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: Members, Houston Ryan White Planning Council

Copy: Glenn Urbach, Ryan White Grant Administration
Mauricia Chatman, Ryan White Grant Administration
Francisco Ruiz, Ryan White Grant Administration
Tiffany Shepherd, The Resource Group
Sha'Terra Johnson, The Resource Group
Diane Beck, Ryan White Office of Support

Email Copy Only:
Lt. Commander Lawrence Momodu, HRSA
Commander Luz Rivera, PACE
Commander Rodrigo Chavez, PACE
Jason Black, Ryan White Grant Administration
Ann Robison, the Montrose Center
Marlene McNeese, Houston Health Department
Charles Henley, Consultant

From: Tori Williams, Director, Ryan White Office of Support
Date: Wednesday, July 5, 2023
Re: Meeting Announcement

Please remember that the Council will be using a hybrid format at all meetings in 2023. That means members can participate by phone, computer or in person. **But, we need 11 people to meet in-person at Bering Church in the Montrose area in order to make quorum.** In an effort to entice you to come in person, we will be providing sandwich trays to those who have a medical need. Others are encouraged to bring a brown bag lunch. Please contact Rod ASAP to RSVP, even if you cannot attend:

Ryan White Planning Council Meeting
12 noon, Thursday, July 13, 2023

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

In Person: Bering Church, 1440 Harold St, Houston, Texas 77006. Use parking lot behind the church and ring the bell to be admitted into the downstairs hallway.

Please RSVP to Rod at 832 927-7926 or by responding to her email reminders. Thank you.

DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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

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

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

AGENDA

12 noon, July 13, 2023

Meeting Location: Online or via phone

Click on the following link to join the Zoom meeting:
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Meeting ID: 995 831 210 Passcode: 577264
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In Person: Bering Church, 1440 Harold St, Houston, Texas 77006

I.	Call to Order	Crystal R. Starr, Chair Ryan White Planning Council
	A. Welcome and Moment of Reflection	
	B. Adoption of the Agenda	
	C. Approval of the Minutes	
	D. Priority Setting and Allocations Processes	Bobby Cruz & Peta Ledbetter, Co-Chairs, Priority & Allocations Committee
	E. TENTATIVE: SMART vs. SMARTIE Goals	Steven Vargas, NMAC Consultant, National Minority AIDS Council

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

III. Reports from Committees

A. Comprehensive HIV Planning Committee — 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 July Council meeting has adjourned. All are welcome and all will be allowed to participate. Check the Council website at www.rwpchouston.org for a meeting packet.

Item: 2023 HIV Care Needs Assessment
Recommended Action: **Motion:** Allow the Comprehensive HIV Planning Committee to have final approval of the 2023 HIV Care Needs Assessment survey form.

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 & 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.

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

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.

E. Operations Committee — Ronnie Galley and Cecilia Ligons, Co-Chairs
No report.

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

VIII. Medical Updates — Shital Patel, MD, Baylor College of Medicine

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

A. AIDS Educational Training Centers (AETC) — Shital Patel
B. Ryan White Part C Urban and Part D — Dawn Jenkins
C. HOPWA — Megan Rowe
D. Community Prevention Group (CPG) — Kathryn Fergus
E. Update from Task Forces:
- Sexually Transmitted Infections (STI)
- African American — Sha'Terra Johnson
- Latino — Steven Vargas
- Youth
- MSM
- Hepatitis C — Steven Vargas
- Project PATHH (Protecting our Angels Through Healing Hearts) formerly Urban AIDS Ministry — Skeet Boyle

F. HIV and Aging Coalition — Skeet Boyle
G. Texas HIV Medication Advisory Committee — Bruce Turner
H. Positive Women's Network — Tana Pradia or Diana M.
I. Texas Black Women's Initiative — Sha'Terra Johnson
J. Texas HIV Syndicate — Steven Vargas
K. END HIV Houston — Jason Black
L. Texans Living with HIV Network — Steven Vargas?

IX. Announcements

X. Adjournment

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

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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

MINUTES

12 noon, Thursday, June 8, 2023
Meeting Location: Bering Church, 1440 Harold Street, Houston, TX & Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Crystal Starr, Chair	Kevin Aloysius, excused	Georgina German, RWPC
Ardry "Skeet" Boyle, Vice Chair	Servando Arellano	Mary Guidry, RWPC
Josh Mica, Secretary	Rosalind Belcher	Charles Henley, Consultant
Titan Capri	Caleb Brown, excused	Keegan Leibrock, CJO
Johanna Castillo	Tony Crawford	Alan Nyitray, PhD
Robert "Bobby" Cruz	Roxanne May, excused	Shabaura Perryman, Merck
Kathryn Fergus	Rodney Mills, excused	
Kenia Gallardo	Oscar Perez	**STAFF PRESENT**
Ronnie Galley	Tana Pradia, excused	*Ryan White Grant Administration*
Dawn Jenkins	Faye Robinson, excused	Glenn Urbach
Daphne L. Jones	Pete Rodriguez, excused	Mauricia Chatman
Peta-gay Ledbetter	Evelio Salinas Escamilla, excused	Jason Black
Cecilia Ligons	Imran Shaikh, excused	
Diana Morgan	Steven Vargas, excused	*The Resource Group*
Allen Murray		Tiffany Shepherd
Shital Patel		
Paul Richards		*Office of Support*
Ryan Rose		Tori Williams
Megan Rowe		Diane Beck
Robert Sliepka		Rod Avila
Carol Suazo		
C. Bruce Turner		

Call to Order: Crystal Starr, Chair, called the meeting to order at 12:10 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. The process of creating the FY24 Allocations will start on Monday. For those who don't know, Matilda Padilla passed away. She was a wonderful Council member who will be greatly missed. Starr will be representing the Council at her service tomorrow. Starr then called for a Moment of Reflection.

Adoption of the Agenda: ***Motion #1:*** *it was moved and seconded (Ligons, Boyle) to adopt the agenda with one change, continue the meeting and allow the guest speaker to present when he arrives on screen.* **Motion carried.**

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Boyle, Ligons) to approve the May 11, 2023 minutes.* **Motion carried.** Abstentions: Castillo, Fergus, Gallardo, Patel.

Results of an Anal Cancer Study: Alan Nyitray, PhD, Center for AIDS Intervention Research at the Medical College of Wisconsin, presented the attached PowerPoint.

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 adjourns today. 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: Ardry Boyle, Jr., Vice Chair, Affected Community Committee, reported on the following:
2022 Project LEAP Evaluation Report: Williams summarized the results of the 2022 Project LEAP and VIDA Evaluation Reports.

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.** Abstention: Rowe.

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 clinics, special events and more. Please spread the word.

Quality Improvement Committee: Josh Mica, Council Secretary, 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 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.* **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 on Monday, June 12, 2023 at noon. See Rod if you wish to receive reminders.

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

Proposed FY 2024 Council Support Budget: Recommended Action: ***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.

Report from The Resource Group: See the attached report.

Medical Update: Patel presented the attached information from the CDC regarding the decline in HIV cases. She also stated the importance of the HPV vaccine as prevention for many cancers, including anal cancer. For more information on the HPV vaccine, refer to the medical update from February 2023.

Task Force Reports: Starr said that the Council agreed not to have verbal Task Force Reports while meeting on Zoom. The Office of Support is happy to receive and distribute written reports in advance of all Council meetings.

Announcements: Ligons said there is still space available at the Positive Living Conference in Florida if anyone is interested. Rowe said that FLAS and Bread of Life are now HOPWA providers. Bread of Life has taken on the existing clients from Avenue 360 and FLAS can take new clients. In July, The Women's Home will also be a provider. Patel thanked the Administrative Agents for their collaboration on the EHE/Rapid Start program with ECHO. The results will be presented in a poster in Paris next week. Murray said that Bering will have a float in the PRIDE parade, if anyone wants to ride let him know.

Adjournment: ***Motion:*** *it was moved and seconded (Mica, Ligons) to adjourn the meeting at 1:37 p.m.* **Motion Carried.**

Respectfully submitted,

_____ Date _____
Victoria Williams, Director

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for June 8, 2023

C = Chaired the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Project LEAP/Proyecto VIDA Svc Def & Student selection guidelines **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Project LEAP/Proyecto VIDA Svc Def & Student selection guidelines **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Crystal Starr, Chair				C				C				C	Robert Sliepka		X				X				X		
Ardry “Skeet” Boyle, Vice Chair		X				X				X			Carol Suazo		X				X				X		
Josh Mica, Secretary		X				X				X			C. Bruce Turner	X				X					X		
Titan Capri		X				X				X															
Johanna Castillo		X				X				X			**MEMBERS ABSENT**												
Robert “Bobby” Cruz		X				X				X			Kevin Aloysius												
Kathryn Fergus		X				X				X			Servando Arellano												
Kenia Gallardo		X				X				X			Rosalind Belcher												
Ronnie Galley		X				X				X			Caleb Brown												
Dawn Jenkins		X				X				X			Tony Crawford												
Daphne L. Jones		X				X				X			Roxanne May												
Peta-gay Ledbetter		X				X				X			Rodney Mills												
Cecilia Ligons		X				X				X			Oscar Perez												
Diana Morgan	X				X					X			Tana Pradia												
Allen Murray		X				X				X			Faye Robinson												
Shital Patel		X				X				X			Pete Rodriguez												
Paul Richards		X				X				X			Evelio Salinas Escamilla												
Ryan Rose		X				X				X			Imran Shaikh												
Megan Rowe		X				X				X			Steven Vargas												

C = Chaired the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #4** FY24 HTBMN Svc Defs and Financial Elig **Carried**				**Motion #5** FY24 Svc Cat Targeting chart **Carried**					**Motion #4** FY24 HTBMN Svc Defs and Financial Elig **Carried**				**Motion #5** FY24 Svc Cat Targeting chart **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Crystal Starr, Chair				C				C	Robert Sliepka		X				X		
Ardry “Skeet” Boyle, Vice Chair		X				X			Carol Suazo		X				X		
Josh Mica, Secretary		X				X			C. Bruce Turner		X				X		
Titan Capri		X				X											
Johanna Castillo		X				X			**MEMBERS ABSENT**								
Robert “Bobby” Cruz		X				X			Kevin Aloysius								
Kathryn Fergus		X				X			Servando Arellano								
Kenia Gallardo		X				X			Rosalind Belcher								
Ronnie Galley		X				X			Caleb Brown								
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Cecilia Ligons		X				X			Oscar Perez								
Diana Morgan		X				X			Tana Pradia								
Allen Murray		X				X			Faye Robinson								
Shital Patel		X				X			Pete Rodriguez								
Paul Richards		X				X			Evelio Salinas Escamilla								
Ryan Rose		X				X			Imran Shaikh								
Megan Rowe		X				X			Steven Vargas								

C = Chaired the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #6** Revised FY 2023 OS Budget **Carried**				**Motion #7** FY 2024 OS Budget **Carried**					**Motion #6** Revised FY 2023 OS Budget **Carried**				**Motion #7** FY 2024 OS Budget **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Crystal Starr, Chair				C				C	Robert Sliepka		X				X		
Ardry "Skeet" Boyle, Vice Chair		X				X			Carol Suazo		X				X		
Josh Mica, Secretary		X				X			C. Bruce Turner		X				X		
Titan Capri				X		X											
Johanna Castillo		X				X			**MEMBERS ABSENT**								
Robert "Bobby" Cruz		X				X			Kevin Aloysius								
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Diana Morgan		X				X			Tana Pradia								
Allen Murray		X				X			Faye Robinson								
Shital Patel		X				X			Pete Rodriguez								
Paul Richards		X				X			Evelio Salinas Escamilla								
Ryan Rose		X				X			Imran Shaikh								
Megan Rowe		X				X			Steven Vargas								

Houston Ryan White Planning Council

Priority Setting Process

May 25, 2023

Principles and Criteria

Principles

Sound priority setting must be based on clearly stated and consistently applied principles for decision-making.

- **These principles are the basic ideals for action**

Criteria

Criteria are the standards on which judgment will be based.

Priority Setting

Needs Assessment Data

The percentages are taken from the needs assessment and then broken down and used to determine the priorities.

Midpoint

When a service percentage is above the set median point it will rank as a high for that column, if below the midpoint then it will be a low rank. This will be done for each column. Later in this presentation, we will use an example which will make it easier to see how the data and the midpoints work.

High Low Score

E.g. Score: LLHL

Attached is a listing of each possible high low scenario.

Priority Setting

The group will then place each service into one of two groups: Core or Non Core

CORE

Outpatient/Ambulatory Medical Care (Primary Care)
Local Pharmaceutical Assistance Program (LPAP)
Oral Health Care
Early Intervention Services
Health Insurance Premium and Cost-Sharing Assistance
Hospice
Home and community based health services
Medical Nutrition Therapy
Mental Health
Outpatient Substance Abuse Treatment
Medical Case Management (including treatment adherence services)

NON-CORE

Case Management (Non-Medical)
Emergency Financial Assistance
Health Education Risk Reduction
Medical Transportation
Outreach Services
Psychosocial Support Services
Referral for healthcare/supportive services
Treatment Adherence Counseling

Prioritization

Lets Try It!

Happy HSDA

Service	*Need*	*Use*	*Availability*
Oral Health Care	68	45	15
Primary Care	82	82	3
Case Management	81	76	10
Medical Case Management	68	68	7
Van Transportation	51	49	15
Health Insurance	77	42	30
Vision Care	74	31	38

Let's set our midpoints!

Hint, Remember the midpoint is the average of the highest and lowest NA percentage.

Need: 67% Use: 57 % Availability: 21%

Prioritization

Happy HSDA

Service	*Need*	*Use*	*Availability*	*Need*	*Use*	*Avail*
Oral Health Care	68	45	15	H	L	L
Primary Care	82	82	3	H	H	L
Case Management	81	76	10	H	H	L
Medical Case Management	68	68	7	H	H	L
Van Transportation	51	49	15	L	L	L
Health Insurance	77	42	30	H	L	H

Midpoints: Need: 67% Use 57 % Availability 21%

Service	High-Low Scores:	C/N	Rank
Primary Care:	HHL	C	1
Medical Case Management:	HHL	C	2
Health Insurance:	HLH	C	3
Oral Health:	HLL	C	4
Case Management:	HHL	N	5
Van Transportation:	LLL	N	6

Prioritization

Tie Breaking and finalizing

Once this is done the committee will use any additional relevant information and public comment to break any ties until there is an established priority list.

Prioritization

What happens when there is NO new Needs Assessment data?

During years where there is no new needs assessment data (or "off years") the group will use data from the most recent needs assessment activities, special studies, HBTMN, etc.

The group does not complete another High-Low process during these years, the work is already done !, instead….

The group will be given the listing of the previous years priorities and make changes in the priorities as appropriate.

SMARTIE Goals Worksheet

Goals are a concrete way to drive results, but without an explicit equity and inclusion component, goals won't produce better outcomes for marginalized communities, address disparities, or support belonging. Introducing SMARTIE goals! SMARTIE stands for:

STRATEGIC	Reflects an important dimension of what your organization seeks to accomplish (programmatic or capacity-building priorities).
MEASURABLE	Includes standards by which reasonable people can agree on whether the goal has been met (by numbers or defined qualities).
AMBITIOUS	Challenging enough that achievement would mean significant progress—a "stretch" for the organization.
REALISTIC	Not so challenging as to indicate lack of thought about resources, capacity, or execution; possible to track and worth the time and energy to do so.
TIME-BOUND	Includes a clear deadline.
INCLUSIVE	Brings traditionally marginalized people—particularly those most impacted—into processes, activities, and decision/policy-making in a way that shares power.
EQUITABLE	Seeks to address systemic injustice, inequity, or oppression.

By incorporating equity and inclusion into your SMART goals, you can make sure your organization's commitment to racial equity and inclusion is anchored by tangible and actionable steps. Here's an example of a SMART goal turned SMARTIE:

SMART	SMARTIE
Build a volunteer team of 100 door-to-door canvassers by May…	…with at least 10 people of color recruited as volunteer leaders first, so that they can help shape the way we run the canvasses.

Please note: *there's a fine line between inclusion and tokenism. What's the difference? Power. In most cases, it's not enough to tack on "…and x number of volunteers/new hires/spokespeople should be people of color" unless the people you're trying to include will be able to influence the work in a meaningful way. SMARTIE goals are about including marginalized communities in a way that shares power, shrinks disparities, and leads to more equitable outcomes.*

Learn more about **How to Embed Inclusion and Equity in Your Goals** and visit our **Goals Bank** for inspiration. *Ready to get started?* Use our SMARTIE goals **practice sheet** below.

Start Writing Your SMARTIE Goals

Use this template to write a goal for yourself or a team member.

Time-Bound: My goals between _____ *(start date)* and _____ *(end date)* are to achieve this **Strategic** and **Ambitious** outcome:

I will know success when I see it using these **Measurable** standards:

-
-

A **Realistic** plan to achieve this goal includes these tactics/activities (consider time, resources, capacity):

	By _____ *(date)*
	By _____ *(date)*
	By _____ *(date)*

Start Writing Your SMARTIE Goals
Thinking about **Equity and Inclusion**: Can you imagine there being any unintentional *disparate impact* along lines of power and identity? How might inequity or exclusion show up? For whom?
How could you *change the goal* to either mitigate that disparate impact or make **Equity and Inclusion** more explicit?

Williams, Victoria (County Judge's Office)

From: Steven Vargas <sivargas68@gmail.com>
Sent: Friday, June 30, 2023 1:58 PM
To: Williams, Victoria (County Judge's Office)
Subject: Fwd: How to SMARTIEs

---------- Forwarded message ---------
From: **Steven Vargas** <sivargas68@gmail.com>
Date: Thu, Jun 29, 2023 at 11:01 PM
Subject: How to SMARTIEs
To: Steven Vargas <sivargas68@gmail.com>

When you're moving from equity-neutral goals to goals with equity and inclusion considerations baked in, practice these tips to stay on track:

Mind the "how"

Some goals don't—at face value—specifically promote equity and inclusion, so you'll want to specify how you're mitigating disparate impact or advancing equity and inclusion in your *tactics, benchmarks, or metrics*. Below are two examples:

- Your development team may have an outcome goal to "raise $X by Y to cover this year's budget and 3 months' operating reserve." There are many ways to do this, and one of them might include this activity goal: "recruit, retain, and develop a total of 30,000 dues-paying members, at least X% of whom identify as [people of color / women / trans or gender non-conforming / poor / Spanish-speaking]."
- Your policy team might have a goal to create and disseminate X policy briefs on immigration by the end of the year. In order to be more inclusive and equitable in the process, you might say explicitly: "We will consult with X coalition or Y community leaders to get feedback before finalizing."

Ask yourself: If the outcome specified in the goal isn't specifically promoting equity and inclusion, is the process of achieving this goal going to improve equity and inclusion on our team/organization?

Check for unintentional disparate impact

A big part of developing a SMARTIE goal is checking for unintentional disparate impact along lines of identity and power and finding ways to mitigate that impact. But sometimes, you just don't have enough information (whether that's precedent or perspective) to

anticipate unintended consequences. If that's the case, make sure you're explicit about how and when you'll check for it along the way. Below are two examples:

- "Lower overhead costs by $X by [date]" can be improved by adding "…with quarterly check-ins with staff to check for negative disparate impact of cost savings."
- "Increase representation of staff with marginalized identities in our hiring processes by [date]" can be improved with the addition of "…with checks to ensure staff with marginalized identities aren't carrying an unequal share of the work."

Ask yourself: What unintended disparate impact might result from this goal? Who have I consulted to check for unintended negative consequences? Any key stakeholders I'm missing from this list?

Make your metrics matter

There's a fine line between inclusion and tokenism. What's the difference? Power. In most cases, it's not enough to tack on "…and x number of volunteers/new hires/spokespeople should be people of color" unless the people you're trying to include will be able to influence the work in a meaningful way. Here's an example:

- "Build a volunteer team of 100 door-to-door canvassers by May, with at least 10% people of color" is a much different goal than "Build a volunteer team of 100 door-to-door canvassers by May, with at least 10 people of color recruited as volunteer leaders first, so that they can help shape the way we run the canvasses."

Ask yourself: If I added an outcome or activity goal related to a specific marginalized community, will achieving this goal help build power and/or shrink disparities for this community? If so, how?

https://www.managementcenter.org/resources/smart-to-smartie-embed-inclusion-equity-goals/

Published: May 3, 2021

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.

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June 15, 2023

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Evelio Salinas Escamilla

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

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Priority and Allocations Committee

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DATE: 06/12/2023

TO: RWPC Priorities & Allocations Committee

FR: Ryan White Grant Administration

RE: FY 2022 Part A/MAI Procurement Report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FY 2022 Ryan White Part A and MAI
Procurement Report

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

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

FY 2022 Ryan White Part A and MAI
Procurement Report

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

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

MAI Procurement Report

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

Footnotes:

All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.
(a)	Single local service definition is multiple HRSA service categories. (1) does not include LPAP. Expenditures must be evaluated both by individual service category and by combined service categories.
(c)	Funded under Part B and/or SS
(e)	10% rule reallocations

Prepared by: Ryan White Grant Administration

FY 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) Service utilization has increased. TRG will reallocate funds to support care delivery

(4) Staff vacancy has resulted in underspending

(5) Slight decrease in utilization

Houston Ryan White Health Insurance Assistance Service Utilization Report

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

Revised: 5/24/2023

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

Comments: This report represents services provided under all grants.

DRAFT 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	
~~**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 Funding Scenario for Ryan White Part A Funding.

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

Increase Funding Scenario for Ryan White Part A Funding.

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

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

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

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

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

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

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

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

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

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

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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.

Table of Contents

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

Houston Area HIV Services Ryan White Planning Council

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

Those services for which no change is recommended include:

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

Hospice Services

Local Pharmacy Assistance Program (LPAP)

Medical Nutritional Therapy/Supplements

Mental Health Services

Oral Health (Untargeted and Targeting the Northern Rural Area)

Outreach

Referral for Health Care (ADAP Enrollment Workers and Incarcerated)

Substance Abuse Treatment

Vision Care

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

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

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

Emergency Financial Assistance – Other

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

Health Insurance Premium and Cost Sharing Assistance

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

Linguistic Services

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

Transportation

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

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

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

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

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

Priorities and Allocations Committee PC approved

FY23 - Increase Scenario with April Reallocation Funding Implemented

April 27, 2023

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

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

Tips:

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

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

[For Staff Only]

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

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

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Houston EMA Ryan White Part A, MAI & EHE
Administrative Agency Report
July 6, 2023

FY 2023 Contract Status

- The 1st Amendment contracts reflecting FY 23 notice of full award have been place on the July 18th Commissioners Court agenda for approval
- Rural Primary Care Bundle (formerly Part B-funded Primary Care Bundle) has been put out to the bid with funding for the remaining six months of FY23 and 4-one year renewal options beginning on 3/1/2024

FY 2022 Contract Status

- Agencies have been notified of FY22 carryover availability. The deadline to submit increased funding requests is July 12th. The requests will be submitted to the P&A committee in advance of its July 27th meeting.
- RWGA anticipates $1,297,645 in FY22 carryover funds, although the final amount may change when the FY22 Federal Financial Report is finalized later this month

EHE Update

- RWGA will be issuing an RFP to solicit bids to provide six-month housing assistance (EFA-Other) using carryover funds—currently, the EHE grant funds three months of housing assistance.
- We will also be issuing a second RFP to secure more Rapid Start providers and to build a robust social media campaign around EHE initiatives

Quality Management & Improvement Updates

- Hosted Case Management/Frontline In-service training addressing self-care and burnout to acknowledge barriers with CM/Frontline staff retention.
- Medical Advisory Subcommittee quarterly meeting was held on 6/8/2023
- Clinical Quality Management Committee quarterly meeting was held on for 6/13/2023

Department of State Health Services (DSHS) Take Charge Texas (TCT) Data Imports:

- RWGA met with DSHS and TCT developers to resolve the double data entry during the importing process. TCT developers are working on a direct resolution to map the TCT client code with the CPCDMS client code. As a temporary resolution RWGA has been

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manually mapping the CPCDMS client code with TCT client ID with help from agencies to prevent duplicates during imports.
- Part A and EHE contracts are being imported into the TCT for FY23

RWGA Vacancies

- RWGA is proud to report that its hired Francisco Ruiz as its next Clinical Quality Improvement Project Coordinator position has been filled. Francisco started on June 26, and before joining us, he worked as clinical care manager at an area dialysis clinic.
    - We expect to begin contracting with a healthcare consulting firm very soon, who in turn will train and mentor Francisco, while providing technical assistance and training regarding various QM and QI activities
- Financial Analyst position-RWGA is in still in the process of interviewing both permanent and temporary candidates for the position

Houston RWPC Steering Committee & Council Report

July 2023

Administrative Agency Update

Installation of new phone system: 713-526-1016

Vacant Positions: Accounting Manager, Program Monitor, HOPWA Resource Identification Specialist, Local Responsible Party (IT)

Contact Tiffany Shepherd for details tshepherd@hivtrg.org

TRG Reports Submission:

Procurement Monthly Report

a. **Ryan White B (April 1 – March 31)**
- FY 22-23 spending through May 2023 **provided 7/5/2023**

b. **State Services (April – August 31):**
- FY 22-23 SS spending through May 2023 **provided 7/5/2023**

Service Utilization Quarterly Report

a. **State Services (September 1-August 31):**
- FY 22-23 1st Quarter (Sept-Nov) provided 2/9/2023
- FY 22-23 2nd Quarter (Dec-Feb) provided 4/6/2023
- FY 22-23 3rd Quarter (Mar-May) **provided 7/5/2023**
- FY 22-23 4th Quarter FINAL (Jun-Aug)

b. **Ryan White Part B (April 1-March 31):**
- FY 22-23 1st Quarter (Apr-Jun)
- FY 22-23 2nd Quarter (Jul-Sept)
- FY 22-23 3rd Quarter (Oct-Dec) provided 2/9/2023
- FY 22-23 4th Quarter FINAL (Jan-Mar) provided 5/4/2023

Health Insurance Assistances Service Utilization Quarterly Report
- FY 22-2023 April 2023 provided 6/5/2023

All reports provided to RWPC OOS

Address: 3700 Buffalo Speedway, Suite 250, Houston Texas 77098-3799
Phone: 713-526-1016
Website: www.hivtrg.org

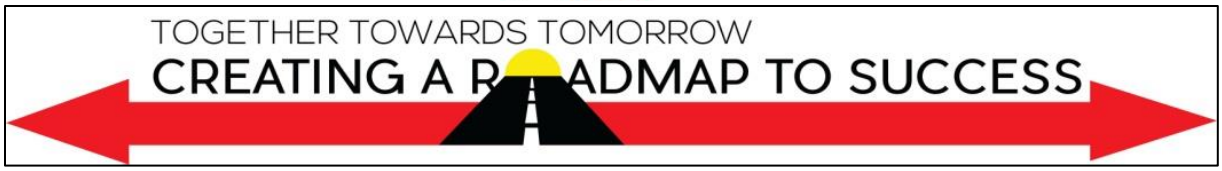
DSHS Funding Ryan White Part B, State-R, State Services & HOPWA Updates

a. **Grant Updates**
b. **Service Categories Updates**
   - **Referral for Healthcare Targeting the Incarcerated and Recently Released:** County system for approval in process.
c. **Houston ADAP Enrollment Workers:**
   - Regional ADAP/Eligibility Liaison Hailey Malcolm Contact email hmalcolm@hivtrg.org
   - All THMP processing dates are current
   - THMP has hired 12 new contractors to assist in application processing
   - Regional AEWs attended in service training with ADAP Liaison June 13-14
   - TCT Helpdesk has created an AEW manual as a guide for completing ADAP applications
   - THMP will host regional calls for Houston and East Tx July 25-26
d. **Rural HOPWA**
   - Rural HOPWA RFP due July 6, 2023; Houston (only specific to Wharton, Colorado, and Matagorda counties).
   - **HOPWA Bridge Re-Entry Initiative (BRI) Project:** This service will be part of the HOPWA RFP process.

Ryan White Part D: The Positive VIBE Project (PVP) of Houston Galveston Update

- HRSA Site Visit: HRSA will be conducting a site review of the PVP in August. TRG has met with the site visit team. TRG has a weekly internal meeting to coordinate the submission of materials to the team. Materials are due by July 15th.
- Youth Transitioning Initiative: TRG's Positive VIBE Network is funding a new initiative to provide counselor facilitated support groups for youths transitioning from pediatric care to adult care providers. These support groups will be available for youth regardless of whether the pediatric provider is funded by TRG's Part D grant. The Montrose Center has created a referral process.
- Disclosure Support Group: Texas Children's Hospital is partnering with The Montrose Center to provide counselor facilitated support groups for parents needing to disclose HIV diagnosis to their children. The Montrose Center has created a referral process that reduces the burden of providing eligibility documents by using TCT.
- Parental Support Network: As a QI initiative, TRG's Positive VIBE Network is using the Postpartum Support International (PSI) model to create a (pre- and post-delivery) parental support network to assist parents in address the stress, anxiety, and needs of adding another member to their household. TRG has purchased the PSI Implementation Guides. Additionally, TRG will be working with the PVP to increase screening and connection to treatment for postpartum depression (PPD).

RYAN WHITE HIV/AIDS PROGRAM PART B



TRG Community Initiatives

Trauma-Informed Care Initiative

- The Change Team continues implementing the trauma principles based on TRG staff feedback.
- The Change Team is working on a Trauma 101 training with a refresher for current staff and onboarding new staff.
- Please contact Reachelian Ellison rellison@hivtrg.org, project lead, with questions.

Serving the Recently Released and Incarcerated

- SIRR met on June 28th. The meeting was virtual. The meeting included a debrief about the Community Forum, an update on the Legislative Session, and planning discussion about the October SIRR Resource Summit.
- To be added to the distribution list for meeting announcements, contact Felicia Booker fbooker@hivtrg.org

Texas Black Women's Health Initiative (TxBWHI) Houston Team

- July meeting with AASOETF 7/14/2023 @ 12:30 pm @ TRG.
- Contact Sha'Terra Johnson tbwihouston@gmail.com

Other: TRG and staff participates in many EMA and HSDA community groups, initiatives and programs that impacts the HIV workforce in prevention, care and support on the national, state and local levels.

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