Houston Area HIV Services Ryan White Planning Council

Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax
http://rwpchouston.org

MEMORANDUM

To: Steering Committee Members:
Crystal R. Starr, Chair
Skeet Boyle, Vice Chair
Josh Mica, Secretary
Rodney Mills, Co-Chair, Affected Community Committee
Diana Morgan, Co-Chair, Affected Community Committee
Allen Murray, Co-Chair, Comprehensive HIV Planning Committee
Steven Vargas, Co-Chair, Comprehensive HIV Planning Committee
Ronnie Galley, Co-Chair, Operations Committee
Cecilia Ligons, Co-Chair, Operations Committee
Bobby Cruz, Co-Chair, Priority and Allocations Committee
Peta-gay Ledbetter, Co-Chair, Priority and Allocations Committee
Tana Pradia, Co-Chair, Quality Improvement Committee
Pete Rodriguez, Co-Chair, Quality Improvement Committee

Copy: Glenn Urbach
Mauricia Chatman
Tiffany Shepherd
Patrick Martin
Mackenzie A. Hudson
Jason Black
Diane Beck

EMAIL ONLY:
Ann Robison
David Williams
Sha'Terra Johnson

From: Tori Williams

Date: Tuesday, June 27, 2023

Re: Meeting Announcement

We look forward to seeing you for the following meeting:

Ryan White Steering Committee Meeting

12 noon, Thursday, July 6, 2023
Join the Zoom meeting by clicking on:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192 Passcode: 885832
Or, use your phone to dial in by calling 346 248-7799
Or, join us in the conference room in our old office at 2223 W. Loop South

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

DRAFT

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

AGENDA

12 noon, Thursday, July 6, 2023

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

I. Call to Order — Crystal R. Starr, Chair, RW Planning Council
- A. Welcoming Remarks
- B. Moment of Reflection
- C. Select the Committee Co-Chair who will be voting today
- D. Adoption of the Agenda
- E. Adoption of the Minutes

II. Public Comment and Announcements

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

III. Reports from Committees

A. Comprehensive HIV Planning Committee — Allen Murray and Steven Vargas, Co-Chairs

Item: 2022 Integrated HIV Prevention and Care Services Plan
Recommended Action: FYI: The Comprehensive HIV Planning Committee is looking at rewording some of the goals in the Integrated Plan so that they are SMART goals. If anyone enjoys this process, feel free to join the Comprehensive HIV Planning Committee meeting at 2 pm after the Council meeting has adjourned, on **Thursday, July 13th**. All are welcome and all will be allowed to participate. Steven Vargas is going to introduce the SMARTIE goals, which will guarantee some fun with words. Check the Council website at www.rwpchouston.org for a meeting packet for the July Comprehensive HIV Planning Committee. Or, call Rod or Diane to request a packet. They can be reached at: 832 927-7926.

Item: 2023 Houston EMA/HSDA Care Needs Assessment
Recommended Action: The Comprehensive HIV Planning Committee hosted a meeting to review the attached, draft copy of the Consumer Survey for the 2023 Houston Area Care Needs Assessment. The

results of the meeting were as follows: **Motion:** to approve the attached survey form with the following changes: (to be added at the Steering Committee).

B. Affected Community Committee — Rodney Mills and Diana Morgan, Co-Chairs
No meeting due to the Juneteenth holiday

C. Quality Improvement Committee — Tana Pradia and Pete Rodriguez, Co-Chairs
No meeting due to a very busy June

D. Priority and Allocations Committee — Peta-gay Ledbetter and Bobby Cruz, Co-Chairs
Item: Reports from the Administrative Agent – Part A/MAI*
Recommended Action: FYI: See the following reports:
FY23 Part A & MAI Memo and FY22 Procurement, dated 06/12/23
FY23 Part A & MAI Service Utilization, dated 06/21/23

Item: Reports from the Administrative Agent – Part B/SS**
Recommended Action: FYI: See the attached reports from the Part B/State Services Administrative Agent:

- FY 22/23 Part B Procurement, dated 06/01/23
- FY 22/23 DSHS SS** Procurement, dated 06/01/23
- FY 22/23 Health Insurance Service Utilization, dated 05/24/23

Item: FY 2024 Ryan White Service Priorities
Recommended Action: **Motion:** Approve the attached FY 2024 Service Priorities for Ryan White Part A/MAI*, Part B and State Services funding.

Item: FY 2024 Level Funding Scenario – All Funding Streams
Recommended Action: **Motion A**: Approve the attached FY 2024 Level Funding Scenario for Ryan White Parts A/MAI*, Part B and State Services funding. See attached chart for details.

Item: FY 2024 MAI* Increase/Decrease Funding Scenarios
Recommended Action: **Motion B:** Approve the attached FY 2024 Increase & Decrease Funding Scenarios for Ryan White MAI* funds.

Item: FY 2024 Part A Increase/Decrease Funding Scenarios
Recommended Action: **Motion C**: Approve the attached FY 2024 Increase & Decrease Funding Scenarios for Ryan White Part A funds.

Item: FY 2024 Part B & SS** Increase/Decrease Funding Scenarios
Recommended Action: **Motion D**: Approve the attached FY 2024 Increase & Decrease Funding Scenarios for Ryan White Part B and State Services funding.

** MAI = Minority AIDS Initiative Funding*
*** SS = State Services Funding*

E.	Operations Committee No report.	Ronnie Galley and Cecilia Ligons, Co-Chairs
V.	Report from the Office of Support	Tori Williams, Director
VI.	Report from Ryan White Grant Administration	Glenn Urbach, Manager
VII.	Report from The Resource Group	Sha'Terra Johnson, Health Planner
IX.	Announcements	
X.	Adjournment	

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

MINUTES

12 noon, Thursday, June 1, 2023
Meeting Location: Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Crystal Starr, Chair	Tana Pradia, excused	*Ryan White Grant Administration*
Skeet Boyle, Vice Chair	Steven Vargas, excused	Glenn Urbach
Josh Mica, Secretary		Mauricia Chatman
Rodney Mills		Jason Black
Diana Morgan		
Allen Murray		*Office of Support*
Ronnie Galley		Tori Williams
Cecilia Ligons		Diane Beck
Bobby Cruz		
Peta-gay Ledbetter		
Pete Rodriguez		

Call to Order: Crystal Starr, Chair, called the meeting to order at 12:07 p.m. During the opening remarks, Starr said the Council is finalizing service definitions and eligibility criteria for fiscal year 2024. She thanked all who participated in How to Best Meet the Need workgroups for their important input and said we look forward to receiving recommendations from the Special Workgroups, such as the HIV and Aging Workgroup. In June, the Priority and Allocations Committee will be prioritizing and attaching funds to the services that we approve today. Please note that we will be hosting our first Council meeting at Bering Church in Montrose next week. Look at the cover page in your Council meeting packet for the address and instructions on how to get to the second floor meeting rooms. We will have an excellent presentation at the Council meeting on "Anal Cancer and HIV" by Dr. Alan G. Nyitray from the Center for AIDS Intervention Research at the Medical College of Wisconsin.

Starr then called for a Moment of Reflection in memory of Matilda Padilla, former Council Member, Operations Co-Chair, and Project LEAP graduate, who recently passed away.

Those selected to represent their committee at today's meeting are: Mills for Affected Community, Murray for Comprehensive HIV Planning, Galley for Operations, Ledbetter for Priority and Allocations and Rodriguez for Quality Improvement.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Ligons, Boyle) to approve the May 4, 2023 minutes.* **Motion carried.** Abstention: Mills.

Public Comment and Announcements: None.

Reports from Committees

Comprehensive HIV Planning Committee: Allen Murray, Co-Chair, reported on the following:
2022-26 Integrated HIV Prevention and Care Plan: The committee will start developing outcome measures for goals in the Integrated Plan. The process will start at 2 pm, after the Council meeting has adjourned, on Thursday, June 8th. All are welcome and all will be allowed to vote since this will be the start of the Evaluation Workgroup. The meeting will use the hybrid format. Check the Council website rwpchouston.org for a meeting packet or call to request one.

Joint Meeting of the Affected Community and Project LEAP/Proyecto VIDA Advisory Committees: Rodney Mills, Co-Chair, Affected Community Committee, reported on the following:
2022 Project LEAP Evaluation Report: Williams summarized the results of the 2022 Project LEAP and Proyecto VIDA Evaluation Reports. In a nutshell, the classes were well attended and produced some excellent new Council members. The energy at the Proyecto VIDA classes made students and staff feel that the program should definitely be offered again in 2023.

2023 Project LEAP and Proyecto VIDA*: **Motion #3:** Use the same service definition and student selection guidelines in 2023 that were used in 2022.* **Motion Carried.**

2023 Project LEAP and Proyecto VIDA will begin in August, with the students graduating shortly after Thanksgiving. They will both be taught using a hybrid format. All Ryan White volunteers are encouraged to help recruit student applicants. See the attached flyers and application forms which will be distributed at Ryan White funded clinic sites, special events and more. See the attached list of distribution sites. Please spread the word in person, virtually and more.

Quality Improvement Committee: Pete Rodriguez, Co-Chair, reported on the following:
Reports from Administrative Agent – Part A/MAI*: See the attached reports.

Reports from the Administrative Agent – Part B/SS: See the attached reports.

FY 2024 Service Definitions and Financial Eligibility: ***Motion #4:*** *Approve the attached, recommended FY 2024 Service Definitions and Financial Eligibility for the Ryan White Part A/MAI, Part B and State Services funded services. See the attached Summary of How To Best Meet the Need recommendations and financial eligibility for a quick review of the larger packet.* **Motion Carried.**

Targeting Chart for FY 2024 Service Categories: ***Motion #5:*** *Approve the attached FY 2024 Targeting Chart for the Ryan White Part A/MAI, Part B and State Services funded Service categories.* **Motion Carried.**

Priority and Allocations Committee: Bobby Cruz, Co-Chair, reported on the following:
FY 2024 Service Priorities: The Committee made recommendations regarding the FY 2024 service priorities, which will be presented to the Steering Committee and Planning Council after the public hearing in late June 2023.

Ryan White FY 2024 Allocations: The process for allocating FY 2024 Ryan White Part A/MAI, Part B and State Services funding will begin in early June 2023. See Rod if you wish to receive reminders.

Operations Committee: Cecilia Ligons, Co-Chair, reported on the following:
Proposed Revisions to the FY 2023 PC Support Budget: ***Motion #6:*** *Approve the attached, revised FY 2023 Planning Council Support Budget.* **Motion Carried.**

Proposed FY 2024 Council Support Budget: ***Motion #7:*** *Approve the attached FY 2024 Council Support Budget.* **Motion Carried.**

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

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

Announcements: Boyle said that St. John's/Bread of Life provides fresh food and household items to the community on the 1st Saturday of the month from 10am-12pm and on the 3rd Saturday from 8am-12pm. As long as you are in line by noon you will be served. They are located downtown at 2019 Crawford and Gray. Bread of Life also has community health workers that can help you with needs including adult diapers. To access a community health worker call the church at 713-659-3237. Murray said that the Wednesday night support group and pot luck at Bering Church is meeting in person and looking to increase attendance. The group meets from 6:30 pm – 8:30pm.

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

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

2023 Steering Committee Voting Record for Meeting Date 06/01/23

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

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

MEMBERS	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Project LEAP/Proyecto VIDA Svc Def & Student selection guidelines **Carried**				**Motion #4** FY24 HTBMN Svc Defs and Financial Elig **Carried**				**Motion #5** FY24 Svc Cat Targeting chart **Carried**				**Motion #6** Revised FY 2023 OS Budget **Carried**				**Motion #7** FY 2024 OS Budget **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Crystal Starr, Chair				**C**				**C**				**C**				**C**				**C**				**C**				**C**
Skeet Boyle, Vice Chair		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Josh Mica, Secretary		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Rodney Mills, Aff		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Allen Murray, Comp		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Ronnie Galley, Op		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Peta-gay Ledbetter, PA		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Pete Rodriguez, QI		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Non-voting members at the meeting:																												
Diana Morgan, Aff																												
Cecilia Ligons, Op																												
Bobby Cruz, PA																												
Absent members:																												
Tana Pradia, QI																												
Steven Vargas, Comp																												

Public Comment

Williams, Victoria (County Judge's Office)

From: Evelio Salinas Escamilla <ESEscamilla@latinoaids.org>
Sent: Thursday, June 15, 2023 3:10 PM
To: Williams, Victoria (County Judge's Office)
Subject: Email Memorandum - RE: HIV and Aging Medical Case Management

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.

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.

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

Guidance: Addressing the Needs of Older Patients in HIV Care

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

Contents

Purpose of This Guidance

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

The goals of this guidance are to:

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

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

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

Definition of terms:

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

Effects of Aging

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

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

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

Approach to Aging in HIV Care

→ GOOD PRACTICES

Approach to Aging in HIV Care

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

→ GOOD PRACTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Geriatric Screening and Assessment

General Screening Tools

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

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

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

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

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

Comprehensive Geriatric Assessment

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

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

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

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

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

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

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

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

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

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

Integrating the Needs of Older Patients Into Medical Care

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

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

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

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

2. Engage older patients with HIV in program planning:

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

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

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

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

4. Develop an assessment strategy:

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

5. Develop protocols for referral:

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

6. Link to the Aging Network for services:

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

◊ ONLINE RESOURCES FOR AGING AND GERIATRIC CARE

Clinical Resources:

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

Services and Entitlements:

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

References

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comprehensive HIV Planning Committee

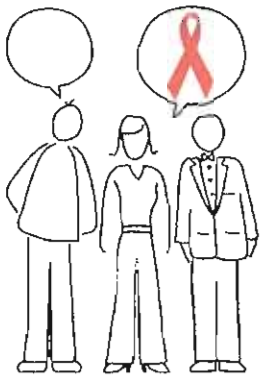
***STAFF USE ONLY**-SURVEY ADMIN*

Date of survey: _____

Agency/location: _____

Staff initials: _____

Gift card #: _____



***STAFF USE ONLY**-DATA ENTRY*

Date of data entry: _____

Auto survey #: _____

Staff initials: _____

2023 Consumer Survey

Dear Participant,

The purpose of this survey is to learn about your needs for HIV care and what it's like for you to be living with HIV. Only people who are living with HIV, 18 years of age or older*, and who live in the greater Houston area should take this survey. If you don't meet these requirements or are not sure, please talk to a staff person now.

* A parent or legal guardian must complete a survey on behalf of a person living with HIV ages 13-17.

Please read the following before you begin:

- Your participation in this survey is 100% voluntary. You do not have to participate. If you do, it will help us learn what people need for HIV care.
- Everything you tell us is 100% confidential. You will not be identified in the report, and no information about you *as an individual* will be collected or shared. All the answers you give will be combined with other surveys and shown as a group.
- You may find some of the questions personal, and they may make you feel uncomfortable. You do not have to continue if you feel this way. Please talk to a staff person at any time if you feel uncomfortable with the survey.
- You will receive an incentive for your participation after you have finished the survey. You will be asked to sign for the incentive, but you do not have to use your legal name.
- If you complete the survey, you are consenting to participate in this project. You are also giving us your consent to use your survey answers. Again, you will not be identified in the report, and no information about you *as an individual* will be collected or shared.
- Please take your time to answer all questions as completely and accurately as possible. There are no right or wrong answers. There is no time limit.
- If you have questions about this survey, please contact the Ryan White Planning Council Office of Support at (832) 927-7926 at any time.

You can begin the survey now. Please bring your completed survey to a staff person when you are done. Thank you for your participation in this project!

Section 1: HIV Services

1. Please tell us about any of the following funded HIV services you have used or needed in the past 12 months:

HIV medical care visits or clinic appointments with a doctor, nurse, or physician assistant (i.e., outpatient primary HIV medical care)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
HIV medication assistance (this is help paying for HIV medications *in addition to or instead of* assistance from the state/ADAP)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Health insurance assistance (this is when you have private health insurance or Medicare and you get help paying for your co-pays, deductibles, or premiums for medications or medical visits)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Oral health care visits with a dentist or hygienist	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

Con't: Please tell us about any of the following HIV services that you have used or needed in the past 12 months:

Case management (these are people at your clinic or program who assess your needs, make referrals for you, and help you make/keep appointments)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was *difficult* to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Outpatient alcohol or drug treatment or counseling	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶ **Did you need this service for:** ***(Check all that apply)*** ☐ Alcohol use concerns ☐ Drug use concerns	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Professional mental health counseling (this is counseling or therapy with a licensed professional counselor or therapist, either individually or as part of a therapy group)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Day treatment (this is a place you go during the day for help with your HIV medical care from a nurse or PA. It is *not* a place you live)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

Con't: Please tell us about any of the following HIV services that you have used or needed in the past 12 months:

Hospice care (this is a program for people in a terminal stage of illness to get end-of-life care)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Nutritional supplements (this includes supplements like Ensure, fish oil, protein powder, etc. and/or nutritional counseling from a professional dietician)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Vision care (this includes routine vision services and glasses provided at your HIV clinic or program)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Language translation (at your clinic or program in a language *other than English or Spanish*).	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

Con't: Please tell us about any of the following HIV services that you have used or needed in the past 12 months:

Transportation (this is when your clinic or program offers van rides or a Metro bus card to help you attend your HIV medical appointments)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶ **Did you need this service for:** ***(Check all that apply)*** ☐ Van ride(s) ☐ Bus pass(es)	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Outreach services (these are people at your clinic or program who contact you to help you get HIV medical care when you have a couple of missed appointments)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
ADAP enrollment workers (these are people at your clinic or program who help you complete an application for ADAP medication assistance from the state)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
*****If you were in Harris County Jail, please tell us about:*** **Pre-discharge planning** (this is when jail staff help you plan how to access HIV medical care after your release)	**Please check one:** ☐ I didn't know this service was available ☐ I did not need this service ☐ I needed this service, and it was easy to get ☐ I needed this service, and it was difficult to get *(go here* ⟶	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

2. The following services are <u>not currently</u> funded through Ryan White, but could be funded in the future. You may have used these services at facility or through a different funder than Ryan White. Please tell us about any of the following unfunded HIV services that you have used or needed <u>in the past 12 months</u>:

Home health care (this is medical care provided specifically for the treatment of HIV when you cannot leave home)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)*	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Child care services (this is child care provided to children living in your household to allow you to attend HIV medical visits)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)*	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Food bank / home delivered meals (this includes food items, personal hygiene produces, cleaning supplies, water filters; hot meals; meal delivery; and vouchers to purchase food)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)* **Did you need this service for:** ***(Check all that apply)*** ☐ Food bank ☐ Home delivered meals	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

Con't: Please tell us about any of the following unfunded HIV services that you have used or needed <u>in the past 12 months</u>:

Health education / risk reduction (this is education about strategies to prevent or reduce the risk of HIV transmission to others)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)*	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Housing (this is temporary or long term housing specifically for people living with HIV)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)*	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Other professional services (these are professional and consultant services for HIV-related: **legal services** like Social Security Disability Insurance denial and discrimination, **permanency planning** including wills and dependent placement, and **tax preparation** if you used the advanced premium tax credit to purchase Affordable Care Act health insurance)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)* **Did you need this service for:** ***(Check all that apply)*** ☐ Legal services ☐ Permanency planning ☐ Tax preparation	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

Con't: Please tell us about any of the following unfunded HIV services that you have used or needed in the past 12 months:

Psychosocial support services (these support group and counseling services not provided by a licensed mental health professional, including bereavement counseling and HIV support groups)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)* **Did you need this service for:** ***(Check all that apply)*** ☐ Online support/groups ☐ In person support/groups	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Rehabilitation services (this is outpatient physical, occupational, speech, and vocational therapy)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)*	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____
Respite care (this is in-home non-medical assistance provided to a person living with HIV to relieve a primary caregiver responsible for the person's daily care)	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here →)*	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

Con't: Please tell us about any of the following unfunded HIV services that you have used or needed <u>in the past 12 months</u>:

Residential or inpatient alcohol or drug treatment or counseling	**Please check one:** ☐ I did not need this service ☐ I needed this service, and it was easy to get from _____ (agency received from) ☐ I needed this service, and it was difficult to get *(go here* ⟶ **Did you need this service for:** ***(Check all that apply)*** ☐ Alcohol use concerns ☐ Drug use concerns	**Briefly, please tell us what made it difficult for you to get this service?** _____ _____ _____

3. **What is your preferred method of communication?** _____

4. **How do you currently communicate with your HIV medical provider?** (*Check all that apply*)

☐ I don't currently have a medical provider (***skip bullets below and go to Question 5***)
☐ Phone calls
☐ Email
☐ Text messaging
☐ An online portal (*ex: MyChart*)
☐ I drop by the office in person
☐ Other: _____

- **Does your HIV medical provider communicate information about your health in a way that is straightforward and easy to understand?**
  ☐ Yes ☐ No

- **How would you rate communication with your HIV medical provider?**

 It's Poor	 It's Not Very Good	 It's Good	 It's Very Good	 It's Great!
☐	☐	☐	☐	☐

- **If communication is "Poor", "Not Very Good", or "Good", what could be changed to make it better? (*skip to Question 5 if "Very Good", or "Great"*)**
  _____
  _____

5. **What other kinds of services do you need to help you get your HIV medical care?**
   _____
   _____

Section 2: When You Were First Diagnosed

6. **What year were you diagnosed with HIV?** _____

7. **Where did you get your HIV diagnosis?** _____

- **If you were diagnosed after 2014, did you get any of the following services from the same agency where you were diagnosed?** (*Check one answer for each item below*)

• **A list of HIV clinics to go to for medical care**	☐ Yes	☐ No	☐ Don't remember
• **An appointment for your first HIV doctor's visit**	☐ Yes	☐ No	☐ Don't remember
• **Someone offered to help you get into HIV care**	☐ Yes	☐ No	☐ Don't remember
• **Someone answered all of my questions about how to live with HIV**	☐ Yes	☐ No	☐ Don't remember
• **Someone told me how to get help paying for HIV medical care**	☐ Yes	☐ No	☐ Don't remember

Section 3: Your HIV Care History

8. **If there was a delay in seeing a doctor for HIV for more than 1 month after you received your HIV diagnosis, what caused the delay?** *(Check all that apply)*
   - ☐ N/a, there was no delay in seeing a doctor for HIV
   - ☐ My first HIV medical appointment was rescheduled
   - ☐ I didn't know services exist to help pay for HIV care
   - ☐ I was diagnosed before HIV treatment existed
   - ☐ I felt fine, I wasn't sick
   - ☐ I didn't want to believe I contracted HIV
   - ☐ I didn't want to take medications
   - ☐ I didn't know where to get HIV medical care
   - ☐ I couldn't afford HIV medical care
   - ☐ I was drinking or doing drugs at the time
   - ☐ I had problems with mental health at the time
   - ☐ There were other priorities in my life at the time
   - ☐ I couldn't get there, no transportation
   - ☐ I was afraid of people finding out I contracted HIV
   - ☐ Don't remember
   - ☐ Other:_____

9. **If you ever stopped seeing an HIV doctor for 12 months or more, why did you stop?** *(Check all that apply)*
   - ☐ N/a, I never stopped seeing a doctor for 12 months
   - ☐ I moved or relocated
   - ☐ My eligibility expired
   - ☐ I felt fine, I wasn't sick
   - ☐ I was tired of it, wanted a break
   - ☐ I didn't want to take HIV medications
   - ☐ I had side effects from my HIV medications
   - ☐ My viral load was undetectable
   - ☐ I couldn't afford it anymore
   - ☐ I lost my health insurance or Ryan White
   - ☐ I was drinking or doing drugs at the time
   - ☐ I had problems with mental health at the time
   - ☐ There were other priorities in my life at the time
   - ☐ I couldn't get there, no transportation
   - ☐ My doctor or case manager left
   - ☐ I had a bad experience at the clinic
   - ☐ Don't remember
   - ☐ Other:_____

10. In the past 12 months, how many times have you:

Visited a doctor, nurse, or PA for HIV: _____
Been prescribed HIV medication (ART): _____
Had a test for your HIV viral load: _____
Had a test for your CD4 (t-cell) count: _____

☐ I haven't done any of these in the past 12 months
☐ I've never done any of these
☐ I don't remember

11. If you are <u>not</u> currently taking HIV medications, why are you not taking them? *(Check all that apply)*

☐ N/a, I *do* take HIV medication
☐ I missed a refill
☐ I am undetectable or an elite controller/long-term non-progressor (***please note that current treatment standards recommend continuing with HIV medication if you are undetectable to help stay undetectable***)
☐ I forget to take them
☐ I did not receive my mail-order medications or I think someone else took them from my mail
☐ My eligibility expired
☐ No doctor has offered them to me
☐ My doctor doesn't think it's a good idea for me
☐ I had bad side effects
☐ They are too hard to take as prescribed
☐ I don't have the correct food to take with them
☐ I can't pay for them
☐ I don't have prescription insurance coverage
☐ I don't have a safe place to keep them
☐ I don't want anyone to know I'm taking HIV meds
☐ I was tired of it, wanted a break
☐ I choose not to take them
☐ I feel fine, I'm not sick
Other:_____

Section 4: Other Health Concerns

12. Has a doctor told you that you <u>currently</u> have any of the following *non-HIV* medical condition? *(Check all that apply)*

☐ Alzheimer's or dementia
☐ Arthritis
☐ Asthma
☐ Auto-immune disease (i.e., MS, lupus)
☐ Blood clotting disorder
☐ Cancer
☐ Chronic pain
☐ Diabetes
☐ Epilepsy or seizures
☐ Heart disease
☐ Hepatitis B
☐ Hepatitis C
If so: ☐ Treated ☐ Not treated
☐ Herpes
☐ High blood pressure
☐ High cholesterol
☐ HPV (human papillomavirus)
☐ Lung disease/COPD
☐ Liver disease
☐ Neuropathy/pain or numbness in hands or feet
☐ Obesity
☐ Osteoporosis, or bone disease
☐ Sleep disorder
☐ TB. If so: ☐ Active TB ☐ Latent TB
☐ Thyroid disease
☐ I have not been told I have any of these
☐ Prefer not to answer
☐ Other:_____

13. Have you been tested for <u>any</u> the following conditions?
(Check all that apply for each item below.)

	In the past 3 months	In the past 6 months	In the past 9 months	In the past 12 months	It has been longer than 12 months	I have never had this test	I don't remember
Chlamydia	☐	☐	☐	☐	☐	☐	☐
Gonorrhea	☐	☐	☐	☐	☐	☐	☐
Syphilis	☐	☐	☐	☐	☐	☐	☐

- **Were you <u>diagnosed</u> with any of the conditions?**
  *(Check all that apply. **If you have never had testing for any of the conditions or you do not remember, skip below and go to Question 14**)*
  ☐ No, I was not diagnosed with any of the conditions
  ☐ Chlamydia
  ☐ Gonorrhea
  ☐ Syphilis

- **If you were <u>diagnosed</u> with any of the conditions, did you complete treatment?**
  (Check all that apply, and write in the condition/s to which each answer applies.)
  ☐ N/a, I was not diagnosed with any of the conditions
  ☐ No, I never got treatment for _____
  ☐ I started treatment, but did not complete it for _____
  ☐ Yes, I completed treatment for _____

14. <u>In the past 12 months</u>, have you felt any of the following *to such a degree* that you thought you wanted help? *(Check all that apply)*

☐ Anger
☐ Anxiety or worry
☐ Fear of leaving your home
☐ Feeling impulsive or out of control
☐ Hallucinations
☐ Loneliness or isolation
☐ Night terrors
☐ Insomnia
☐ Mood swings
☐ Trouble remembering
☐ Trouble focusing
☐ Sadness
☐ Thoughts of hurting yourself or others
☐ Other:_____
☐ None of the above
☐ Prefer not to answer

***If you are having any of these thoughts <u>right now</u>, contact your counselor immediately or refer to the resource list attached to this survey.*

15. Has a doctor told you that you <u>currently</u> have any of the following conditions?
(Check all that apply)

☐ ADD/ADHD
☐ Agoraphobia
☐ AIDS Survivor Syndrome
☐ Anxiety or panic attacks
☐ Bipolar disorder
☐ Depression
☐ Gender dysphoria/gender identity disorder
☐ Obsessive compulsive disorder
☐ PTSD
☐ Schizophrenia or episodes of psychosis
☐ Other: _____
☐ I don't have a mental health diagnosis

16. **In the past 12 months, have you experienced any of the following?** *(Check all that apply)*

- ☐ Been treated differently because you're living with HIV
- ☐ Been denied services because you're living with HIV
- ☐ Been asked to leave a public place
- ☐ Verbal harassment/taunts
- ☐ Threats of violence by someone you know
- ☐ Threats of violence by a stranger
- ☐ Physical assault by someone you know
- ☐ Physical assault by a stranger
- ☐ Sexual assault by someone you know
- ☐ Sexual assault by a stranger
- ☐ None of the above
- ☐ Prefer not to answer

17. **Are you currently in an intimate relationship with someone who makes you feel afraid, threatened, isolated, forces you to have sex, or physically hurts you?** *(Check one)*

☐ Yes ☐ No ☐ Prefer not to answer

***If you currently feel unsafe in an intimate relationship, refer to the resource list attached to this survey for help.*

Section 5: Substance Use

18. **In the past 12 months, has alcohol or drug use interfered with you getting HIV medical care?** *Examples could include alcohol or drug use that led to missing HIV medical appointments, having trouble taking HIV medications as prescribed, avoiding medical care for fear of legal issues, or fear telling your HIV doctor about alcohol or drug use. (Check one)*

- ☐ No, I have not used alcohol or drugs
- ☐ No, I have used alcohol or drugs, but it has not interfered with me getting HIV medical care
- ☐ Yes
- ☐ Prefer not to answer

If you answered no or prefer not to answer, *skip bullet below and go to Question 19.*
***If you answered yes*, which substance(s)?** *(Check all that apply)*

- ☐ Alcohol
- ☐ Club/party drugs (e.g., *ecstasy/MDMA/Molly, GHB, roofies, ketamine*)
- ☐ Cocaine or crack
- ☐ Hallucinogens (e.g., *LSD, PCP, mushrooms*)
- ☐ Heroin
- ☐ Inhalants (*e.g., poppers, glue*)
- ☐ Marijuana
- ☐ Methamphetamine/meth
- ☐ Prescription drugs not prescribed to you (*e.g., painkillers, opioids, tranquilizers*)
- ☐ Prescription drugs prescribed to you, but used differently than intended
- ☐ Legal drugs from a shop (*e.g., bath salts, kush/spice*)
- ☐ Other: _____
- ☐ None of the above
- Prefer not to answer

Section 6: Housing, Transportation, and Social Support

19. Did you have trouble obtaining housing in the past 12 months?

- ☐ Yes
- ☐ No

20. Did you experience barriers to obtaining housing in the past 12 months?

- ☐ Didn't have enough money for the deposit
- ☐ Could not find affordable housing
- ☐ Was put on a waiting list
- ☐ Didn't qualify for housing assistance
- ☐ Had a criminal record
- ☐ Had a mental/physical disability
- ☐ Other
- ☐ Felt discriminated against
- ☐ Had substance use issues
- ☐ No money for rent
- ☐ Not having enough to eat

21. How long have you stayed at your current residence?

- ☐ Less than 6 months
- ☐ 6 months to a year
- ☐ More than a year

22. How many nights in the past 12 months have you spent homeless or without a place to sleep? *Examples could include couch surfing, staying at a homeless shelter, or staying outside or "camping"*

- ☐ None
- ☐ 1-30
- ☐ 31-90
- ☐ More than 90

23. What is your rent or mortgage that you pay out of pocket monthly?

_____

24. Have you had to move due to inability to afford rent or mortgage in the last 3 years?

- ☐ Yes
- ☐ No

25. How many places have you lived in the past six months?

- ☐ 1
- ☐ 2
- ☐ 3+

Section 7: Financial Resources

26. What is your employment situation? *(Check all that apply)*

- ☐ Employed full time
- ☐ Employed part time
- ☐ Employed as a contractor (*ex: Lyft, Uber, Instacart, DoorDash, etc.*)
- ☐ Employed for cash (*ex: cleaning, childcare, landscaping, construction, etc.*)
- ☐ Self-employed
- ☐ I support myself through sex work
- ☐ I support myself through street work (*ex: panhandling, drug trade, etc.)*
- ☐ Retired
- ☐ Not working due to disability
- ☐ Unemployed, but currently seeking employment
- ☐ Unpaid volunteer
- ☐ Full time student
- ☐ Part time student
- ☐ Stay at home parent
- ☐ Unpaid caregiver for a family member or friend
- ☐ Other: _____

27. What is your current monthly household income? $_____

☐ Prefer not to answer

- **How many people, including you, depend on this income?** _____
- **Of these, how many are children under 18 years old?** _____

28. How do you pay for *general* medical care for yourself or your family?
(Check all that apply)

- ☐ Private health insurance. *If so, which company do you have?*_____ *(e.g., Aetna, Anthem, Blue Cross/ Blue Shield, CIGNA, Humana)*
- ☐ COBRA
- ☐ Medicaid
- ☐ Medicare
- ☐ Gold Card
- ☐ VA
- ☐ Indian Health Service
- ☐ Self-pay
- ☐ I don't get medical care because I can't pay for it
- ☐ I only get medical care for HIV through Ryan White
- ☐ Other:_____

29. Do you have trouble paying for the following types of medications on your own?
(Check one answer for each item below)

	Yes	No	I do not take this
HIV medication(s)	☐	☐	☐
Non-HIV related medications	☐	☐	☐
Medications for mental health conditions	☐	☐	☐

- **<u>If you have trouble paying for your medications,</u> are you getting help paying for them?** *(Check one)*
  - ☐ Yes
  - ☐ No
  - ☐ Don't know
  - ☐ N/a, I do not take medication

30. Do you regularly have difficulty accessing healthy food? *(Check one)*

☐ Yes ☐ No (***skip bullet below and go to Question 30***)

- **What are the reasons you regularly have difficulty accessing healthy food?**
  - ☐ Healthy food is too expensive
  - ☐ There is nowhere to buy healthy food near where I live
  - ☐ It takes too long to travel to buy healthy food
  - ☐ I don't have time to buy healthy food
  - ☐ I'm not sure what kinds of food are healthy
  - ☐ I don't like the taste of healthy food or I find it boring
  - ☐ My family doesn't like healthy food
  - ☐ I just choose not to eat healthy food
  - ☐ I don't know how to cook
  - ☐ I don't have the resources to be able to cook or store food
  - ☐ I don't have time to prepare healthy food
  - ☐ The options available at the food bank or food pantry I use are not healthy
  - ☐ Other:_____

Section 8: Please Tell Us About Yourself…

31. What zip code do you live in? _____

32. What is your age (in years)?

- ☐ 13-17 years old (***parent / guardian completed***)
- ☐ 18-24 years old
- ☐ 25-34 years old
- ☐ 35-49 years old
- ☐ 50-54 years old
- ☐ 55-64 years old
- ☐ 65-74 years old
- ☐ 75+ years old

33. What sex were you assigned <u>at birth</u>? *(Check one)*

☐ Male ☐ Female ☐ Intersex *(someone born with both male and female reproductive or sex organs; or with reproductive or sex organs that were not clearly male or female)*

34. What is your *primary* gender identity or gender expression <u>today</u>? *(Check one)*

☐ Man ☐ Woman ☐ Non-binary or gender fluid ☐ Other: _____ _____

35. Are you <u>currently</u> pregnant? *(Check one)* ☐ Yes ☐ No ☐ Don't know

- **If you are currently pregnant, are you in prenatal care?** *(Check one)* ☐ Yes ☐ No ☐ Don't know

36. How do you identify in terms of your sexual orientation? *(Check one)*

- ☐ Straight/Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Pansexual *(someone who feels sexual attraction, desire, love toward all sexes/genders)*
- ☐ Asexual *(someone who does not feel sexual attraction)*
- ☐ Undecided
- ☐ Other: _____

37. Are you of Hispanic or Latin(o/a/x) origin? ☐ Yes ☐ No

38. What is your primary race? *(Check one)*

☐ White
☐ Black/African American
☐ Hispanic/Latin(o/a/x)
☐ Asian American
☐ Pacific Islander or Native Hawaiian
☐ Native American or Alaska Native
☐ Multiracial
☐ Other:_____

39. How long have you lived in the U.S.? *(Check one)*

☐ I was born in the U.S.
(***if you were born in the U.S., skip bullet below and go to Question 39)***
☐ More than 5 years
☐ Less than 5 years
☐ I am here temporarily on a visa (student, work, tourist, etc.)
☐ Prefer not to answer
☐ Other: _____

- **What is your country of origin?** *(Please specify):*_____
  ☐ Prefer not to answer

40. <u>In the past 12 months</u>, have you been released from jail or prison?
(Check one) ☐ Yes ☐ No

Section 9: Prevention Activities

41. <u>In the past 12 months</u>, have you received any information about preventing HIV transmission? *(Check one)* ☐ Yes ☐ No

- **If so, where did you get this information?** _____
- **What was the information?** _____

42. People living with HIV who maintain an undetectable viral load (under 20 copies/mL) for at least 6 months have essentially no risk of transmitting HIV to another person through sex. This is sometimes called Undetectable = Untransmittable, or U = U. **Have you heard about U = U before today?**
(Check one) ☐ Yes ☐ No ☐ Don't remember

43. Pre-Exposure Prophylaxis (also called PrEP) is a way for people who don't have HIV to prevent getting HIV by taking a pill every day. **Have you heard about PrEP before today?**
(Check one) ☐ Yes ☐ No ☐ Don't remember

44. Do you know where a person who does not have HIV can go to get on PrEP?
(Check one) ☐ Yes ☐ No
***See the resource list attached to this survey for more information about PrEP.*

45. Post-exposure Prophylaxis (also called PeP) is a way for people who don't have HIV to prevent getting HIV if they think they may have been exposed through sex or needle sharing in the last 72 hours. **Have you heard about PeP before today?**
(Check one) ☐ Yes ☐ No ☐ Don't remember

46. Do you know where a person who does not have HIV can go to get PeP?
(Check one) ☐ Yes ☐ No
***See the resource list attached to this survey for more information about PeP.*

47. <u>If you've had sex in the past 6 months,</u> what is the HIV status of your sex partner(s)? This could be anal, vaginal, or oral sex, either receptive (bottom) or insertive (top), with any person. *(Check all that apply)*

- ☐ I have not had sex in the past 6 months (***skip Questions 47-49 below and go to Question 50***)
- ☐ HIV positive
- ☐ HIV negative, taking PrEP
- ☐ HIV negative, not taking PrEP
- ☐ I don't know
- ☐ I don't remember
- ☐ Prefer not to answer

48. How often do you talk about your HIV status with new sex partners? *(Check one)*

- ☐ Always, with every partner
- ☐ Sometimes, with some partners
- ☐ Never, my partner already knows
- ☐ Never, I always use condoms, so I don't feel like I have to share my status
- ☐ Never, I have an undetectable viral load, so I don't feel like I have to share my status
- ☐ Never, I don't feel comfortable sharing my status
- ☐ Never, I don't want to share my status
- ☐ Never, I do not have sex

49. <u>If you've had sex in the past 6 months</u>, how often did you use a condom (or female / internal condom) for each of the following? *(Check one answer for each item below)*

	Every time	Most of the time	About half of the time	Rarely	Never	N/A, I didn't do this
Getting oral sex	☐	☐	☐	☐	☐	☐
Giving oral sex	☐	☐	☐	☐	☐	☐
Vaginal sex	☐	☐	☐	☐	☐	☐
Anal sex, receptive (bottom)	☐	☐	☐	☐	☐	☐
Anal sex, insertive (top)	☐	☐	☐	☐	☐	☐

50. If you've had sex in the past 6 months, and you did not use a condom, why?
(Check all that apply)

- ☐ I only ever have sex with one person
- ☐ My sex partner(s) is living with HIV
- ☐ My sex partner(s) is on PrEP
- ☐ My viral load is undetectable
- ☐ I don't think I can get HIV again
- ☐ I can't get condoms
- ☐ I don't like condoms
- ☐ I'm not comfortable using condoms
- ☐ I'm allergic to condoms
- ☐ I can't find condoms that fit
- ☐ I'm too drunk / high at the time to remember to use condoms
- ☐ I get caught up in the moment, and forget to use them
- ☐ I don't think my partner likes condoms
- ☐ I'm afraid my partner(s) will tell other people about my HIV status
- ☐ I'm not comfortable talking to partners about condoms
- ☐ I'm afraid of what my partner(s) will do if I bring up condoms
- ☐ I only have oral sex, so I don't feel like I need a condom
- ☐ I only use condoms when I have vaginal or anal sex, not with oral
- ☐ I want to have a baby
- ☐ Sex with a condom doesn't feel as good
- ☐ I only use sex toys for penetrative sex
- ☐ Other:_____

51. In the past 12 months, did you use a needle to inject any substance, including medications, insulin, steroids, hormones, silicone, or drugs? This does not include an injection or blood test from a medical professional. (*Check one*)

- ☐ No (***skip Questions 51-52 below and go to Question 53***)
- ☐ Yes

52. In the past 12 months, how often did you share or use needles or injection equipment that somebody else may have used?

- ☐ N/a, I never share or use other people's needles or injection equipment
- ☐ Never
- ☐ Only a few times
- ☐ About half the time
- ☐ Often
- ☐ Always

53. In the past 12 months, how often did you clean your needles or injection equipment with bleach?

- ☐ N/a, I never share or reuse needles or injection equipment
- ☐ Never
- ☐ Only a few times
- ☐ About half the time
- ☐ Often
- ☐ Always

Final Questions…

54. In the <u>past 12 months</u>, did you get help for yourself from any of the following agencies? (***Check all that apply***)

- ☐ AAMA
- ☐ Accesshealth in Fort Bend
- ☐ AIDS Foundation Houston (**AFH**)
- ☐ AIDS Healthcare Foundation (**AHF**)
- ☐ Avenue 360 Health & Wellness
- ☐ Bee Busy Inc.
- ☐ Bee Busy Wellness Center
- ☐ Bering Omega Community Services
- ☐ Change Happens!
- ☐ Covenant House
- ☐ Fundación Latinoamericana De Acción Social (**FLAS**)
- ☐ Harris County Jail
- ☐ Legacy Community Health
- ☐ Memorial Hermann
- ☐ Positive Efforts
- ☐ St. Hope Foundation
- ☐ TDCJ
- ☐ Texas Children's Hospital
- ☐ The Montrose Center (formerly Montrose Counseling Center)
- ☐ Thomas Street Health Center
- ☐ Veteran's Affairs/VA
- ☐ Other:_____

55. Do you know how to file a grievance or a complaint? *(Check one for each item below)*

	Yes	No
With an agency	☐	☐
With Ryan White*	☐	☐

***See the resource list attached to this survey for the Ryan White grievance/complaint lines.*

Thank you for taking our survey!

Your answers will help us learn what people need for HIV care in the Houston Area.

If you have questions about this survey after today, please contact:

Ryan White Planning Council

Office of Support

(832) 927-7926

Please bring your completed survey to a staff person now.

RESOURCE LIST – YOURS TO KEEP! ***Please tear off this page and take it with you.***

If you need immediate help, please contact the agencies below.

All services are available in English and Spanish.

CRISIS HOTLINES (available 24 hours/7 days)	
Abuse/Neglect Hotline (Adult, Child, Disabled)	1-800-252-5400
Coalition for the Homeless	713 739-7514
Crisis Intervention of Houston	832 416-1177
LGBT Switchboard Helpline	713 529-3211
National Suicide Prevention Lifeline **Ayuda En Español**	1-800-273-TALK (8255) 1-888-628-9454
Rape Crisis Hotline	713 528-RAPE (7273)
TeenTalk Crisis Hotline	832 416-1199 or text 281 201-4430
Texas Youth Hotline	1-800-989-6884 or text 512 872-5777
Trevor Project Lifeline (LGBTQ youth)	1-866-488-7386 or text START to 678678
United Way of Greater Houston HELPLINE	2-1-1
Veterans Crisis Line	1-888-947-4431

DOMESTIC/INTIMATE PARTNER VIOLENCE	
Aid to Victims of Domestic Abuse	713 224-9911
Domestic Violence Hotline	713 528-2121 or 1-800-256-0551
LGBT Switchboard Helpline	713 529-3211

DOMESTIC VIOLENCE EMERGENCY SHELTER (available 24 hours/7 days)	
Fort Bend County Women's Center	281 342-HELP (4357)
Houston Area Women's Center	713 528-2121
Montgomery County Women's Center	936 441-7273
The Montrose Center (LGBT)	713 529-3211

MENTAL HEALTH CRISIS (available 24 hours/7 days)	
The Harris Center Emergency Psychiatric Services	713 970-7070
Tri-County Emergency Psychiatric Services (Montgomery, Liberty, and Walker counties)	1-800-659-6994

PRE-EXPOSURE PROPHYLAXIS (PrEP) and POST-EXPOSURE PROPHYLAXIS (PEP)			
AIDS Healthcare Foundation	713 524-8700	**Kelsey Seybold**	713 442-0000
Avenue 360 Health & Wellness	832 384-1406	**Legacy Community Health**	832 548-5221
Bee Busy Wellness Center	713 771-2292	**Planned Parenthood**	1-800-230-7526
Dr. Gorden Crofoot	713 526-0005	**St. Hope Foundation**	713 778-1300
Dr. Joseph Gathe Jr.	713 526-9821	**Thomas Street Health Center**	713 873-4000

SUBSTANCE & ALCOHOL USE	
Alcoholics Anonymous	713 686-6300
Al-Anon	713 683-7227
Cocaine Anonymous	713 668-6822
Narcotics Anonymous	713 661-4200
Palmer Drug Abuse Program	281 589-4602

QUESTIONS ABOUT THE SURVEY	832 927-7926

GRIEVANCE/COMPLAINT PROCEDURES

If you have questions on how to file a complaint with one of the agencies listed below regarding a Ryan White funded service, please contact:

FUNDED AGENCIES

RYAN WHITE PART A:

- Accesshealth (Fort Bend)
- AIDS Healthcare Foundation
- Avenue 360 Health and Wellness
- Houston Health Department
- Legacy Community Health
- Montrose Center
- St. Hope Foundation
- Thomas Street Health Center
- UT Health Science Center (pediatrics)
- VA Medical Center

RYAN WHITE PART B & STATE SERVICES:

- Avenue 360 Health and Wellness
- Harris County Jail
- Legacy Community Health
- Montrose Center
- St. Hope Foundation

RYAN WHITE PART A:

English: **713-439-6089**

Spanish: **713-439-6095**

Or write to:

Harris County Public Health
Ryan White Grant Administration
2223 West Loop South, Suite 417
Houston, TX 77027

RYAN WHITE PART B & STATE SERVICES:

Reachelian Ellison, Consumer Relations Coordinator
713-526-1016, Ext. 104
rellison@hivtrg.org

Or write to:

The Resource Group
500 Lovett Boulevard, Suite 100
Houston, TX 77006

If your complaint remains unresolved after you have followed all procedures with the agency, you will be informed on how to file a formal grievance.

Priority and Allocations Committee

Barbie Robinson, MPP, JD, CHC
Executive Director
1111 Fannin | Houston, Texas 77002

Harris County Public Health
Building a Healthy Community

Ericka Brown, MD, MBA, FACHE
Director Community Health and Wellness Division
1111 Fannin | Houston, Texas 77002

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

Barbie Robinson, MPP, JD, CHC
Executive Director
1111 Fannin | Houston, Texas 77002

Ericka Brown, MD, MBA, FACHE
Director Community Health and Wellness Division
1111 Fannin | Houston, Texas 77002

- 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

Glenn Urbach, LMSW
RWGA Program Manager
Harris County Public Health
(713) 274-5790
glenn.urbach@phs.hctx.net

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

FY 2022 Ryan White Part A and MAI Procurement Report

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

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

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments (to avoid UOB penalty)	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
	Grant Administration	1,795,958	169,915	0	0	0	1,965,873	8.16%	1,965,873	0	N/A	1,556,004	79%	100%
BEU27617	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%
BEU27621	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%

		Originel 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

Prepared by: Ryan White Grant Administration

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

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2223 Ryan White Part B

Procurement Report

April 1, 2022 - March 31, 2023

Reflects spending through March 2023 (FINAL)

Spending Target: 100%

Revised 6/1/23

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

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

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

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

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2223 DSHS State Services

Procurement Report

September 1, 2022 - August 31, 2023

Chart reflects spending through April 2023

Spending Target: 67%

Revised 6/1/2023

Priority	Service Category	Original Allocation per	% of Grant	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$864,506	47%	$0	$864,506	$0	$864,506	9/1/2022	$771,355	89%
6	**Mental Health Services (2)**	$300,000	16%	$0	$300,000	$0	$300,000	9/1/2022	$69,629	23%
11	**Hospice (3)**	$259,832	14%	$0	$259,832	$0	$259,832	9/1/2022	$234,080	90%
13	**Non Medical Case Management (4)**	$350,000	19%	$0	$350,000	$0	$350,000	9/1/2022	$115,595	33%
16	**Linguistic Services (5)**	$68,000	4%	$0	$68,000	$0	$68,000	9/1/2022	$36,180	53%
	Total Houston HSDA	**1,842,338**	**100%**	**$0**	$1,842,338	$0	$1,842,338		1,226,839	67%

Note

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

(2) Demand for services has been lower than expected

(3) Serviee utilization has increased. TRG will reallocate funds to support care delivery

(4) Staff vacancy has resulted in underspending

(5) Slight decreasc in utilization

Houston Ryan White Health Insurance Assistance Service Utilization Report

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

Revised: 5/24/2023

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	611	$71,336.66	278	*0*	*$0.00*	*0*
Medical Deductible	210	$177,222.18	159	*0*	*$0.00*	*0*
Medical Premium	4952	$1,735,534.41	864	*0*	*$0.00*	*0*
Pharmacy Co-Payment	4351	$1,462,509.24	1708	*0*	*$0.00*	*0*
APTC Tax Liability	0	$0.00	0	*0*	*$0.00*	*0*
Out of Network Out of Pocket	0	$0.00	0	*0*	*$0.00*	*0*
ACA Premium Subsidy Repayment	14	$1,137.06	12	*NA*	*NA*	*NA*
Totals:	10138	$3,445,465.43	3021	0	$0.00	

Comments: This report represents services provided under all grants.

DRAFT 05-26-23

Worksheet for Determining FY 2024 Service Priorities

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

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

*Hospice does not have HL Score or HL Rank.

FY 2024 - Increase Scenario Part A, MAI, Part B and State Services

Priorities and Allocations Committee PC approved 06/22/2023

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

FY 2024 - Increase Scenario Part A, MAI, Part B and State Services

Priorities and Allocations Committee PC approved 06/22/2023

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

FY 2024 - Increase Scenario Part A, MAI, Part B and State Services

Priorities and Allocations Committee PC approved 06/22/2023

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

Tips:

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

Core medical $17,535,493 81%

[For Staff Only]

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

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

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Houston Ryan White Planning Council
Priority and Allocations Committee

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

(Priority and Allocations Committee approved 06-22-23)

MOTION A: All Funding Streams – Level Funding Scenario

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

MOTION B: MAI Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Minority AIDS Initiative (MAI).
Primary care subcategories will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Minority AIDS Initiative (MAI).
Primary care subcategories will be increased by the same percent. This applies to the total amount of service dollars available.

MOTION C: Part A Increase / Decrease Scenarios

Decrease Fnnding Scenario for Ryan White Part A Funding.
All service categories except subcategories 2.h. Medical Case Management-Older adults (50+), 2.i. Medical Case Management-Veterans, 2.j. Medical Case Management-Youth, 10. Substance Abuse Services-Outpatient, 13.a. Service Linkage-Youth, and 13.b. Service Linkage-Newly Diagnosed/Not in Care will be decreased by the saine percent. This applies to the total amount of service dollars available.

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

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

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

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

Decrease Funding Scenario for Ryan White Part B and State Services Funding.
A decrease in funds of any amount will be allocated by the Ryan White Planning Council after the notice of grant award is received.

Increase Funding Scenario for Ryan White Part B and State Services Funding.
Step 1: Allocate the first $200,000 to be divided evenly between Oral Health – General Oral Health (category 4.a.) and Oral Health – Prosthodontics (category 4.b.).

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

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

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Priority and Allocations
FY 2024 Guiding Principles and Decision Making Criteria

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

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

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

Principles

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

Allocations only

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

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

(Continued)

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DECISION MAKING CRITERIA STEP 1:

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

DECISION MAKING CRITERIA STEP 2:

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

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

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Priority and Allocations

FY 2024 Guiding Principles and Decision Making Criteria

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

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

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

Principles

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

Allocations only

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

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

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DECISION MAKING CRITERIA STEP 1:

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C. Documented response to the epidemiology of HIV in the EMA and HSDA

D. Documented response to emerging needs reflecting the changing local epidemiology of HIV while maintaining services to those who have relied upon Ryan White funded services.

E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services

F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan, the Continuum of Care, the National HIV/AIDS Strategy, the Texas HIV Plan and their underlying principles to the extent allowable under the Ryan White Program to:

- build public support for HIV services;
- inform people of their serostatus and, if they test positive, get them into care;
- help people living with HIV improve their health status and quality of life and prevent the progression of HIV;
- help reduce the risk of transmission; and
- help people with advanced HIV improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

DECISION MAKING CRITERIA STEP 2:

A. Services have a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable

B. Services are accessible to all people living with or affected by HIV, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines

C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).

D. Services emphasize access to and use of primary medical and other essential HRSA defined core services

E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs

F. Services are available to meet the needs of all people living with HIV and families, as applicable under Part A and B guidelines

G. Services meet or exceed standards of care

H. Services reflect latest medical advances, when appropriate

I. Services meet a documented need that is not fully supported through other funding streams

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

Table of Contents

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

DRAFT

Houston Area HIV Services Ryan White Planning Council

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

Those services for which no change is recommended include:

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

Hospice Services

Local Pharmacy Assistance Program (LPAP)

Medical Nutritional Therapy/Supplements

Mental Health Services

Oral Health (Untargeted and Targeting the Northern Rural Area)

Outreach

Referral for Health Care (ADAP Enrollment Workers and Incarcerated)

Substance Abuse Treatment

Vision Care

Services with recommended changes include the following:

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

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

Emergency Financial Assistance – Other

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

Health Insurance Premium and Cost Sharing Assistance

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

Linguistic Services

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

Transportation

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

Priorities and Allocations Committee PC approved

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

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

Priorities and Allocations Committee PC approved

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

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

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

Tips:

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

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

[For Staff Only]

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

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

Priorities and Allocations Committee PC approved

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

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