$0**	$1,842,338	$0	$0	$1,842,338		1,274,669	69%

Note

(1) TRG will reallocate as needed to support service delivery

(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

2022-2023 DSHS State Services Service Utilization Report

09/01/2022 thru 05/31/2023 Houston HSDA

3rd Quarter

Revised 6/30/2023

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums	***925***	1,356	80.70%	18.08%	0.05%	1.17%	39.20%	28.40%	30.00%	2.40%	0.00%	0.00%	1.03%	13.05%	16.50%	22.87%	31.41%	15.14%
Mental Health Services	***192***	76	64.37%	34.32%	0.00%	1.31%	64.71%	9.51%	25.40%	0.38%	0.00%	0.13%	0.52%	39.89%	25.00%	16.37%	13.15%	4.94%
Hospice	***35***	12	83.33%	16.67%	0.00%	0.00%	34.68%	44.66%	18.83%	1.83%	0.00%	0.00%	0.00%	0.00%	8.34%	33.33%	58.33%	0.00%
Non Medical Case Management	***315***	106	93.86%	5.20%	0.00%	0.94%	30.13%	33.91%	34.92%	1.04%	0.00%	0.00%	0.46%	16.43%	23.69%	18.86%	33.96%	6.60%
Linguistic Services	***50***	49	50.02%	45.90%	0.00%	4.08%	46.85%	8.16%	6.22%	38.77%	0.00%	0.00%	0.20%	6.12%	26.53%	43.85%	14.28%	9.02%
Unduplicated Clients Served By State Services Funds:	*NA*	1,599	74.46%	24.12%	0.01%	1.41%	43.11%	24.93%	23.07%	8.88%	0.00%	0.03%	0.44%	15.10%	20.01%	27.06%	30.23%	7.14%

completed by:
lledezma

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.

2022-2023 DSHS State Services Service Utilization Report

09/01/2022 thru 05/31/2023 Houston HSDA

3rd Quarter

Revised 6/30/2023

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums	***925***	1,356	80.70%	18.08%	0.05%	1.17%	39.20%	28.40%	30.00%	2.40%	0.00%	0.00%	1.03%	13.05%	16.50%	22.87%	31.41%	15.14%
Mental Health Services	***192***	76	64.37%	34.32%	0.00%	1.31%	64.71%	9.51%	25.40%	0.38%	0.00%	0.13%	0.52%	39.89%	25.00%	16.37%	13.15%	4.94%
Hospice	***35***	12	83.33%	16.67%	0.00%	0.00%	34.68%	44.66%	18.83%	1.83%	0.00%	0.00%	0.00%	0.00%	8.34%	33.33%	58.33%	0.00%
Non Medical Case Management	***315***	106	93.86%	5.20%	0.00%	0.94%	30.13%	33.91%	34.92%	1.04%	0.00%	0.00%	0.46%	16.43%	23.69%	18.86%	33.96%	6.60%
Linguistic Services	***50***	49	50.02%	45.90%	0.00%	4.08%	46.85%	8.16%	6.22%	38.77%	0.00%	0.00%	0.20%	6.12%	26.53%	43.85%	14.28%	9.02%
Unduplicated Clients Served By State Services Funds:	*NA*	1,599	74.46%	24.12%	0.01%	1.41%	43.11%	24.93%	23.07%	8.88%	0.00%	0.03%	0.44%	15.10%	20.01%	27.06%	30.23%	7.14%

completed by:
lledezma

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.

Table of Contents

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

Service Definition	Approved FY23 Financial Eligibility Based on federal poverty guidelines	Recommended FY24 Financial Eligibility Based on federal poverty guidelines	Page #
Ambulatory/Outpatient Medical Care (includes Medical Case Management[1], Service Linkage[2], Outreach[3], EFA-Pharmacy Assistance[4], Local Pharmacy Assistance[5]) - Part A - CBO - Public Clinic - Rural	**300%** (None[1], None[2], None[3], 500%[4], 500%[5])	**300%** (None[1], None[2], None[3], 500%[4], 500%[5])	**1** **18** **35**
Case Management: - Clinical - Part A - Non-Medical (Service Linkage at Testing Sites) - Part A - Non-Medical (targeting Substance Use Disorders) - State Services	**No Financial Cap**	**No Financial Cap**	**51** **57** **63**
Emergency Financial Assistance (EFA) - Other - Part A	**400%**	**400%**	**68**
Health Insurance Premium and Cost Sharing Assistance: - Part B/State Services - Part A	**0 - 400%** **ACA plans: must have a subsidy** (see Part B service definition for exception)	**0 - 400%** **ACA plans: must have a subsidy** (see Part B service definition for exception)	**71** **74**
Hospice Services - State Services	**300%**	**300%**	**77**
Linguistic Services - State Services	**300%**	**500%**	**81**
Medical Nutritional Therapy and Nutritional Supplements - Part A	**400%**	**400%**	**83**
Mental Health Services - State Services	**500%**	**500%**	**87**
Oral Health: - Untargeted - Part B - Rural (North) - Part A	**300%**	**300%**	**92** **95**
Referral for Health Care: - ADAP Enrollment Workers - State Services - Incarcerated - State Services	**500%** **No Financial Cap**	**500%** **No Financial Cap**	**98** **100**
Substance Abuse Treatment - Part A	**500%**	**500%**	**103**
Transportation - Part A	**400%**	**400%**	**106**
Vision Care - Part A	**400%**	**400%**	**112**