Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

PLANNING COMMISSION (COHAH) GENERAL BODY/EMA WIDE PRIORITY SETTING RESOURCE ALLOCATIONS MEETING

MEETING AGENDA

THURSDAY, AUGUST 24, 2023 – 5:30PM TO 8:30PM

ZOOM CONFERENCE AND VIDEO CALL

Note: all times are approximate

5:30 pm	**1. Welcome, Call To Order and Moment of Silence**
5:40 pm	**2. Review and Adoption of the Meeting Agenda for August 24, 2023** **3. Review and Approval of the Meeting Minutes from July 27, 2023**
5:45 pm	**4. Ryan White HIV/AIDS Program (RWHAP) Recipient Report/ Updates**
5:50 pm	**5. Standing Committee Updates** • *Research & Evaluation Committee (REC) {Next mtg.: Tue. September19th@3pm}* • *Community Engagement & Education Committee (CEEC) {Next mtg.: Thu. September 21st @5pm}* • *Comprehensive Planning Committee (CPC) Next mtg.: Wed.September 27th @10am}* • *Integrated Strategies Committee (ISC) {Next mtg.: Wed.September 27th @ 1pm}*
	PRIORITY SETTING AND RESOURCE ALLOCATIONS
6:00 pm	**6. GY'34/FY'24 PSRA Process Review:** Lamont Clark • Clarifying Information, expectations and outcomes
6:10 pm	**7. EMA's Epidemiological Overview:** Kate Drezner, Chief Epidemiologist, DC Health
6:20 pm	**8. Service Utilization and Spending:** Jose Delao Hernadez & Jason Edmonds, DC Health
6:40 pm	**9. The Service System for GY'34 (3-1-24 to 2-28-25) & Minority AIDS Initiative (MAI):** Ave-Maria Smith • Changes to Services System for GY'34/FY'24
7:00 pm	**10. Financial Inventory:** Naomi Seiler, Greg Dwyer, George Washington University
7:20 pm	**11. Needs Assessment Data:** Julie Orban, HIV Services Planner, DC Health
7:40 pm	**12. Priority Setting for the Washington, DC Eligible Metropolitan Area (EMA)** • Review of DC EMA Priorities from past 2 years & Setting of DC EMA Priorities for GY'34/FY'24
8:00 pm	**13. Resource Allocation for the DC EMA** • Review of DC EMA Allocations from past 2 years & Setting of DC EMA Allocations for GY'34/FY'24
8:20 pm	**14. Approval of EMA and Jurisdiction Priorities and Allocations**
8:30 pm	**15. New Business, Announcements & Adjournment**
NEXT PLANNING COMMISSION (COHAH) MEETING:	**THURSDAY SEPTEMBER 28, 2023 6PM-8PM**

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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PLANNING COMMISSION (COHAH) GENERAL BODY MEETING MINUTES

THURSDAY, JULY 27, 2023 - 6:00PM

ZOOM CONFERENCE AND VIDEO CALL

ELECTRONIC – ONLINE MEETING

ATTENDEES/ROLL CALL

COMMISSIONERS	PRESENT	ABSENT	COMMISSIONERS	PRESENT	ABSENT
Barnes, Clover (Ex-Officio)	X		Hutton, Kenya		X
Barton, Jedidiah		X	Keita, Ramatoulaye		X
Blocker, Lakisa		X	Massie, Jenné	X	
Brown, Charles		X	Mekonnen, Betelhem *(Comm. Co-Chair)*		X
Camara, Farima		X	Murdaugh, Henry		X
Carney, Misty	X		Olinger, Joshua	X	
Cauthen, Melvin	X		Palmer, Kentrell	X	
Clark, Lamont (Gov. Co-Chair)	X		Penner, Murray	X	
Coker, Sharon	X		Pettigrew, Kenneth	X	
Cooper-Smith, Marjorie	X		Rakhmanina, Natella	X	
Copley, Mackenzie	X		Ramos, Claudia	X	
Corbett, Wallace	X		Rhodes, Stefanie	X	
Cox, Derrick		X	Sain, Philip		X
Dean, Traci		X	Shaw-Richardson, Re'ginald		X
DeMartino, Peter	X		Wallis, Jane *(Comm. Vice-Chair)*	X	
Fogal, Doug	X		Yocum, Ashley	X	
Ford, Jasmine	X				
Forman, Lynn		X			
Gomez, Ana		X			
Gutierrez. Anthony	X				
Hickson, DeMarc		X			
RECIPIENT STAFF	**PRESENT**	**ABSENT**	**PRESENTERS**	**PRESENT**	**ABSENT**
Price, Ashley	X				
HAHSTA STAFF	**PRESENT**	**ABSENT**	**COMMISSION STAFF**	**PRESENT**	**ABSENT**
Orban, Julie	X		Bailey, Patrice	X	
			Johnson, Alan	X	

HIGHLIGHTS

This is a draft version of the July 27, 2023, COHAH General Body Meeting Minutes which is subject to change. The final version will be approved on August 24, 2023.

AGENDA

Item	Discussion
Call to Order	Lamont C. called the meeting to order at 6:15 pm followed by the welcome, and a moment of silence. Attendance was taken via Zoom chat. With 22 of 34 voting commissioners present, a quorum was established.
Review and Adoption of the Agenda	Jane W. asked for a motion to adopt the COHAH Agenda for July 27, 2023. Murray P. made the motion. Jenné M. seconded. The agenda was adopted unanimously via poll vote.
Review and Approval of the Minutes	Jane noted that Melvin C. was documented in the June minutes as the person who both moved and seconded the motion to approve the minutes. Melvin C. made the motion to approve the June 29, 2023 minutes with the necessary correction. Sharon C. seconded. The minutes were approved unanimously via poll vote.
Ryan White HIV/AIDS Program (RWHAP) Recipient Report/Updates	**Ashley P., Ryan White Part A Coordinator, presented the Recipient Report** The Part A and Part A MAI report is being presented for the month of May for Grant Year 33. The full award is in the amount of $32,652,189.00. **FISCAL STATUS** Twenty-five (25) of the twenty-six (26) providers have submitted payment requests that were processed, and one (1) provider has not submitted an invoice for Part A and Part A MAI in May. **PART A FISCAL SUMMARY** Part A expenditures are at 23% and should be at 25%. Service areas affected by unprocessed invoices were Early Intervention Services (EIS), and Psychosocial Support Services (PSS). Services spending 30% below expected were Early Intervention Services (EIS), and Health Insurance Premium and Cost Sharing Assistance (HIPCSA) due to staff vacancies. Services spending 30% above expected were Mental Health Services (MHS) and Other Professional Services (OPS). The spending is being closely monitored in these service categories and a reprogramming is expected. **PART A MAI FISCAL SUMMARY** Part A MAI expenditures were at 17% and should be at 25%. There were no service areas affected by unprocessed invoices.

	Services spending 30% below expected were Early Intervention Services (EIS), Medical Case Management (MCM), Psychosocial Support Services (PSS), and Substance Abuse Services – Outpatient (SASO). There were no services areas spending 30% above expected. RECIPIENT REPORT The Recipient is in receipt of the Data Request for PSRA 2023 and is working to compile all required elements for the PRSA meeting in August. During the meeting the Recipient will make a reprogramming request to reduce the lapse rate of the Part A Award for GY33. On August 3, 2023, the Recipient will convene a jurisdictional meeting with the Virginia and Maryland Departments of Health to discuss Ryan White programmatic overlaps within our respective jurisdictions. The Recipient submitted the Core Medical Services Waiver for GY 33 with the Non-competing Continuation (NCC) progress report and awaiting review and approval from HRSA.
Standing Committee Updates	**Research and Evaluation Committee (REC) reported by Lamont C.** Although REC did not meet this month, Lamont reported that during next month's meeting, students will give a presentation on the Needs Assessment that closed on June 30th and present at PSRA as needed. The final number was over 400 usable surveys completed. REC is also working on the Assessment of the Efficiency of the Administrative Mechanism (AEAM), which currently sits in Microsoft Forms but will be transferred into the recently procured Qualtrics system. AEAM is a survey that is sent to service providers asking about their experience with HAHSTA's disbursement of funds. A similar survey is also sent to the Recipient. The information is then sent to HRSA who compiles it into a report. REC will seek the Care team's assistance in getting the AEAM out to the appropriate Ryan White providers. Lamont announced that Qualtrics will replace the use of SurveyForce moving forward. **Community Education and Engagement committee (CEEC) reported by Jenné M**. The CEEC did not meet this month and there were no updates to report. **Comprehensive Planning Committee (CPC) reported by Mackenzie C.** The Recipient presented the fiscal report. The committee was satisfied with the numbers presented. **Integrated Strategies Committee (ISC) reported by Jane W.** The ISC discussed the vote needed to approve the Health Equity Paper and possible next steps. The ISC will continue to brainstorm in August and develop a work plan after the PSRA meeting. Lamont added that after PSRA, it is recommended that all committees review their plans for the new year and set committee goals in accordance with HRSA mandates.

	ISC is waiting to receive EHE updates from DC, Prince Georges County and Montgomery County. It is hoped that all will report on a quarterly basis.
Other Business	**Vote to Approve the Health Equity Paper** Lamont opened the vote to approve the Executive Summary and the full Health Equity Position Paper as presented. It was approved by majority vote. **Virginia Department of Health (VDH) updates reported by Ashley Y.** VDH will not accept any emails referencing or inquiring about client level data. If you need to communicate with VDH about such information, use your SSTP folder. Clients should call VDH to discuss their needs. VDH is holding the next in-person Qmac meeting on August 23, 2023, in Fredericksburg Virginia. VDH is exploring ways to provide services along the life span of people with HIV (i.e., aging with HIV, long-term (15-20 years+) survivors who may not fit the definition of aging with HIV, and perinatal transmittal). **Maryland Department of Health (MDH) updates reported by Peter D.** MDH participated in the Baltimore City Fast Track Initiative today, July 27, 2023. MDH is drawing attention to the pending bicillin shortage, which is used to treat syphilis, especially in pregnant women. The pharmaceutical companies will be totally out of stock until the second or third quarter of 2024. MDH is asking Maryland providers to use doxycycline for non-pregnant individuals and reserve the bicillin for pregnant women with syphilis. Peter put the link to the Maryland HIV Statistic website in the chat. Prior year data will be frozen on June 30th and new data products will be seen. MDH will submit the Appropriation Request for the next fiscal year in August. MDH is moving forward with the Integrated Plan which has been broken down into six (6) workgroups. 1. Inventory of organizations, 2. Inventory of web-based locators, 3. Needs assessments of needs assessments, 4. Community mobilization, 5. Related to data and 6. Data to action. **DC Health updates reported Clover B.** Clover B. announced Dr. Ayanna Bennett as the new Director for the Department of Health starting July 17, 2023. Dr. Bennett most recently served as Chief Health Equity Officer and Director of the San Francisco Department of Public Health's Office of Health Equity, where she focused on quality improvements and sustaining systemic change through policy improvement. Clover looks forward to sharing the Health Equity Paper with her now that it has been approved.

	Clover announced the placement of a staff member to the EHE Coordinator position. She asked the ISC to give the interim coordinator about a month to acclimate before expecting an updated EHE report. Clover announced budget cuts of approximately $700 million in Ryan White Funds are expected. Although she, nor the COHAH board can lobby, advocate, or protest the budget cuts, individuals and persons working with advocacy organizations can. She may, however, be able to provide information that will help in composing language about how the cuts will impact services in our region.
New Business	None noted.
Old Business	None noted.

ANNOUNCEMENTS/OTHER DISCUSSION

Lamont announced the launch of HAHSTA's Positive Voices Podcast Season 2. HAHSTA staff are looking for guests and a host. Lamont will get the flyer from Ashley Coleman or Malachi Stewart to send out via email.

Alan J. announced that the youth team is restarting their Youth Consumer Advisory Board (CAB). Alan will send information on how youth can sign up for the Youth CAB along with information on the podcast.

Ken Pettigrew announced in August, Health HIV will have a one (1) month Black Women's Initiative that will focus on amplifying the voices of Black women. If anyone has a startup or small group or knows of anyone or agency in DC that has a project serving women, please let him know.

Ken also talked about the Health Equity Paper and the opportunity to discuss what webinars would look like around health equity.

Jenné announced that sponsorship is needed for the host committee that's putting on the welcome reception at the USCHA Conference in September. If anyone is interested, please let her know. She will also put a link in the chat for volunteers.

Jenné also announced the happy news of her pregnancy. She anticipates having to take leave or possibly stepping down from the board to attend to her family. She will keep the board posted.

HANDOUTS

- Planning Commission (COHAH) Meeting Agenda July 27, 2023
- Meeting Minutes June 29, 2023
- Recipient Reports for May 2023

MEETING ADJOURNED	**6:51 pm**	**NEXT MEETING**	**THURSDAY, AUGUST 24, 2023 6:00pm to 8:00pm ZOOM CONFERENCE AND VIDEO CALL**

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Date: August 23, 2023

To: Comprehensive Planning Committee (CPC)

From: Ryan White HIV/AIDS Program (RWHAP) Recipient Staff

Re: Monthly Fiscal and Recipient Report (Part A and Part A MAI Funding)
Year 33 - Reporting Period: June 1 – 30, 2023

Part A and Part A MAI. The Ryan White HIV/AIDS Program (RWHAP) Part A Grant Year 32 includes two components: Part A and Part A Minority AIDS Initiative (MAI). These reports are designed to report distinctly on the associated program activities. **For GY 33 the recipient received the full award in the amount $32,652,189.00.**

Notes on Overview. The fiscal spreadsheets list the service categories by Part and jurisdiction and identifies the reported expenditure as a proportion of expected-to-date. The COHAH has requested an explanation of those service categories with a 30% variance from the target percentage.

FISCAL STATUS

For Part A and Part A MAI in June **2023**, of the twenty-six (**26**) providers, twenty-five (**25**) submitted payment request that were processed, and one (**1**) provider has not yet submitted May 2023 invoices.

SERVICE DELIVERY CHALLENGES

DC: No challenges.

MD: No challenges.

VA: No challenges.

PART A FISCAL SUMMARY

Part A expenditures are 33% and should be 33%. (Overall Expenditure rates by funding source for the reporting period)

Service areas affected by unprocessed invoices:

Early Intervention Services (EIS)
Psychosocial Support Services (PSS)

Medical Case Management (MCM)
Medical Transportation Services (MT)
Outreach Services (OS)
Psychosocial Support Services (PSS)

Services 30% below expected:

Early Intervention Services (EIS)
Health Insurance Premium and Cost Sharing Assistance (HIPCSA)

Services 30% above expected:

Mental Health Services (MHS)
Emergency Financial Assistance (EFA)
Other Professional Services (OPS)

PART A MAI FISCAL SUMMARY

Part A MAI expenditures are 24% and should be 33%. (Overall Expenditure rates by funding source for the reporting period)

Service areas affected by unprocessed invoices:

Early Intervention Services (EIS)
Psychosocial Support Services (PSS)
Mental Health Services (MHS)
Medical Case Management (MCM)
Substance Abuse Services - Outpatient (SASO)
Psychosocial Support Services (PSS)

Services 30% below expected:

Medical Case Management (MCM)
Psychosocial Support Services (PSS)
Substance Abuse Services – Outpatient (SASO)

Services 30% above expected:

N/A

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RECIPIENT REPORT

1. **FY23 Priority Setting and Resource Allocation (PSRA) Meeting:** The Recipient is prepared to present programmatic, fiscal, and service utilization data during the August PSRA meeting.
2. **Reprogramming Request:** The Recipient will make a reprogramming request to reduce the lapse rate of the Part A award for GY33 during the August CPC meeting.
3. **GY32 Final Carryover Request:** The Recipient is preparing to submit the final GY32 carryover request, which is due August 31, 2023.
4. **Regional Health Department Collaboration:** The Ryan White Programs from Washington, DC, Maryland and Virginia met in early August. On the agenda: shared providers/funding overlap; funding gaps; new partnerships; and site visits.

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GY'34/FY'24 (March 1, 2024 – February 28, 2025)
Ryan White Priority Setting and Resource Allocation (PSRA) Process Overview

Purpose
The PSRA process determines how the EMA's Ryan White Part A funds are allocated among the Ryan White service categories and is the Planning Commission's primary legislative responsibility.

Priorities should be reviewed annually, though decisions may be a continuation of existing services.

Priority Setting: Members use data to determine which Ryan White service categories to fund and rank those categories based on the service needs of people living with HIV (PLWH) in the EMA.

Resource Allocation: Members determine how much Ryan White Part A funding to allocate to each of the ranked service categories. Remember the PC must allocate at least 75% to core services. Waivers of this requirement can be applied for within a HRSA-specified timeframe.

Service Categories
There are 27 service categories defined by HRSA. The service categories are divided into "core services" (12) and "support services" (15). The Planning Commission (PC) may use a more limited definition of a service category than the one approved by HRSA, but not a more expansive one.

Data
PSRA is a data-driven process. Key data may include:

- Epidemiological data
- Expenditure and service delivery report and narrative
- Needs assessments
- Unduplicated client data
- Town hall meetings
- Resource Inventory (Funding Stream Analysis)
- Scorecards
- Clinical quality management and performance measures

Directives
The PC uses directives to provide guidance to the recipient on how to best meet the identified priorities. Directives may be developed and proposed by any PC committee and will be reviewed as a part of the PSRA process, as they may have funding implications.

Public Process
PSRA is an open, public process, in which community can and should contribute, though only PC members can vote on priorities and allocations. The process is open to grievance procedures and must be transparent and well-documented.

Minimizing Conflict of Interest
The PSRA process includes protections to minimize conflicts of interest among PC members, while not excluding conflicted members from the discussion and process those with needed service knowledge and expertise. Commissioners must sign a conflict of interest disclosure statement before beginning the PSRA process.

THE WASHINGTON, DC EMA'S PROCESS

Ground Rules
- All decisions will be made based on data, not personal experience.
- PC members must participate in priority setting in order to participate in resource allocation.
- PC members who do not participate in required data presentations may ***not*** vote.
- PC members who have an identified conflict of interest may ***not*** initiate or participate in a discussion about a service category in which they have a conflict of interest, but may answer objective questions or request explanations.
- The PC will use GY'33 Priorities and allocations as the starting points for GY'34 priorities and allocations.
- The PC will use percentages when allocating funds across categories.

Before PSRA
- The Comprehensive Planning Committee (CPC) will review and determine the PSRA process and timeline.
- CPC, in collaboration with the recipient and sub recipients, will make a formal request to the recipient for data.
- PC members will participate in mandatory PSRA trainings. This will include a review of service category definitions, including service requirements and allowable services; a review of the 75/25 requirement; a review on how to read and interpret data; and PSRA ground rules.
- The PC will review and approve the principles, criteria and decision-making process/voting procedures to be used for priority setting and resource allocation.
- PC members will identify all conflicts of interest.

During PSRA
- PC members will receive presentations on a variety of topics as a part of the PC general body meetings, trainings and other special meetings. Presentations will include information on how to set priorities and allocate funds; information about directives; data available for planning; how to read and interpret data; and information on the transition to unit-based cost reimbursement (UBC) and its impact on expenditures.
- PSRA Meetings and other town hall-style meetings held throughout the EMA will allow public stakeholders to provide input into the PSRA process, including their insights about services needs

and gaps.

- Throughout this time, PC members will spend time reviewing materials and thinking about what service categories they believe should be a priority based on data. Members should write down their thoughts so they are prepared during PSRA.
- Following a summary data presentation, the full PC will set EMA-wide priorities and determine the amount of any regional allocations (funds used for EMA-wide initiatives). Different data sources may be weighed differently, recognizing the number and diversity of PLWH represented. The PC will plan based on decisions that will have the most impact on PLWH in the DC EMA.
- Each jurisdiction will have a meeting with a data presentation to set their jurisdictional priorities and allocations. PC members will participate and vote in their respective jurisdictions. No others may vote in the jurisdictional processes.
- The PC will vote on a roll-up of the EMA-wide resource allocation.
- The PC will review and approve all proposed directives.

Conclusion

The Health Resources and Services Administration (HRSA) changed from an every year application process to a every three year process During the past few years, the DC EMA PSRA process has been a 'review and adjustment' exercise which we have been calling "PSRA lite". In fall 2024 our EMA will have to submit an application for funds to HRSA, therefore we should expect a fuller, more robust, PSRA process in the summer/fall of 2024.

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HIV Surveillance in the DC EMA

DC Health

HIV/AIDS, Hepatitis, STD, and TB Administration

August 24, 2023

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Washington, DC Eligible Metropolitan Area (EMA) Ryan White Part A & Part A MAI Expenditure Data

Grant Year 33 PSRA Presentation

Jason Edmonds | August 2023

AGENDA

- Ryan White PART A & MAI GY30 Expenditures
- Ryan White PART A & MAI GY31 Expenditures
- Ryan White PART A & MAI GY32 Expenditures
- Summary
- Q & A

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Ryan White GY30 PART A & MAI Services Expenditures

Total Service Expenditures: $24,902,014

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GY30 Part A Core Services Expenditures

Service Category	Budget Allocation	Total GY30 Expenditures	% of Allocation
Early Intervention Services	$6,954,464	$5,700,040	82%
Health Insurance Premium & Cost Sharing Assistance	$126,854	$114,118	90%
Home and Community-Based Health Services	$285,103	$317,261	111%
Medical Case Management	$2,406,958	$2,005,211	83%
Medical Nutrition Therapy	$192,367	$161,688	84%
Mental Health Services	$217,453	$218,620	101%
Oral Health Care	$688,907	$156,835	23%
Outpatient/Ambulatory Health Services	$2,282,360	$2,228,409	98%
Substance Abuse Outpatient Care	$87,002	$252,713	290%
CORE SERVICES TOTAL	**$13,241,468**	**$11,154,895**	**84%**

GY30 Part A Support Services Expenditures

Service Category	Budget Allocation	Total GY30 Expenditures	% of Allocation
Emergency Financial Assistance	$2,189,991	$1,990,971	91%
Food Bank/Home Delivered Meals	$3,662,714	$3,756,762	103%
Housing	$706,134	$57,804	8%
Linguistics Services	$54,229	$45,627	84%
Medical Transportation	$109,763	$91,732	84%
Non-Medical Case Management Services	$3,412,267	$3,703,253	109%
Other Professional Services	$109,368	$102,522	94%
Outreach Services	$787,697	$1,118,789	142%
Psychosocial Support Services	$435,206	$384,321	88%
SUPPORT SERVICES TOTAL	**$11,467,369**	**$11,251,781**	**98%**

GY30 Part A MAI Core Services Expenditures

Service Category	Budget Allocation	Total GY30 Expenditures	% of Allocation
Outpatient/Ambulatory Health Care	$665,903	$602,374	90%
Early Intervention Services	$587,086	$566,591	96%
Mental Health Services	$284,653	$256,957	90%
Medical Case Management	$435,648	$494,037	113%
Substance Abuse Services – Outpatient	$140,436	$124,954	89%
MAI CORE SERVICES TOTAL	**$2,113,726**	**$2,044,913**	**97%**

GY30 Part A MAI Support Services Expenditures

Part A MAI Service Category	Budget Allocation	GY 30 Expenditures	% of Allocation
Psychosocial Support Services	$534,902	$450,425	84%
PART A MAI SUPPORT SERVICES TOTAL EXPENDITURES	**$534,902**	**$450,425**	**84%**

Ryan White GY31 PART A & MAI Services Expenditures

Total Service Expenditures: $24,509,630

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GY31 Part A Core Services Expenditures

Part A Service Category	Budget Allocation	GY 31 Expenditures	% of Total Expenditures
Early Intervention Services	$6,737,449	$6,287,783	93%
Health Insurance Premium & Cost Sharing Assistance	$153,021	$130,489	85%
Home and Community-Based Health Services	$285,000	$233,560	82%
Medical Case Management	$2,321,445	$2,072,330	89%
Medical Nutrition Therapy	$193,504	$161,525	83%
Mental Health Services	$188,029	$185,075	98%
Oral Health Care	$540,000	$988,526	183%
Outpatient/Ambulatory Health Services	$2,915,857	$2,264,308	78%
Substance Abuse Outpatient Care	$87,686	$10,171	12%
CORE SERVICES TOTAL	**$13,421,991**	**$12,333,767**	**92%**

GY31 Part A Support Services Expenditures

Part A Service Category	Budget Allocation	GY 31 Expenditures	% of Allocation
Emergency Financial Assistance	$2,179,400	$2,279,173	105%
Food Bank/Home Delivered Meals	$3,262,286	$2,865,921	88%
Housing	$60,000	$42,860	71%
Linguistics Services	$53,177	$52,220	98%
Medical Transportation	$108,500	$100,443	93%
Non-Medical Case Management Services	$3,733,813	$3,150,340	84%
Other Professional Services	$109,368	$108,152	99%
Outreach Services	$788,881	$862,846	109%
Psychosocial Support Services	$435,000	$411,304	95%
SUPPORT SERVICES TOTAL	**$10,730,425**	**$9,873,256**	**92%**

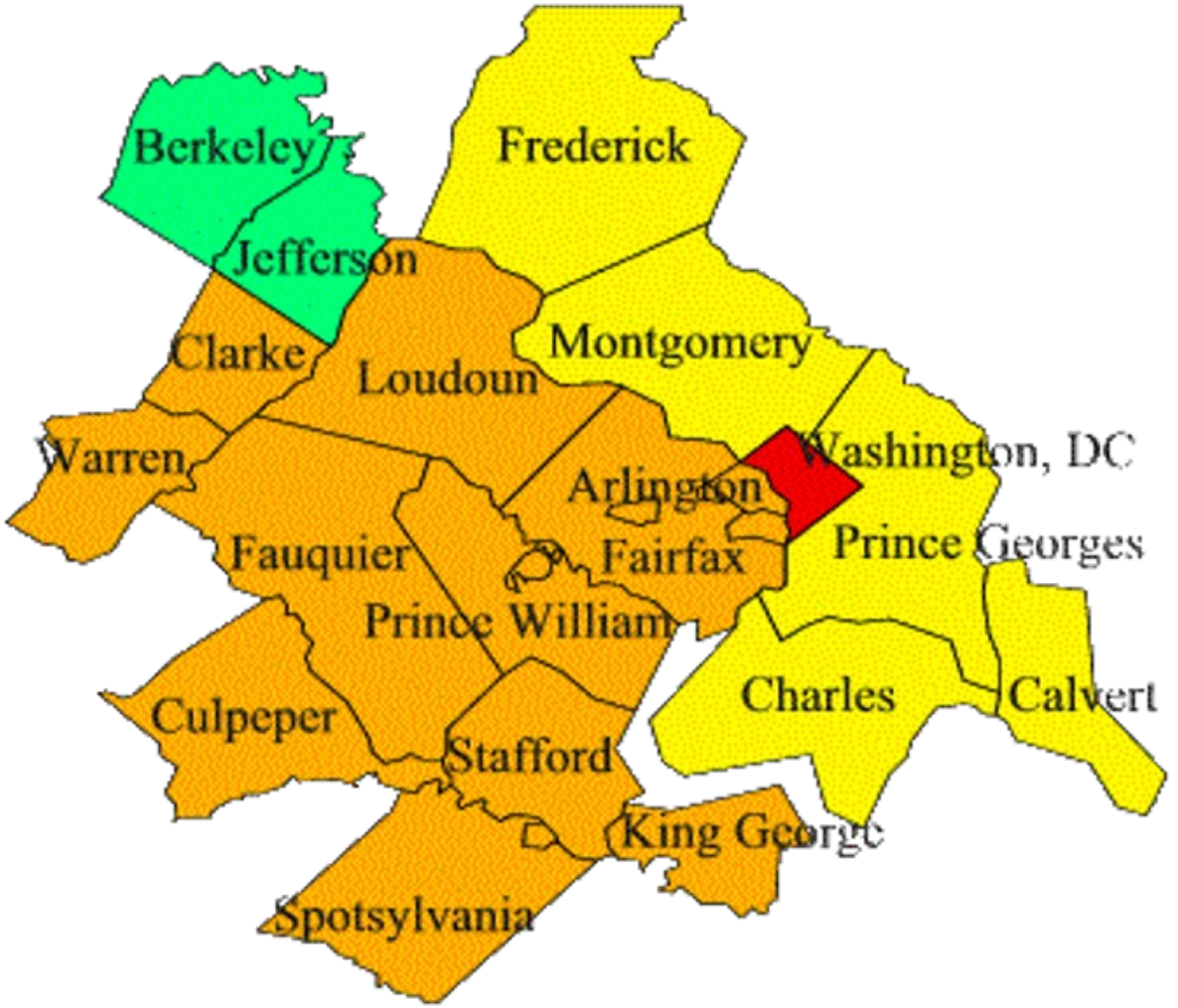
GY31 Part A MAI Core Services Expenditures

Part A MAI Service Category	Budget Allocation	GY 31 Expenditures	% of Allocation
Outpatient/Ambulatory Health Care	$655,787	$550,589	84%
Early Intervention Services	$591,189	$512,647	87%
Mental Health Services	$265,131	$227,126	86%
Medical Case Management	$488,029	$467,970	96%
Substance Abuse Services – Outpatient	$124,228	$96,331	78%
MAI CORE SERVICES TOTAL	**$2,124,364**	**$1,854,663**	**87%**

GY31 Part A MAI Support Services Expenditures

Part A MAI Service Category	Budget Allocation	GY 31 Expenditures	% of Allocation
Psychosocial Support Services	$480,818	$447,944	93%
PART A MAI SUPPORT SERVICES TOTAL EXPENDITURES	**$480,818**	**$447,944**	**93%**

Total RYAN WHITE PART A & PART A MAI Grant Year 32 Expenditures: $29,033,456



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Ryan White PART A GY 32 Core Services Expenditures

Total Core Service Expenditures: $13,844,920

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GY32 Part A Core Services Expenditures

Service Category	Initial Budget Allocation	Reprogrammed Budget Allocation	DC Expenditures	Maryland Expenditures	Northern VA Expenditures	West VA Expenditures	Total GY32 Expenditures	% of Reprogrammed Allocation
Early Intervention Services	$8,301,718	$4,934,636	$3,393,125	$57,937	$141,807		$4,026,453	83%
Health Insurance Premium & Cost Sharing Assistance	$74,102	$99,803	$9,051	$19,071		$69,113	$97,235	97%
Home and Community-Based Health Services	$258,668	$165,379	$157,408				$157,408	95%
Medical Case Management	$2,425,109	$4,268,375	$2,046,977	$798,831	$225,626	$121,934	$3,193,368	77%
Medical Nutrition Therapy	$290,510	$299,435	$261,694	$32,791		$3,253	$297,738	99%
Mental Health Services	$524,995	$551,023	$536,300		$24,564		$560,864	102%
Oral Health Care	$1,049,990	$1,376,669	$1,032,771	$372,027	$21,401		$1,426,199	104%
Outpatient/Ambulatory Health Services	$1,574,985	$3,842,171	$3,162,907	$509,400	$79,566		$3,751,873	106%
Substance Abuse Outpatient Care	$174,998	$356,071	$304,231		$29,551		$333,782	94%
CORE SERVICES TOTAL	**$14,675,074**	**$15,893,562**	**$11,338,048**	**$1,790,057**	**$522,515**	**$194,300**	**$13,844,920**	**90%**

Core Services Underspending Assessment

- $3,367,082, or 40%, was reprogrammed from Early Intervention Services because there was not enough demand for funding/applications.
- $93,289, or 36%, was reprogrammed from Home and Community Based Health Services because there was not enough demand for funding/applications.

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Ryan White PART A GY 32 Support Services Expenditures

Total Support Service Expenditures: $10,338,000

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GY32 Part A Support Services Expenditures

Service Category	Initial Budget Allocation	Reprogrammed Budget Allocation	DC Expenditures	Maryland Expenditures	Northern VA Expenditures	West VA Expenditures	Total GY32 Expenditures	% of Reprogrammed Allocation
Emergency Financial Assistance	$1,077,127	$1,975,110	$2,278,950			$150,915	$2,429,865	123%
Food Bank/Home Delivered Meals	$2,799,973	$2,405,085	$1,611,468				$1,611,468	67%
Medical Transportation	$298,765	$265,413	$181,564	$38,905	$7,686	$43,200	$271,355	102%
Non-Medical Case Management Services	$2,449,977	$3,235,734	$2,249,384	$482,231	$167,617		$2,899,232	90%
Other Professional Services	$690,305	$74,380	$110,900				$110,900	149%
Outreach Services	$779,738	$251,168	$638,458	$140,716		$10,087	$789,261	314%
Psychosocial Support Services	$880,571	$1,848,274	$2,035,687	$89,641	$82,676	$17,915	$2,225,919	120%
SUPPORT SERVICES TOTAL	**$10,687,002**	**$10,055,164**	**$8,642,807**	**$751,492**	**$257,979**	**$222,117**	**$10,338,000**	**103%**

Support Services Underspending Assessment

- $528,570, or 68%, was reprogrammed from Outreach Services because there was not enough demand for funding/applications and the service a component of EIS.

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Ryan White PART A GY 32 MAI Core Services Expenditures

Total PART A MAI Core Service Expenditures: $1,845,585

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GY32 Part A MAI Core Services Expenditures

Service Category	Initial Budget Allocation	Reprogrammed Budget Allocation	DC Expenditures	Maryland Expenditures	Northern VA Expenditures	Total GY32 Expenditures	% of Reprogrammed Allocation
Outpatient/Ambulatory Heath Care	$608,935	$608,935	$464,756	$26,269	$44,447	$535,472	88%
Early Intervention Services	$450,138	$450,138	$309,881	$49,387	$59,306	$418,573	93%
Mental Health Services	$359,728	$359,728	$230,097	$23,019	$10,357	$263,473	73%
Medical Case Management	$552,710	$552,710	$417,844	$16,379	$27,539	$461,762	84%
Substance Abuse Services - Outpatient	$182,102	$182,102	$144,420	$18,857	$3,028	$166,305	91%
MAI CORE SERVICES TOTAL	**$2,153,613**	**$2,153,613**	**$1,566,998**	**$133,911**	**$144,677**	**$1,845,585**	**86%**

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Ryan White PART A MAI GY 32 Support Services Expenditures

Total PART A MAI Support Service Expenditures: $433,604

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GY32 Part A MAI Support Services Expenditures

Service Category	Initial Budget Allocation	Reprogrammed Budget Allocation	DC Expenditures	Maryland Expenditures	Northern VA Expenditures	Total GY32 Expenditures	% of Reprogrammed Allocation
Psychosocial Support Services	$342,154	$342,154	$316,051	$25,848	$91,705	$433,604	127%
MAI SUPPORT SERVICES TOTAL	**$342,154**	**$342,154**	**$316,051**	**$25,848**	**$91,705**	**$433,604**	**127%**

In Summary

- Insufficient initial allocations, an increase in demand for services (as seen in EFA), and increased cost of services were factors that contributed to the over expenditures illustrated in this presentation.
- Decreased utilization, staff vacancies, an over-estimation of service costs, and late distribution of the FFV value enhancement funds contributed to the under expenditures illustrated in this presentation.
- In the final quarter of the grant year, we were able to reprogram funds from under-utilized service categories into over-utilized service categories.
- Overall, we spent 87% of the total Part A award for GY32.

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Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

EMA WIDE & JURISDICTION SERVICES

GY 33 /FY'23 SERVICE PRIORITIES

KEY:

CORE SERVICE
SUPPORT SERVICE
NOT FUNDED IN GY32/FY22

SERVICE CATEGORY	EMA	DC	MD	VA
Outpatient/Ambulatory Health Services (OAHS)	1	1	2	1
Medical Case Management (MCM)	2	2	1	2
Oral Health Care (OH)	4	5	3	3
Mental Health Services (MH)	3	3	4	4
AIDS Pharmaceutical Assistance – Local (LPAP)	10	10	12	6
Substance Abuse Outpatient Care (SAO)	9	8	11	7
Health Insurance Premium & Cost Sharing Assistance	6	7	8	7
Non-Medical Case Management (NMCM)	5	4	7	5
Early Intervention Services (EIS)	7	9	5	10
Emergency Financial Assistance (EFA)	7	6	10	11
Medical Transportation	12	13	9	9
Food Bank/Home Delivered Meals	13	11	15	13
Housing Services	11	12	6	12
Medical Nutrition Therapy (MNT)	15	15	14	14
Psychosocial Support Services	14	14	13	15
Home & Community Based Health Services	19	19	19	16
Substance Abuse Services – Residential (SAR)	17	17	18	19
Linguistics Services	20	19	20	18
Health Education/Risk Reduction (HE/RR)	16	16	17	17
Home Health Care (HHC)	21	22	22	22
Outreach Services	18	18	16	20
Child Care Services	23	21	23	25
Referral for Health Care/Supportive Services	21	23	21	21
Hospice Services	26	27	24	27
Rehabilitation Services	24	25	24	24
Respite Care	26	26	27	26
Other Professional Services	24	24	26	24

COHAH PSRA - GY33/FY'23 - ALLOCATIONS WORKBOOK (As of

	APPROVED GY'33	APPROVED GY'33	APPROVED GY'33	APPROVED GY'33
SERVICE CATEGORY	**REGIONAL SERVICES**	**DC/WV**	**MD**	**VA**
Outpatient/Ambulatory Health Services (OAHS)	6.00%			
Oral Health Care (OHC)	4.00%			
Medical Case Management (MCM)		10.50%	47.00%	52.00%
Mental Health Services (MHS)	2.00%			
Substance Abuse Outpatient Care (SAO)	1.00%			
Medical Nutrition Therapy (MNT)		4.00%	5.50%	
Early Intervention Services (EIS)	30.00%	14.00%	10.00%	
Health Insurance Prem.& Cost-Sharing Assta (HIPCA)		0.25%	2.50%	0.00%
Home & Community-Based Health Services		7.00%		
Subtotal, CORE SERVICES	*43.00%*	*35.75%*	*65.00%*	*52.00%*
B. Support Services				
Emergency Financial Assistance (EFA)		18.00%	8.00%	13.00%
Medical Transportation		3.00%	3.00%	7.00%
Food Bank/Home Delivered Meals	11.00%			
Non-Medical Case Management Svcs (NMCMS)	10.00%			
Housing Services	5.00%			
Outreach Services		10.25%	10.00%	9.00%
Linguistic Services		5.00%		8.00%
Psychosocial Support Services		14.00%	14.00%	
Health Education/Risk Reduction (HE/RR)				
Other Professional Services		14.00%		11.00%
Subtotal, SUPPORT SERVICES	*26.00%*	*64.25%*	*35.00%*	*48.00%*
TOTAL	**69.00%**	**100.00%**	**100.00%**	**100.00%**

Number of People Diagnosed and Living with HIV (Prevalence)		
Jurisdiction	**# of PLWH**	**% of PLWH**
Washington, DC	17,217	46.17%
West Virginia	265	0.71%
Suburban Maryland	12,273	32.91%
Northern Virginia	7,539	20.22%
Total	**37,294**	**100.00%**

Jurisdiction	**% of service dollars**
DC + West Virginia*	46.88%
Suburban Maryland	32.91%
Northern Virginia	20.22%
Total	**100.00%**

Number of People Diagnosed and Living with HIV (Prevalence) [as of 12/31/2018]		
Jurisdiction	**# of PLWH**	**% of PLWH**
Washington, DC	17,830	46.42%
West Virginia	265	0.69%
Suburban Maryland	12,558	32.69%
Northern Virginia	7,761	20.20%
Total	**38,414**	**100.00%**

Jurisdiction	**% of service dollars**
DC + West Virginia*	47.11%
Suburban Maryland	32.69%
Northern Virginia	20.20%
Total	**100.00%**

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

GY'34/FY'24 (March 1, 2024 – February 28, 2025)
Ryan White Priority Setting and Resource Allocation (PSRA) Process Overview

Purpose
The PSRA process determines how the EMA's Ryan White Part A funds are allocated among the Ryan White service categories and is the Planning Commission's primary legislative responsibility.

Priorities should be reviewed annually, though decisions may be a continuation of existing services.

Priority Setting: Members use data to determine which Ryan White service categories to fund and rank those categories based on the service needs of people living with HIV (PLWH) in the EMA.

Resource Allocation: Members determine how much Ryan White Part A funding to allocate to each of the ranked service categories. Remember the PC must allocate at least 75% to core services. Waivers of this requirement can be applied for within a HRSA-specified timeframe.

Service Categories
There are 27 service categories defined by HRSA. The service categories are divided into "core services" (12) and "support services" (15). The Planning Commission (PC) may use a more limited definition of a service category than the one approved by HRSA, but not a more expansive one.

Data
PSRA is a data-driven process. Key data may include:

- Epidemiological data
- Expenditure and service delivery report and narrative
- Needs assessments
- Unduplicated client data
- Town hall meetings
- Resource Inventory (Funding Stream Analysis)
- Scorecards
- Clinical quality management and performance measures

Directives
The PC uses directives to provide guidance to the recipient on how to best meet the identified priorities. Directives may be developed and proposed by any PC committee and will be reviewed as a part of the PSRA process, as they may have funding implications.

Public Process
PSRA is an open, public process, in which community can and should contribute, though only PC members can vote on priorities and allocations. The process is open to grievance procedures and must be transparent and well-documented.

Minimizing Conflict of Interest
The PSRA process includes protections to minimize conflicts of interest among PC members, while not excluding conflicted members from the discussion and process those with needed service knowledge and expertise. Commissioners must sign a conflict of interest disclosure statement before beginning the PSRA process.

THE WASHINGTON, DC EMA'S PROCESS

Ground Rules
- All decisions will be made based on data, not personal experience.
- PC members must participate in priority setting in order to participate in resource allocation.
- PC members who do not participate in required data presentations may ***not*** vote.
- PC members who have an identified conflict of interest may ***not*** initiate or participate in a discussion about a service category in which they have a conflict of interest, but may answer objective questions or request explanations.
- The PC will use GY'33 Priorities and allocations as the starting points for GY'34 priorities and allocations.
- The PC will use percentages when allocating funds across categories.

Before PSRA
- The Comprehensive Planning Committee (CPC) will review and determine the PSRA process and timeline.
- CPC, in collaboration with the recipient and sub recipients, will make a formal request to the recipient for data.
- PC members will participate in mandatory PSRA trainings. This will include a review of service category definitions, including service requirements and allowable services; a review of the 75/25 requirement; a review on how to read and interpret data; and PSRA ground rules.
- The PC will review and approve the principles, criteria and decision-making process/voting procedures to be used for priority setting and resource allocation.
- PC members will identify all conflicts of interest.

During PSRA
- PC members will receive presentations on a variety of topics as a part of the PC general body meetings, trainings and other special meetings. Presentations will include information on how to set priorities and allocate funds; information about directives; data available for planning; how to read and interpret data; and information on the transition to unit-based cost reimbursement (UBC) and its impact on expenditures.
- PSRA Meetings and other town hall-style meetings held throughout the EMA will allow public stakeholders to provide input into the PSRA process, including their insights about services needs

and gaps.

- Throughout this time, PC members will spend time reviewing materials and thinking about what service categories they believe should be a priority based on data. Members should write down their thoughts so they are prepared during PSRA.
- Following a summary data presentation, the full PC will set EMA-wide priorities and determine the amount of any regional allocations (funds used for EMA-wide initiatives). Different data sources may be weighed differently, recognizing the number and diversity of PLWH represented. The PC will plan based on decisions that will have the most impact on PLWH in the DC EMA.
- Each jurisdiction will have a meeting with a data presentation to set their jurisdictional priorities and allocations. PC members will participate and vote in their respective jurisdictions. No others may vote in the jurisdictional processes.
- The PC will vote on a roll-up of the EMA-wide resource allocation.
- The PC will review and approve all proposed directives.

Conclusion

The Health Resources and Services Administration (HRSA) changed from an every year application process to a every three year process During the past few years, the DC EMA PSRA process has been a 'review and adjustment' exercise which we have been calling "PSRA lite". In fall 2024 our EMA will have to submit an application for funds to HRSA, therefore we should expect a fuller, more robust, PSRA process in the summer/fall of 2024.

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Grant Year 33 Ryan White Part A Minority AIDS Initiative (MAI) Youth Reach Program

Avemaria Smith, M.Ed.

August 24, 2023

MAI Overview

- COHAH directive since GY27/FY17

- A targeted initiative created to provide a comprehensive set of core and support services to Youth of Color, ages 13 to 30 and within these sub populations:
  - *African American/Hispanic/Latino MSM*
  - *African American Heterosexual Men*
  - *African American/Hispanic/Latino Transgender Women*
  - *African American Women*

MAI Program Goals

MAI Youth Reach supports a subset of services for persons living with HIV and persons affected by HIV that aims to:

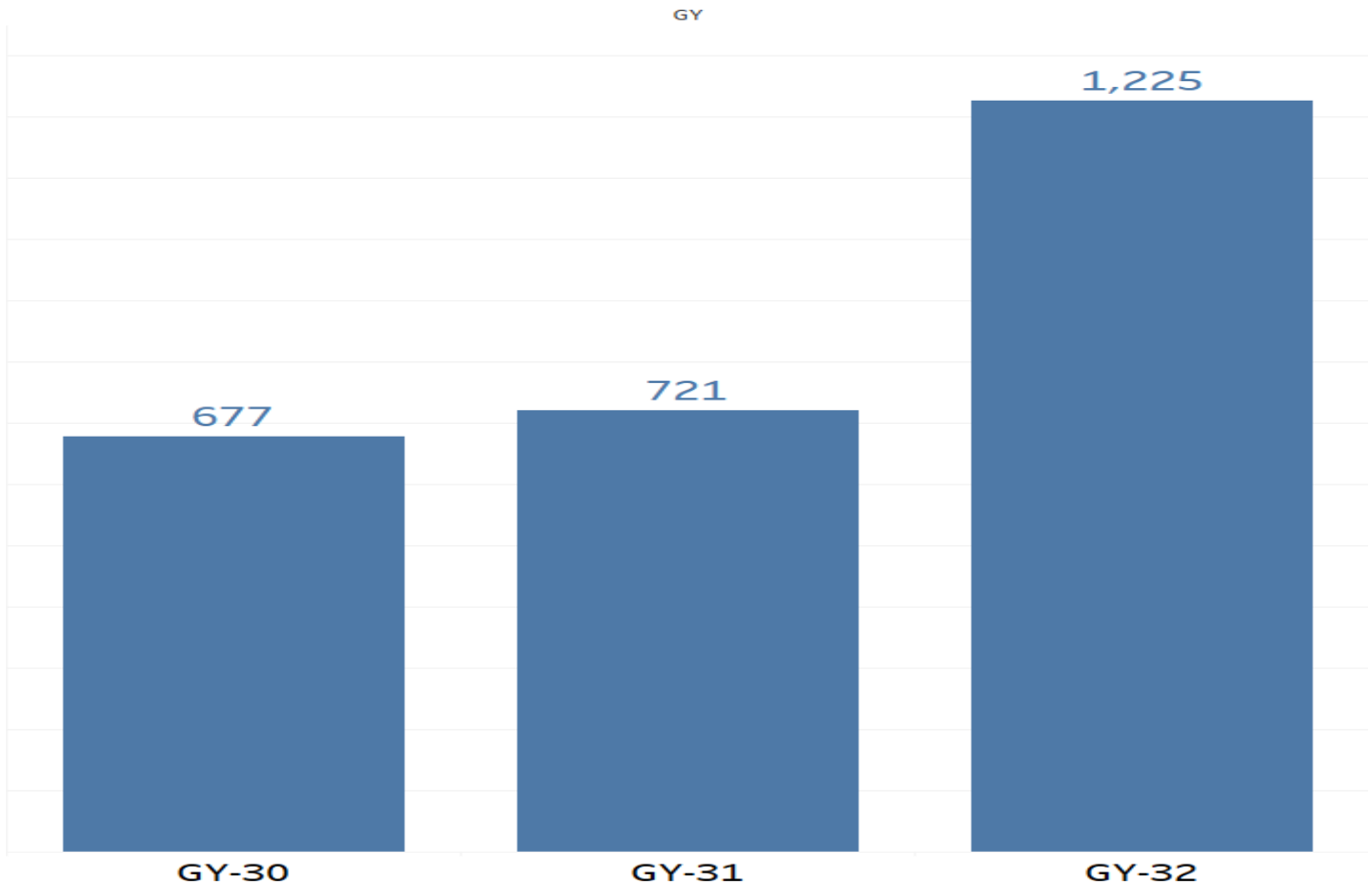
- Reduce health disparities in HIV-related health outcomes
- Increase timely access to HIV-related care and treatment
- Increase engagement and retention in HIV care
- Increase viral suppression among persons living with HIV

MAI Required Service Categories

- Outpatient/Ambulatory Health Services (on-site or approved partnership)
- Medical Case Management (on-site)
- Mental Health (on-site)
- Substance Abuse Outpatient Care (on-site or approved partnership)
- Early Intervention Services (on-site)
- Psychosocial Support Services (on-site)

MAI Youth Reach GY30-GY32

MAI Youth Reach Unique Customers Served GY30-GY32



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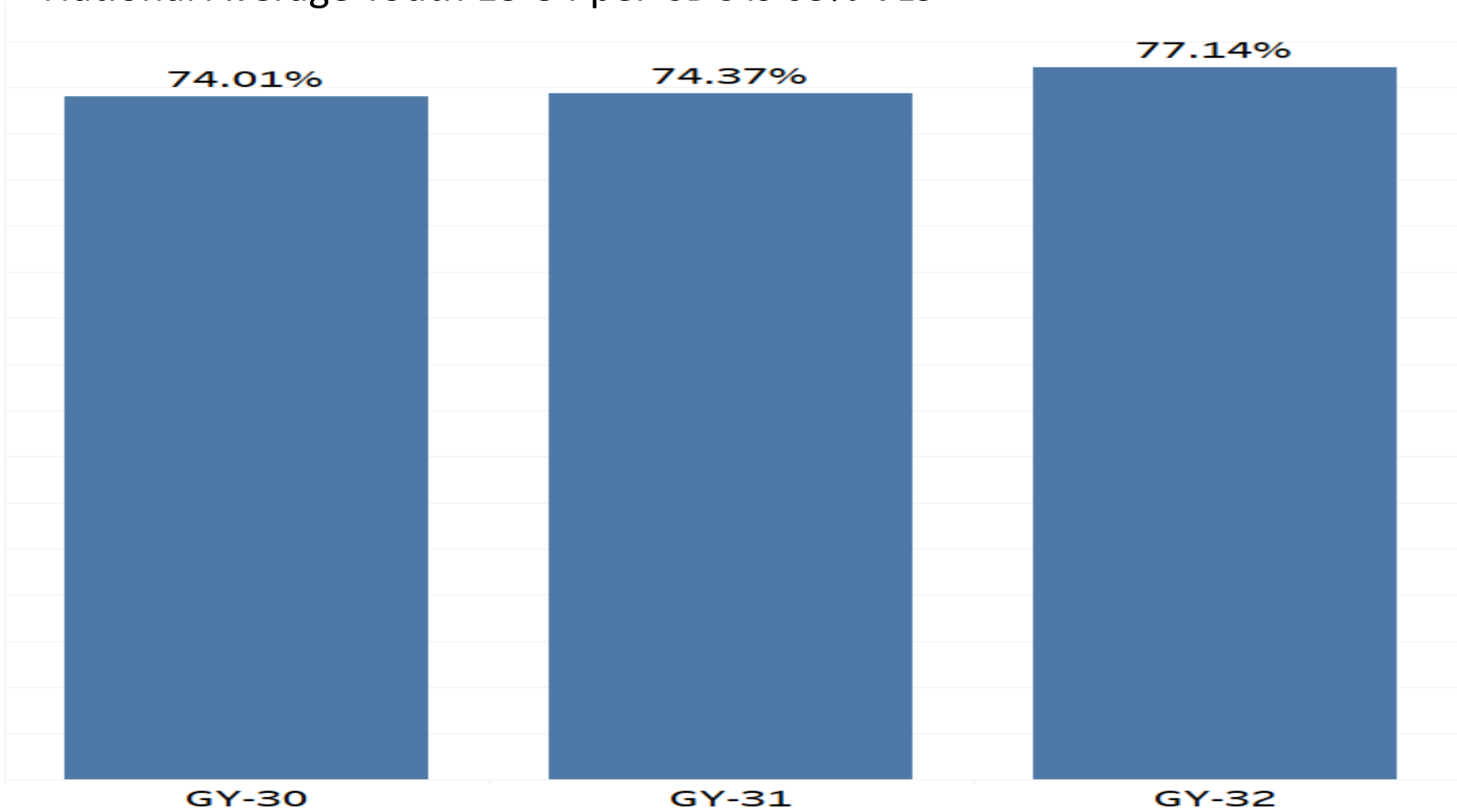
MAI Youth Reach Overall VLS GY30-32

*National Average Youth 13-34 per CDC is 63% VLS



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GY33 MAI Awards by Service Category

Service Category	MAI Direct Service Amounts
Outpatient/Ambulatory Health Services	$ 510,586
Medical Case Management	$ 321,964
Mental Health	$ 261,443
Substance Abuse Outpatient	$162,573
Early Intervention Services	$ 409,217
Psychosocial Support Services	$311,048
Total	$1,976,831

*Five providers in the Washington DC EMA are funded for MAI- Youth Reach.

GY33 MAI Unobligated Amounts by Service Category

Service Category	MAI Direct Service Amounts
Outpatient/Ambulatory Health Services	$ 255,676
Medical Case Management	$ 175,000
Psychosocial Support Services	$ 125,500
Total	$ 556,176

MAI Youth Reach

- Does the COHAH want to continue with the current directive?
- Based on our recent MAI sub-recipient program meeting, providers have suggested adding NMCM and MT and removing SAOC.
  - Based on level funding, adding two additional service categories will not impact service provision in the other service categories.

Questions?
Discussion

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Washington DC Eligible Metropolitan Area Priority Setting and Resource Allocation (PSRA) CY-2022 Customer Utilization and Outcome Data

HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

Jose Delao Hernandez | August 24th, 2023

Outline

- Introduction
- Customer's Demographic Characteristics
  - EMA
  - DC
  - MD
  - VA
  - WVA
- RW service utilization
- Outcome Data: Continuum of Care

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Part 1. Introduction

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Sources of Data and Methodology

- Source of Data: CAREWare
- Data: Part A service funding data
- Reporting Period: CY 2022 (January 1-December 31, 2022)
- Pre-processing, Analysis and Visualization: Excel, & Tableau

Purpose of the Report

- The purpose of this presentation is to provide data to guide the identification of service priorities and determine allocation of Ryan White (RW) resources for the Eligible Metropolitan Area (EMA).

Part 2

Characteristics of Customers Using RW Services

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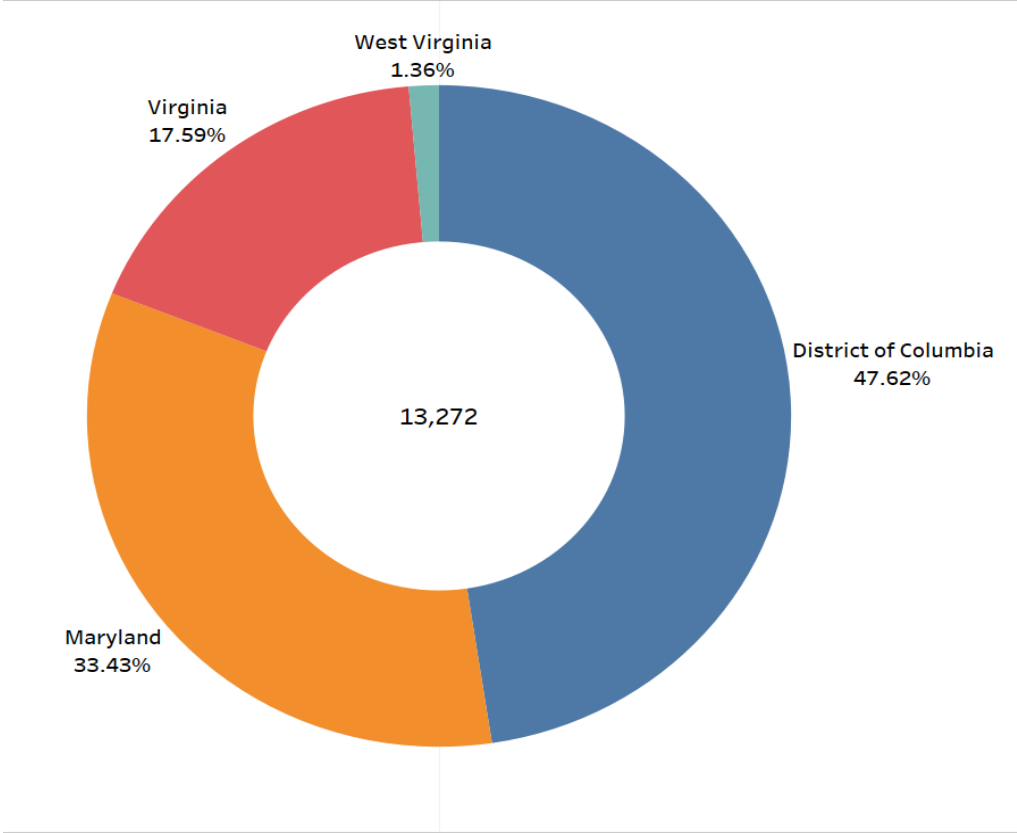
Characteristics of Customers Using RW Services in EMA

CUSTOMERS UTILIZING RYAN WHITE SERVICES IN 2022

- Total number of RW customers in EMA is 13,272 clients
- It has shown a 9.0 % increase in the total number of EMA RW Customers from the 2021 Report



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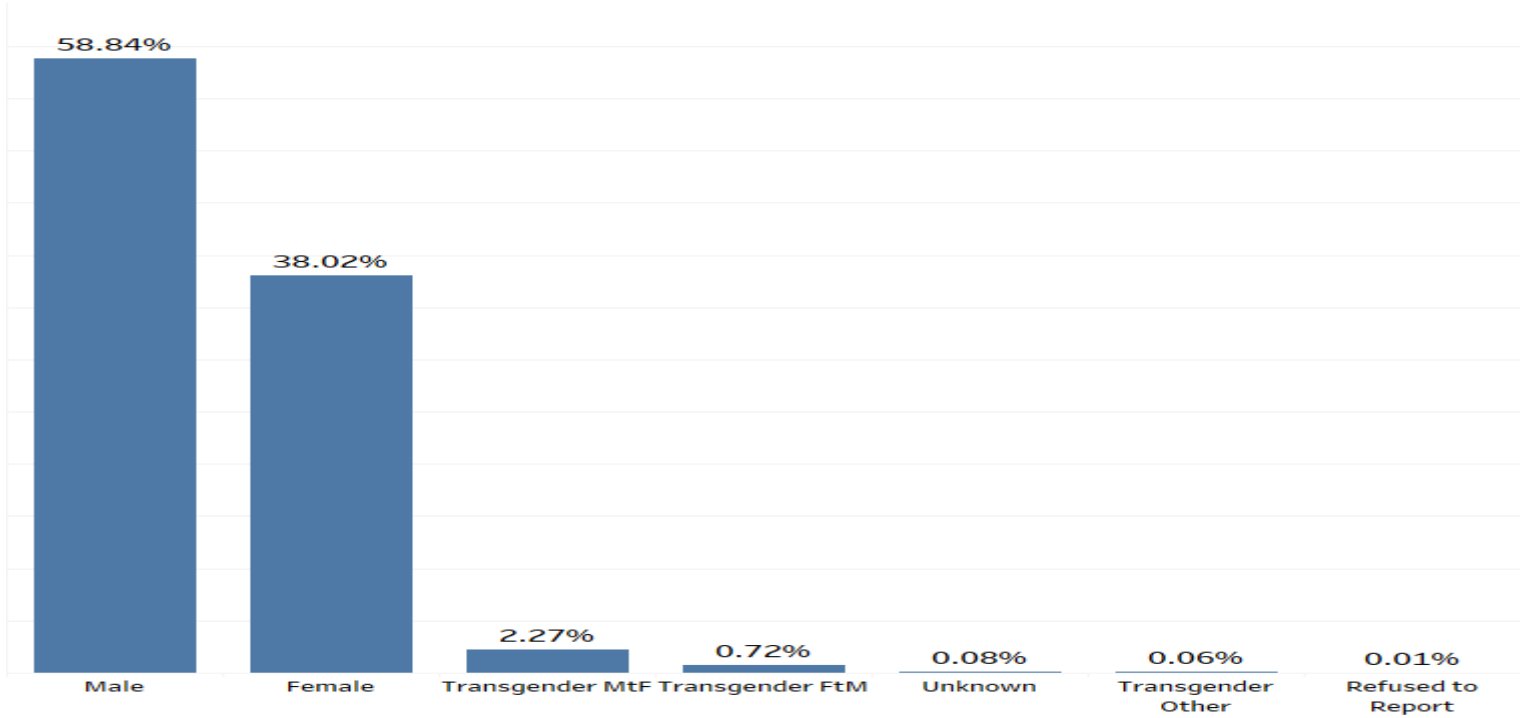
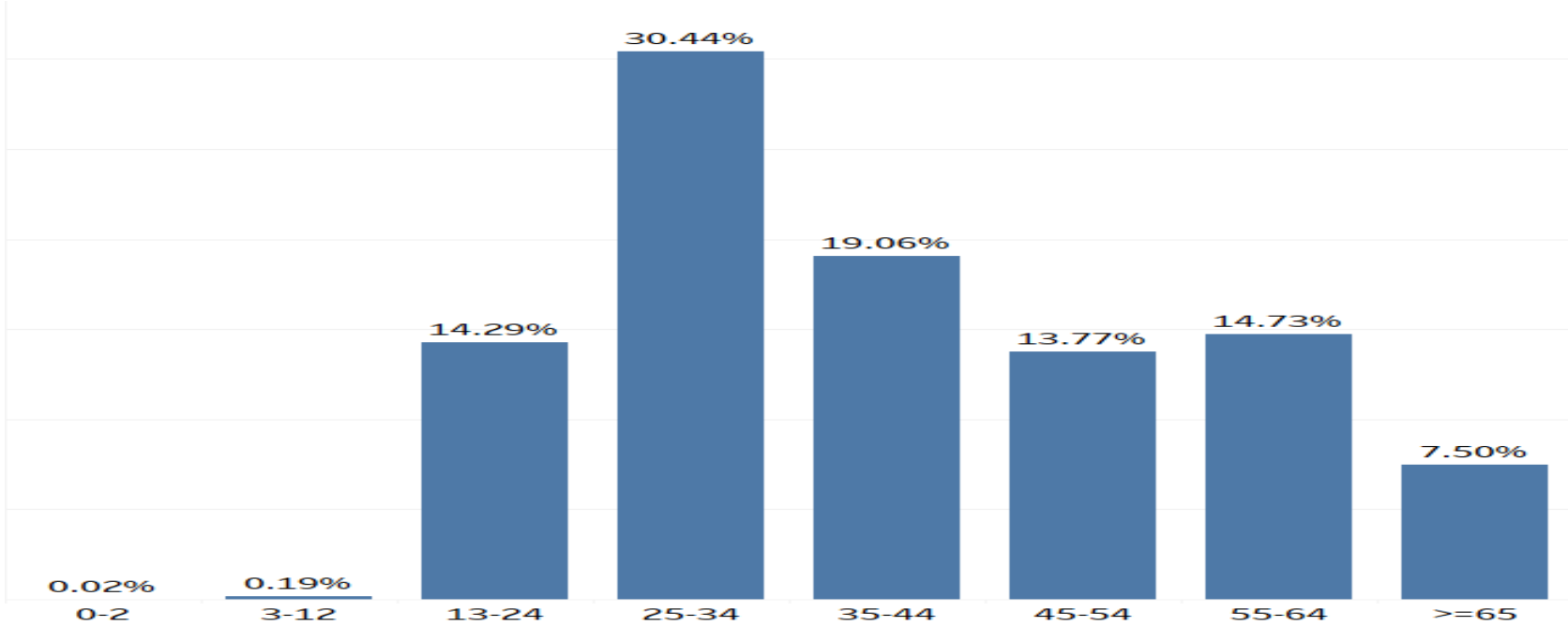
RW Customers Served in 2022 by Gender (N= 13,272)

- 38% of the EMA RW customers identify as Female, indicating a 2.2% increase from the 2021 report.



RW Customers Served in 2022 by Age Groups (N= 13,272)

- 30% of the RW EMA customers were in the 25-34 age range.
- 36% were 45 years old or older.



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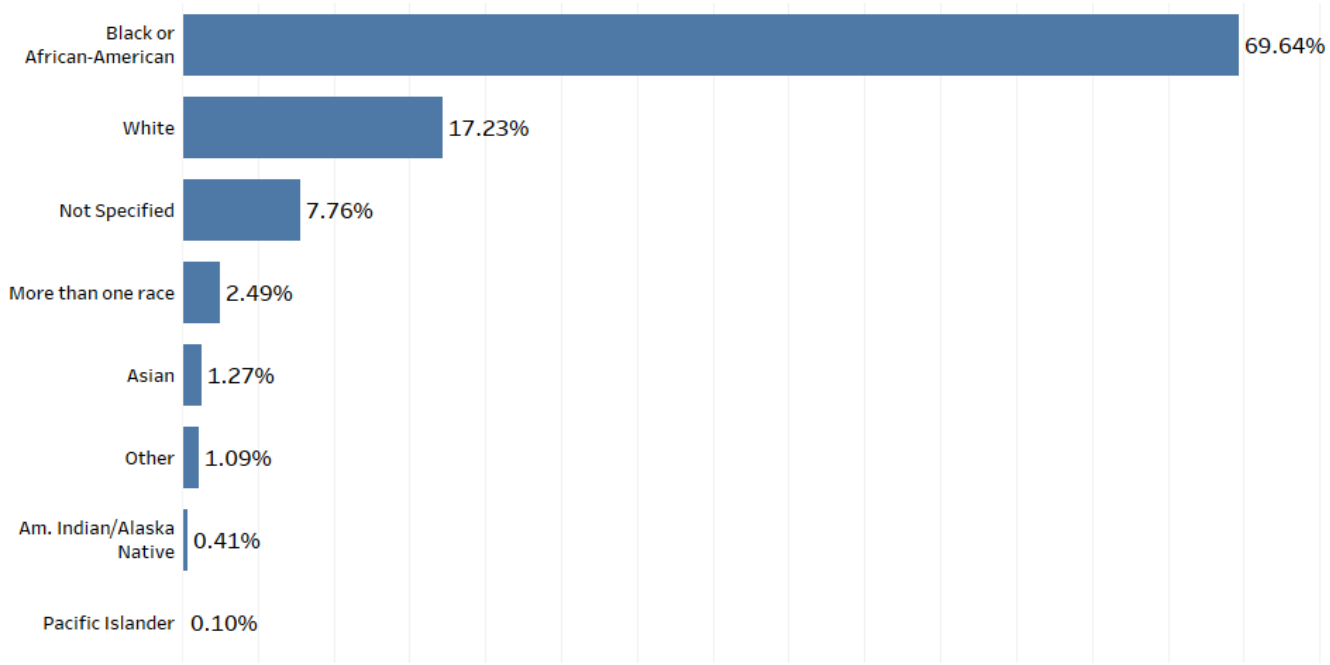
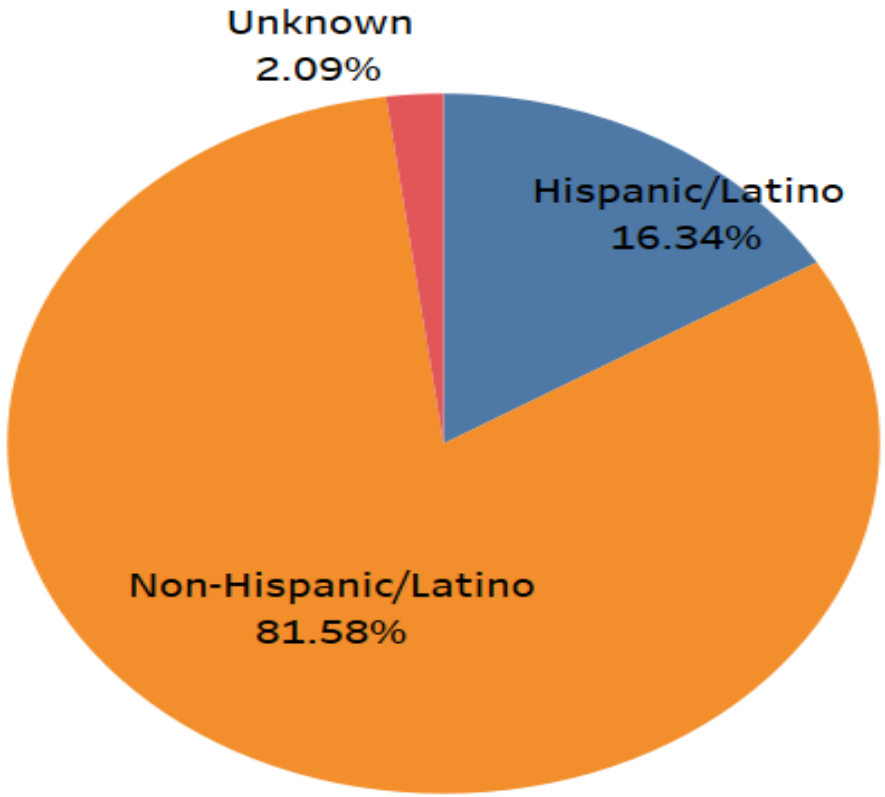
RW Customers Served in 2022 by Race (N= 13,272)

- 70% of the RW EMA customers are African American; indicating a 1.6% decrease from 2021 data



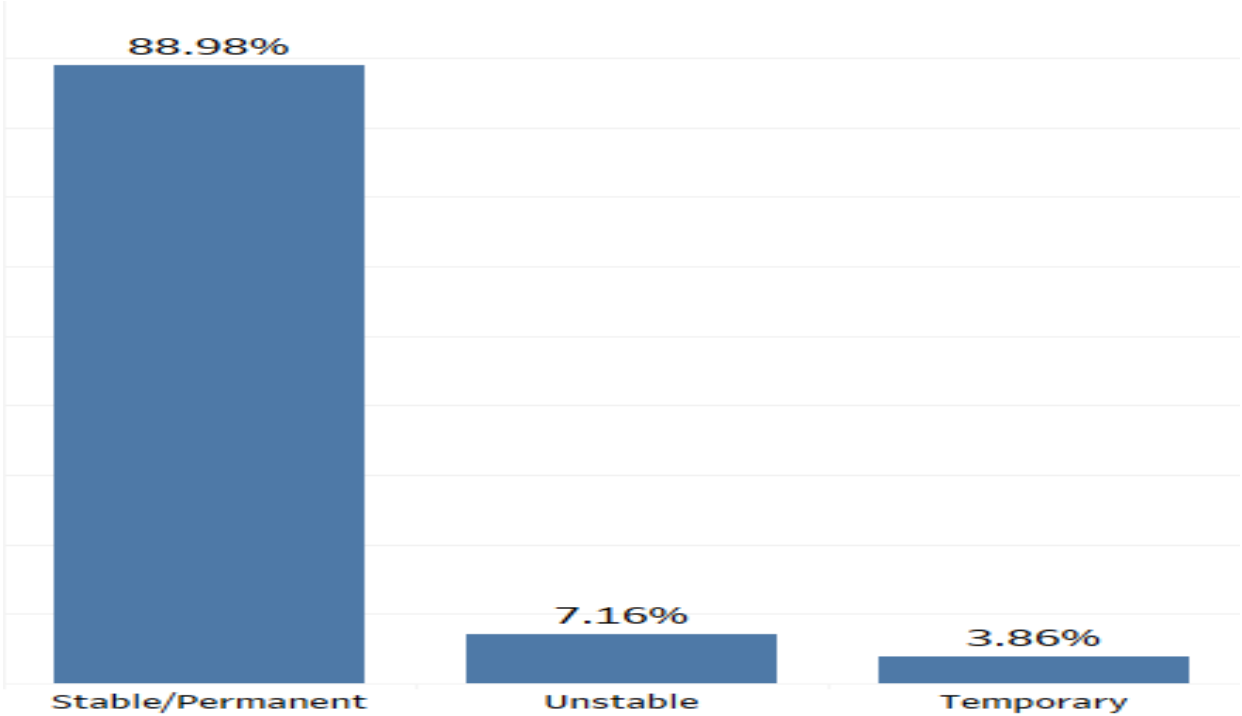
RW Customers Served in 2022 by Ethnicity (N= 13,272)

- 16% of the RW EMA customers are Hispanic/Latinx, reflecting a 1.4% increase from 202



RW Customers Served in 2022 by Known Housing Status (N = 6,288)

- 7% of the RW EMA customers had unstable housing, indicating a 1.4% decrease from the 2021 report.



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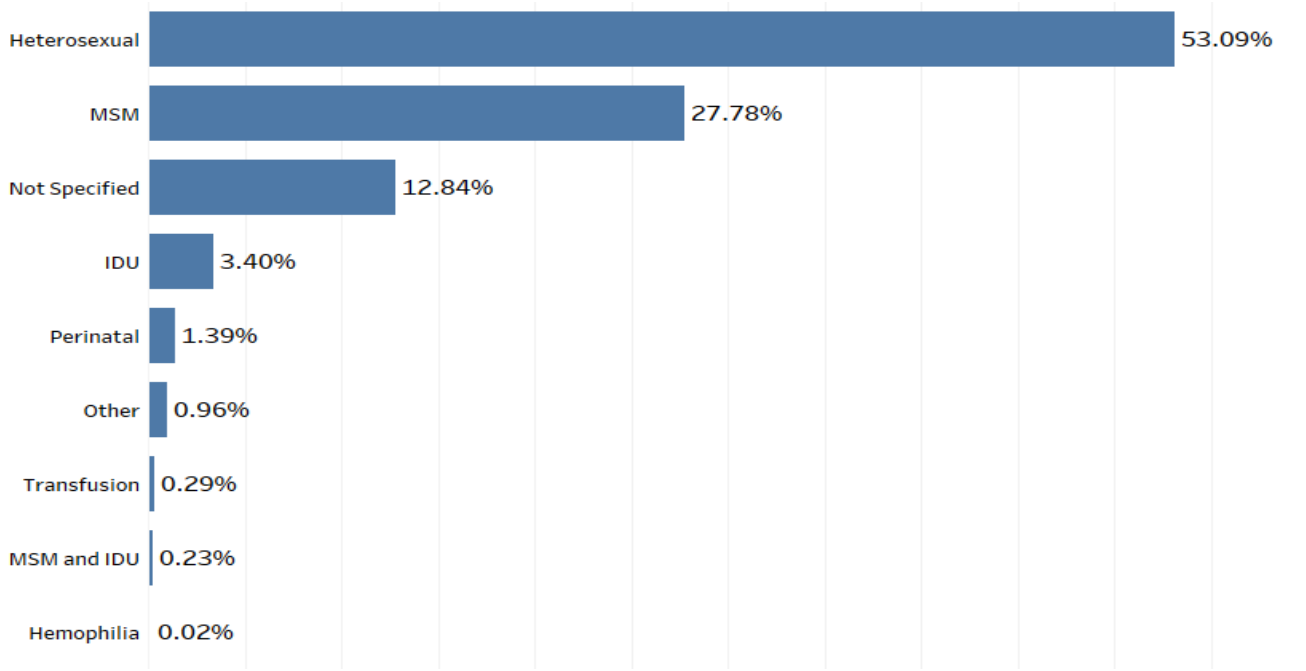
RW Customers Served in 2022 by Risk Factor (N= 13,272)

- Heterosexual contact constitute 53% of the identified risk factors, while Men having Sex with Men (MSM) make up 28%.



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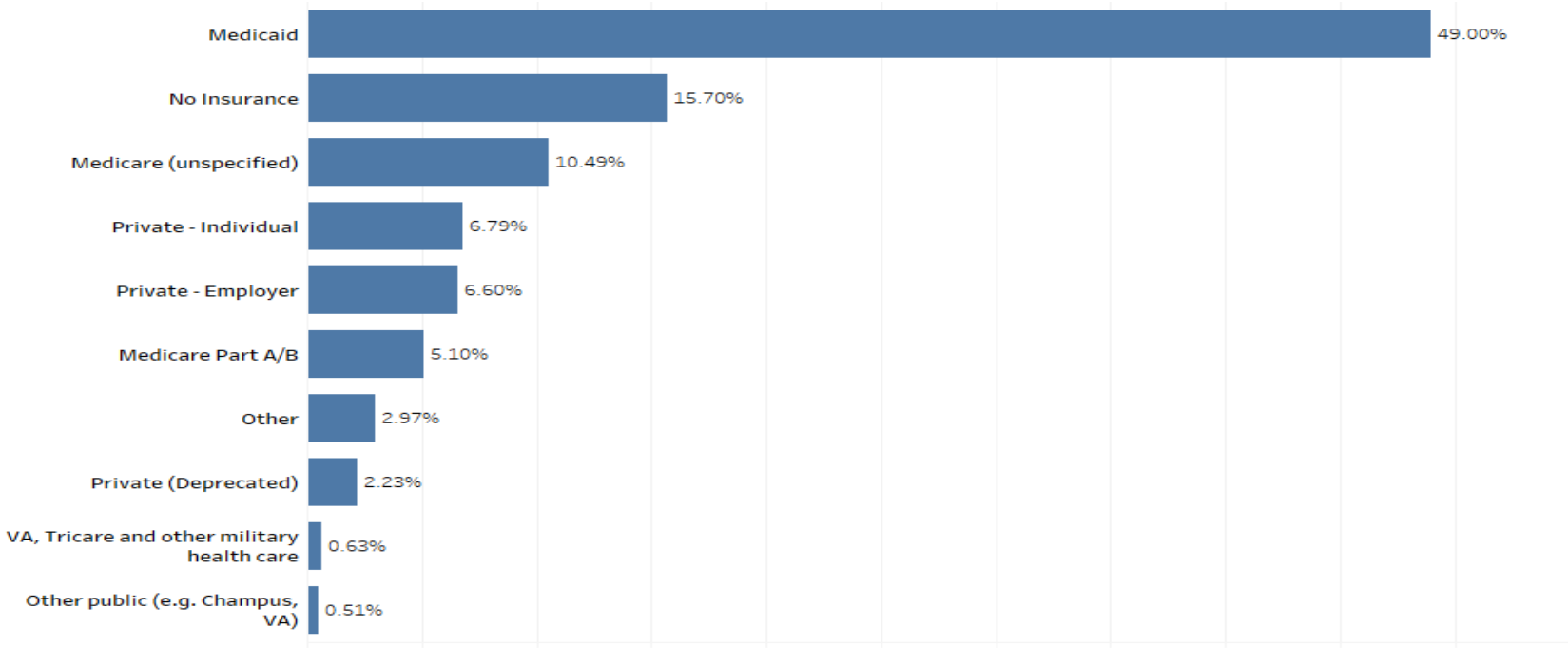
RW Customers Served in 2022 by Known Medical Insurance (N= 6,470)

- 49% of the customers were Medicaid recipients.
- 16% of the customers had no medical insurance



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RW Customers Served in 2022 by Known Federal Poverty Level (N= 5,743)

- 64% of the RW EMA customers were living at or below 100% FPL, demonstrating a 3.4% decrease from the 2021 report.

Part 3 – Customers Service Utilization

Core Services:

- **Customers**
- **Units**

Support Services:

- **Customers**
- **Units**

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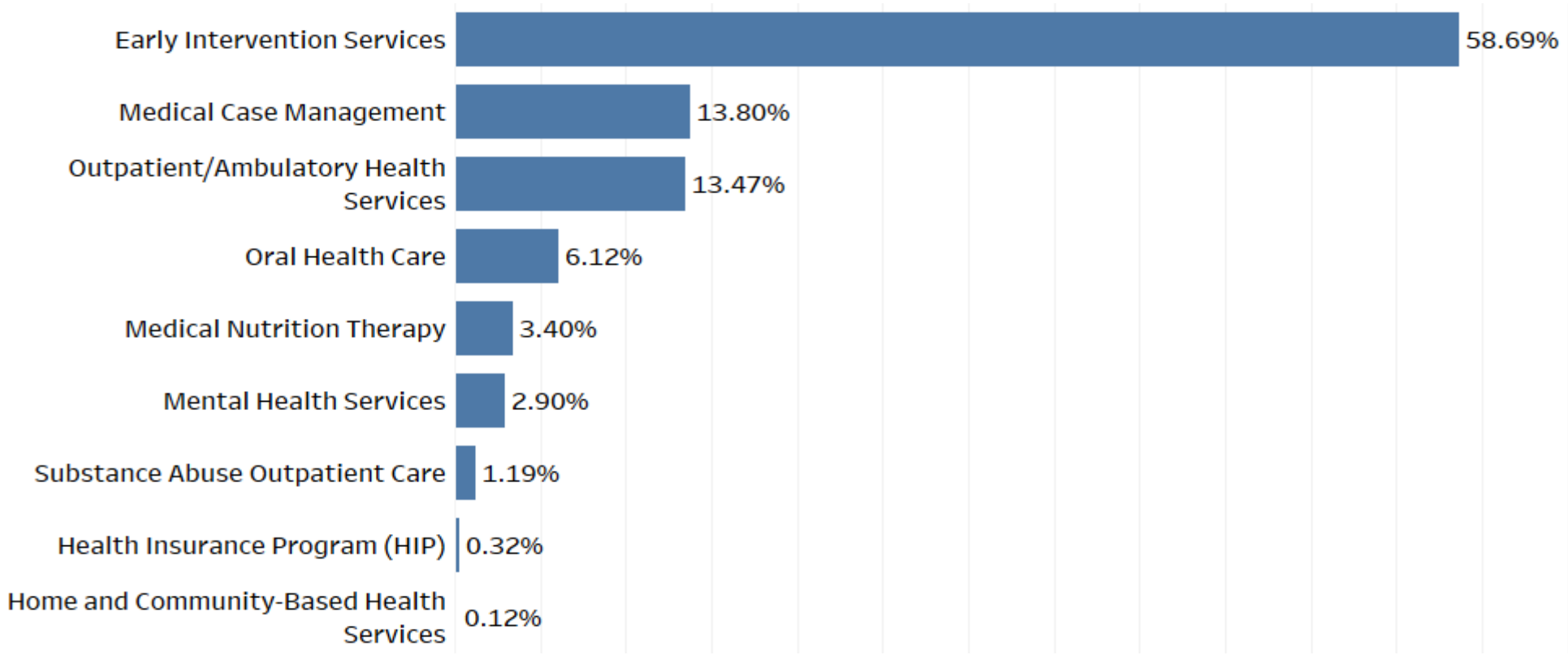
Core Services:

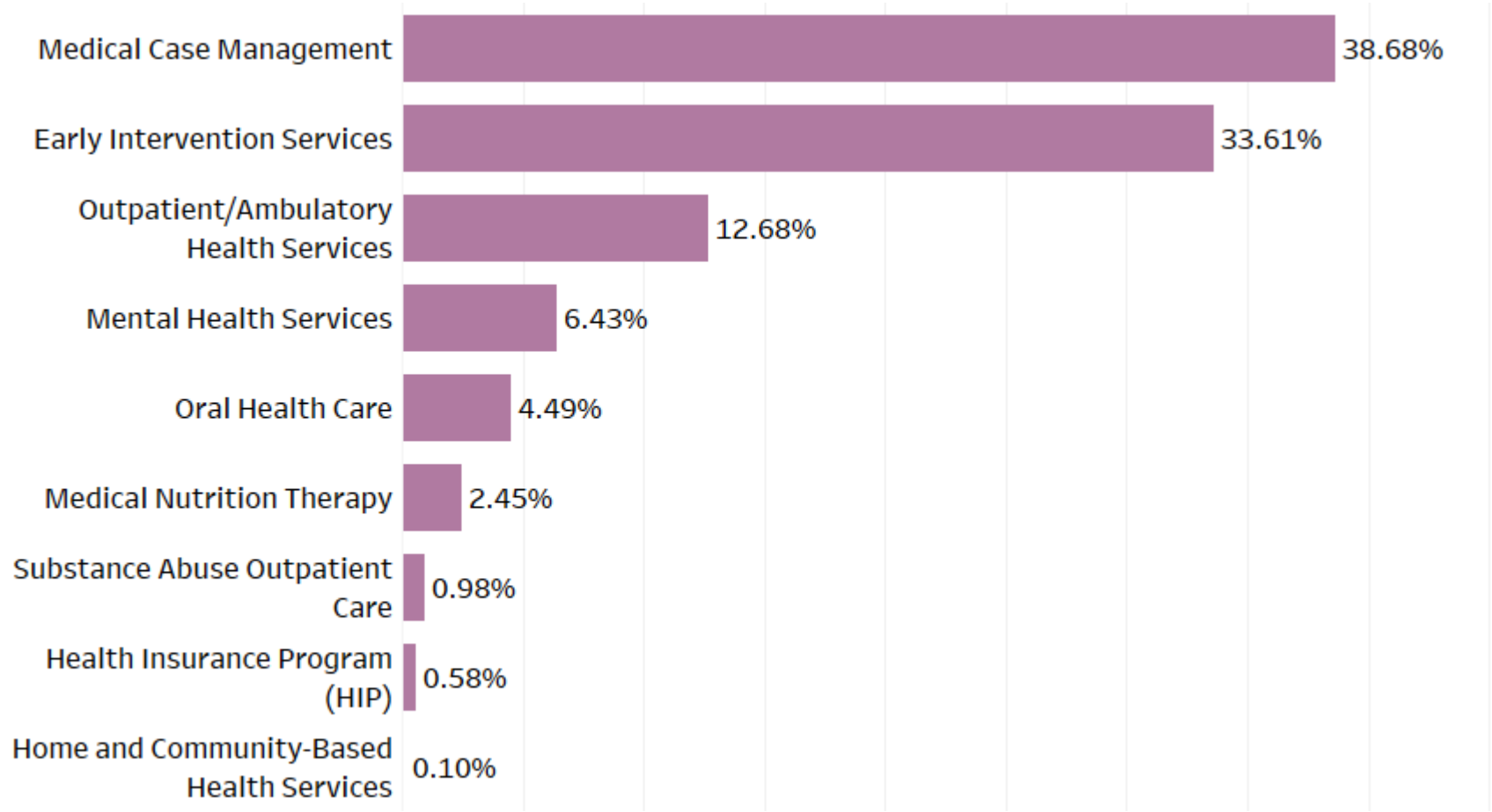
- Customers
- Units

EMA Customers by Core Services, 2022

- About 59% of Customers utilized EIS



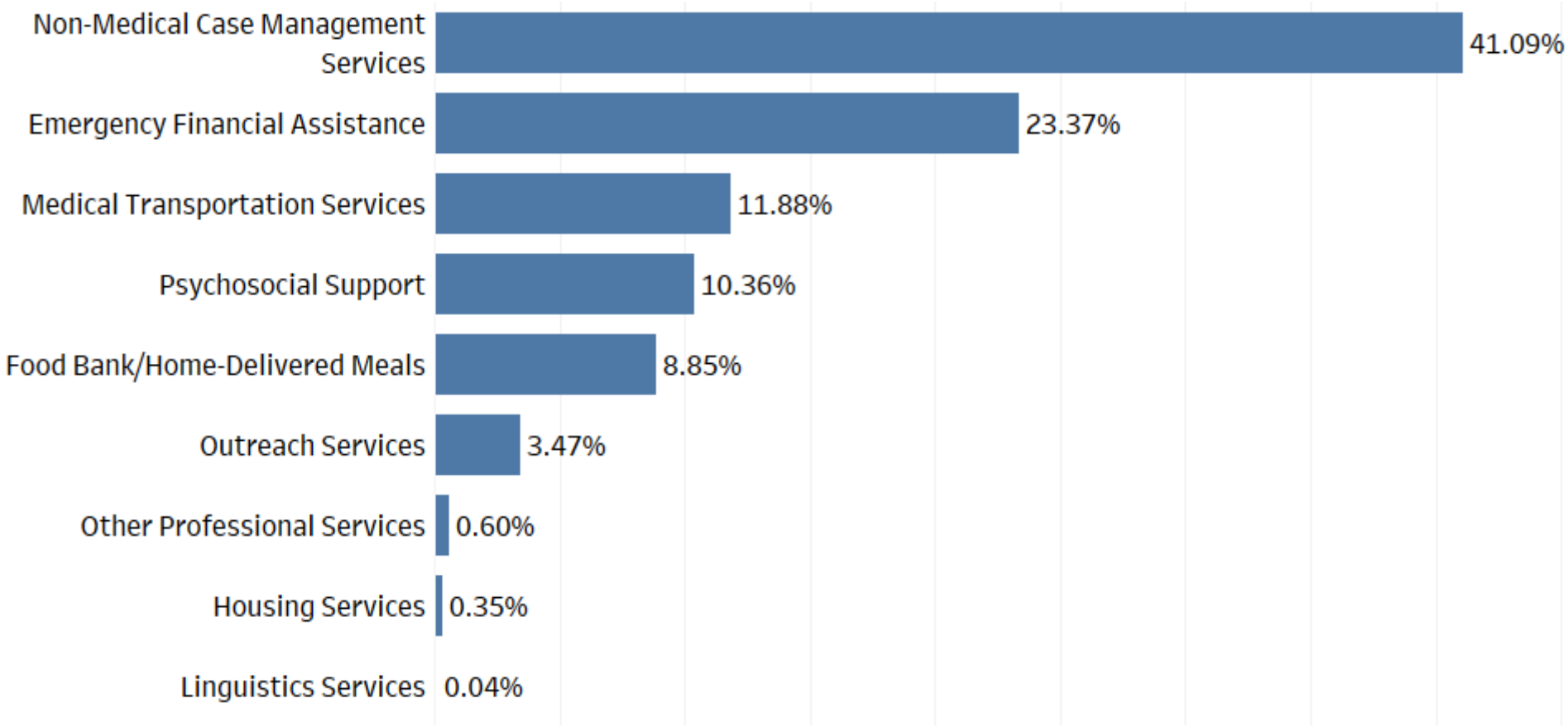
EMA Units by Core Services, 2022



Support Services:

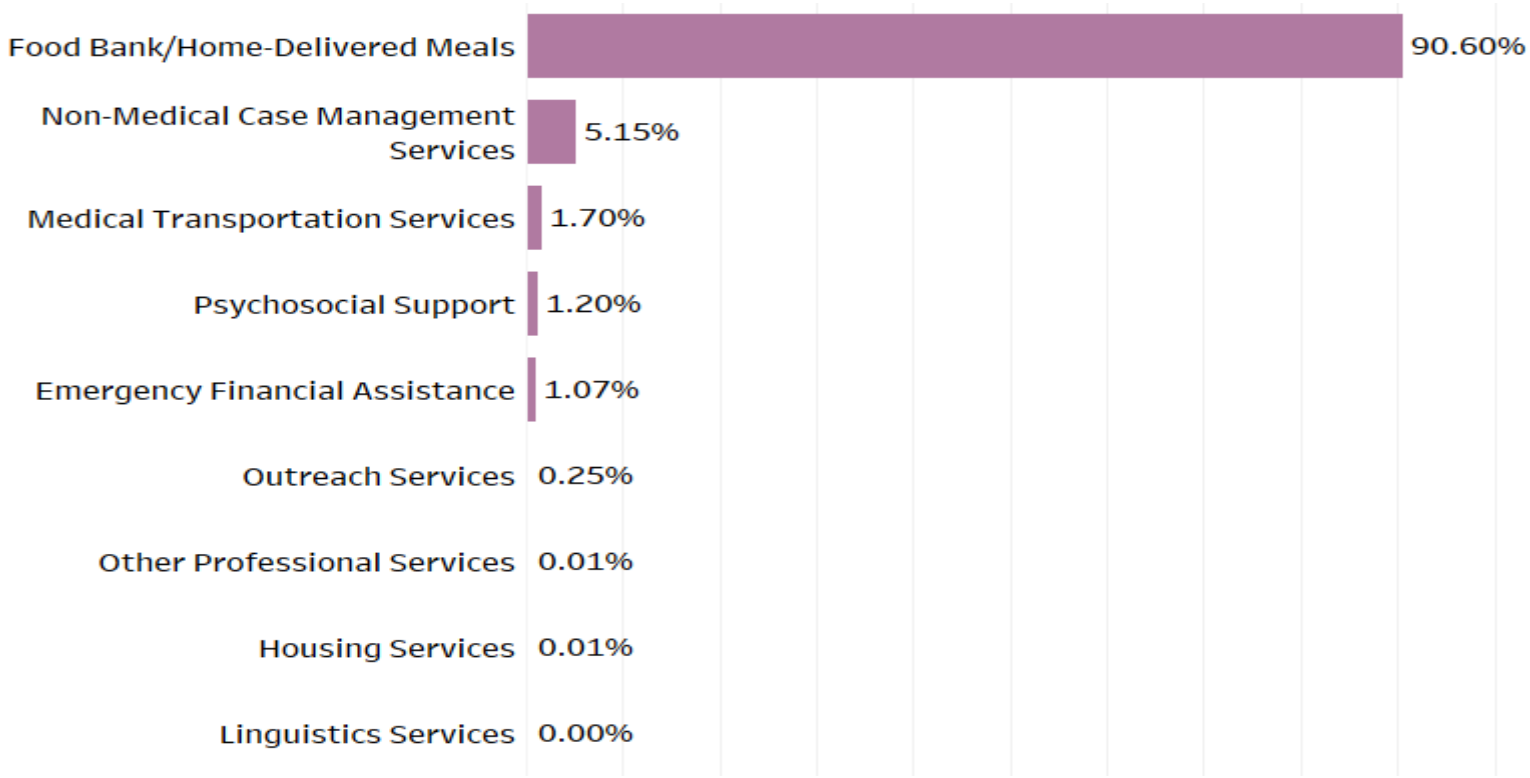
- Customers
- Units

EMA Customers by Support Services, 2022



EMA Units by Support Services, 2022

Food Bank/Home-Delivered Meals were predominant in terms of Units of Service



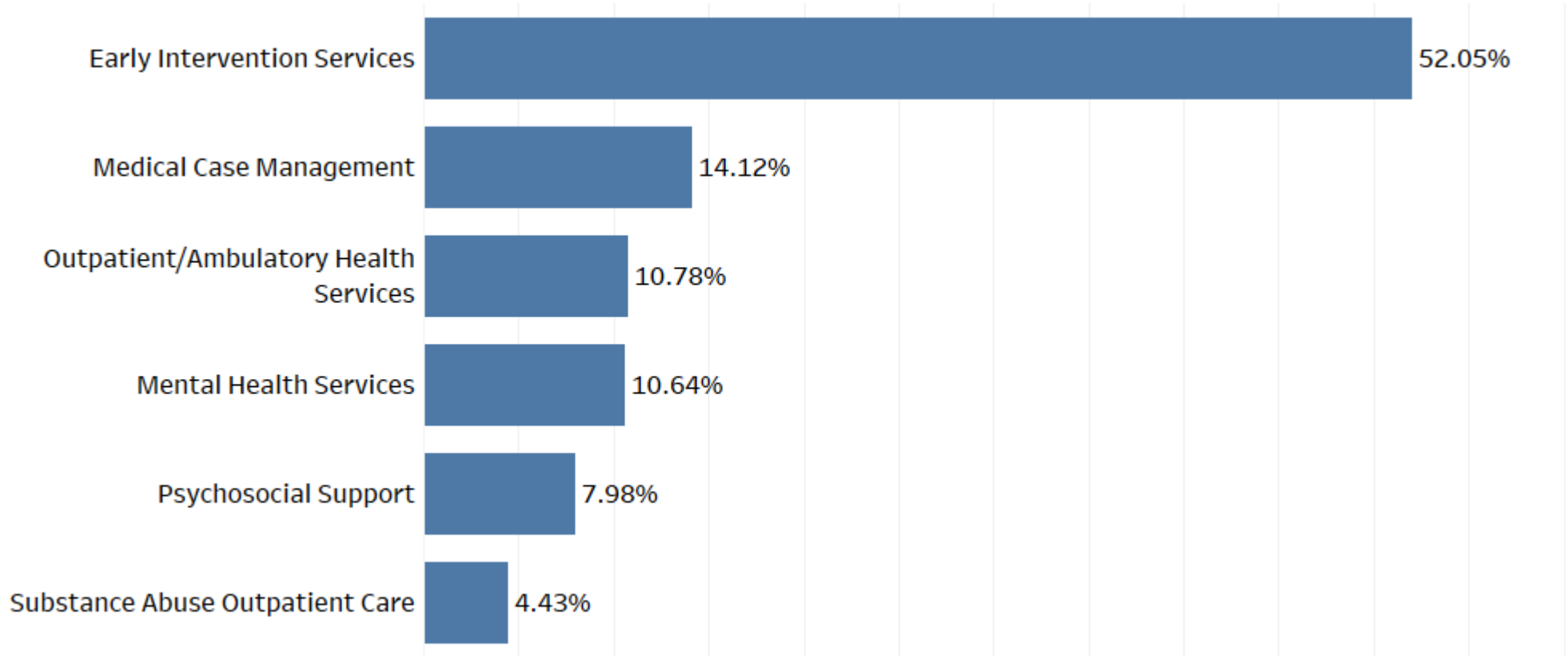
EMA Top 5 Ranked Service Categories, 2022

Service Category	Total Clients	Percent
Early Intervention Services	7,811	37.85%
Non-Medical Case Management Services	3,010	14.59%
Medical Case Management	1,837	8.90%
Outpatient/Ambulatory Health Services	1,793	8.69%
Emergency Financial Assistance	1,712	8.30%

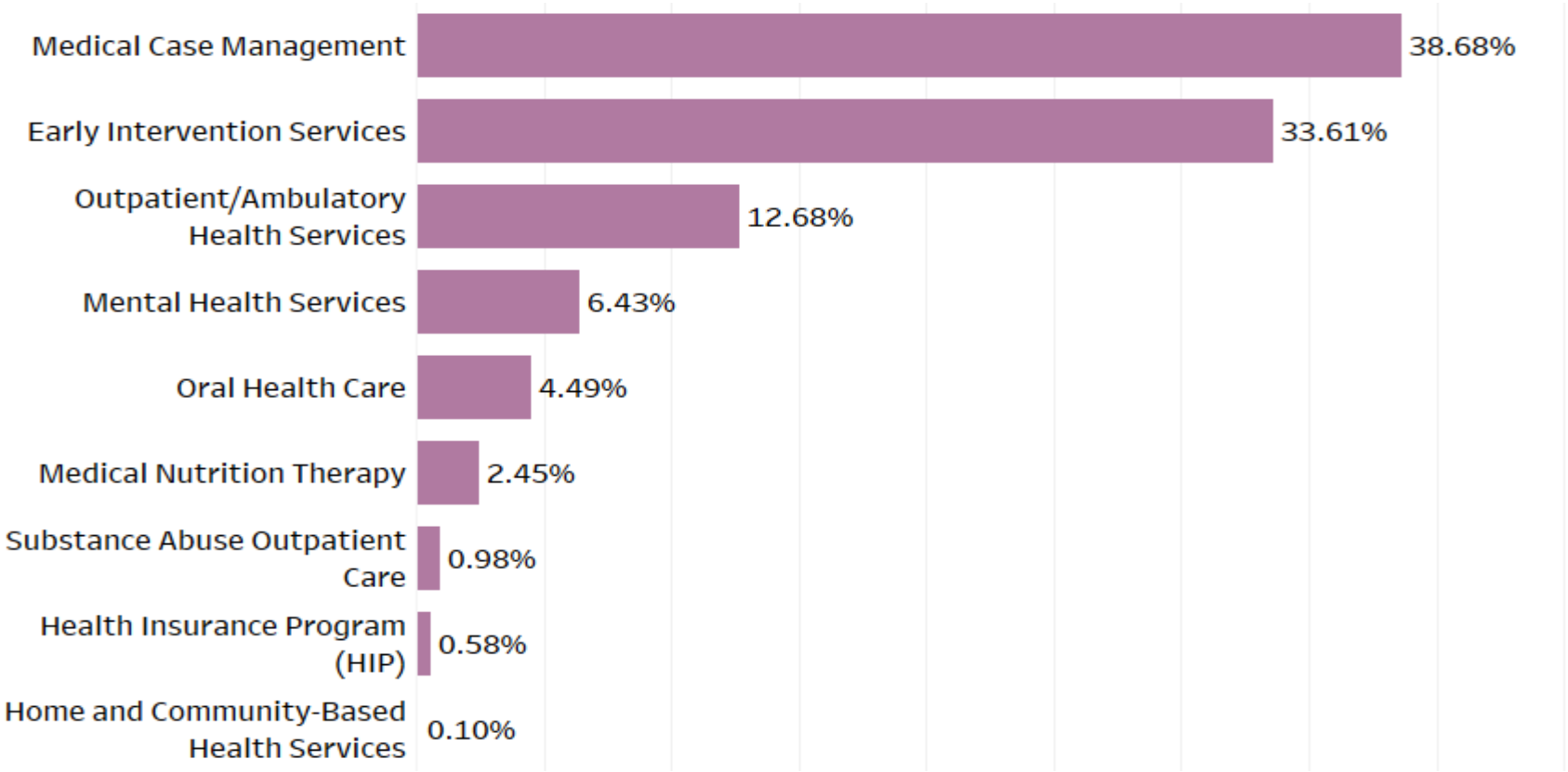
Minority AIDS Initiative(MAI) - Youth Reach

- Goal: provide a seamless transition from prevention and testing programs into care.
- Targeted initiative geared towards serving youth of color ages 13-30

Minority AIDS Initiative clients by Services



Minority AIDS Initiative Units by Services



Part 4 – Trends and outcomes

Continuum of Care

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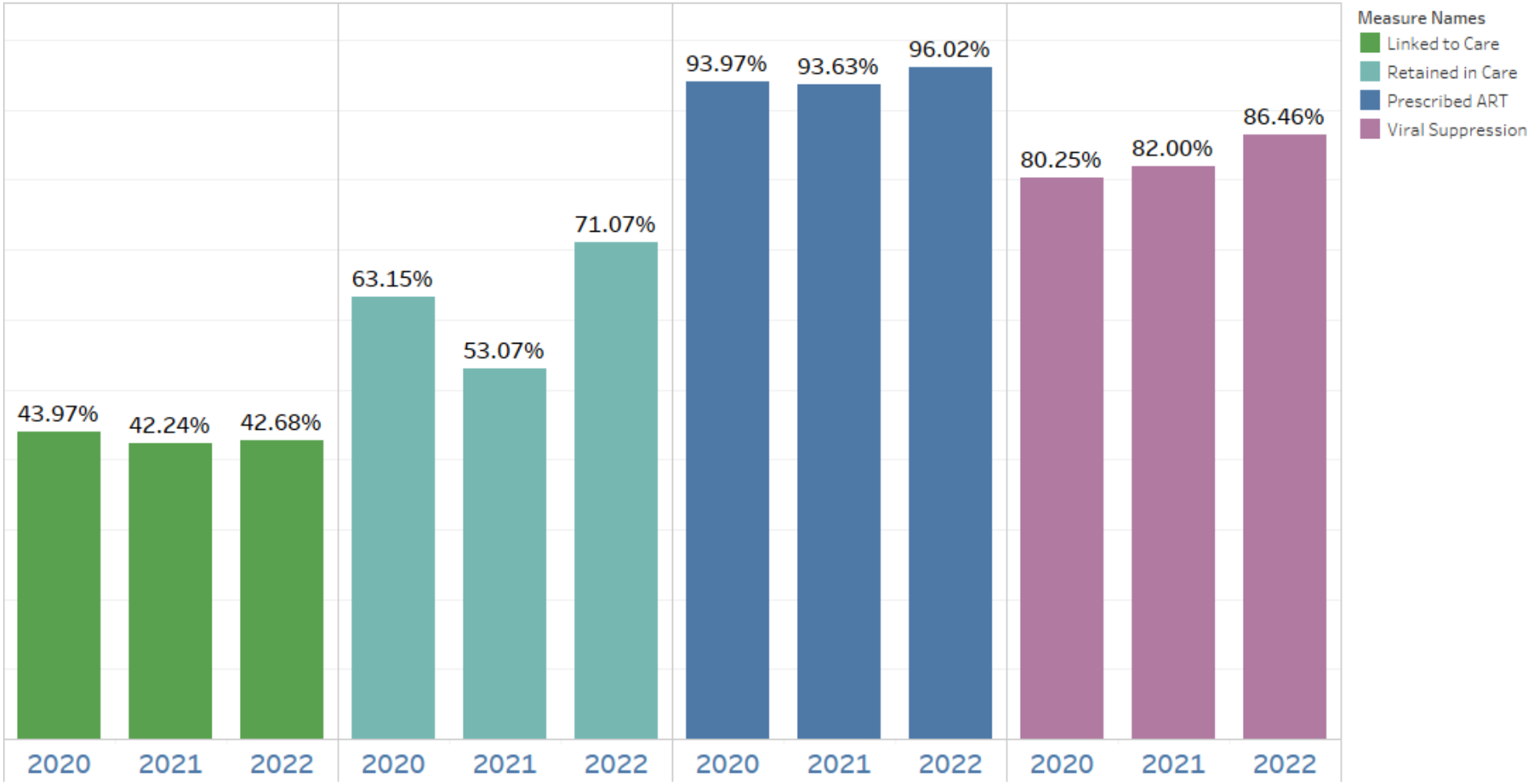
EMA Continuum of Care, 2020 - 2022



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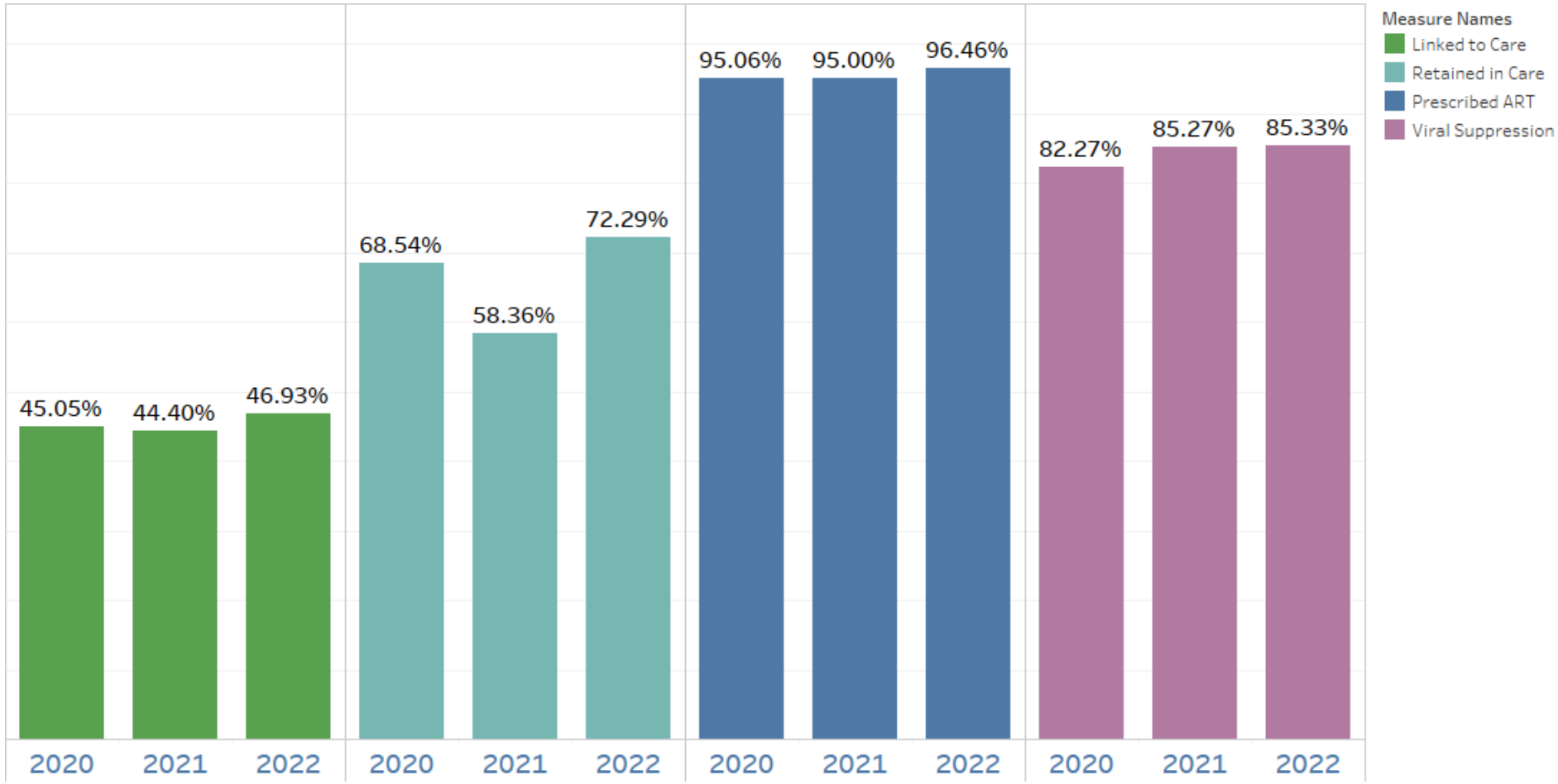
DC Continuum of Care, 2020 - 2022



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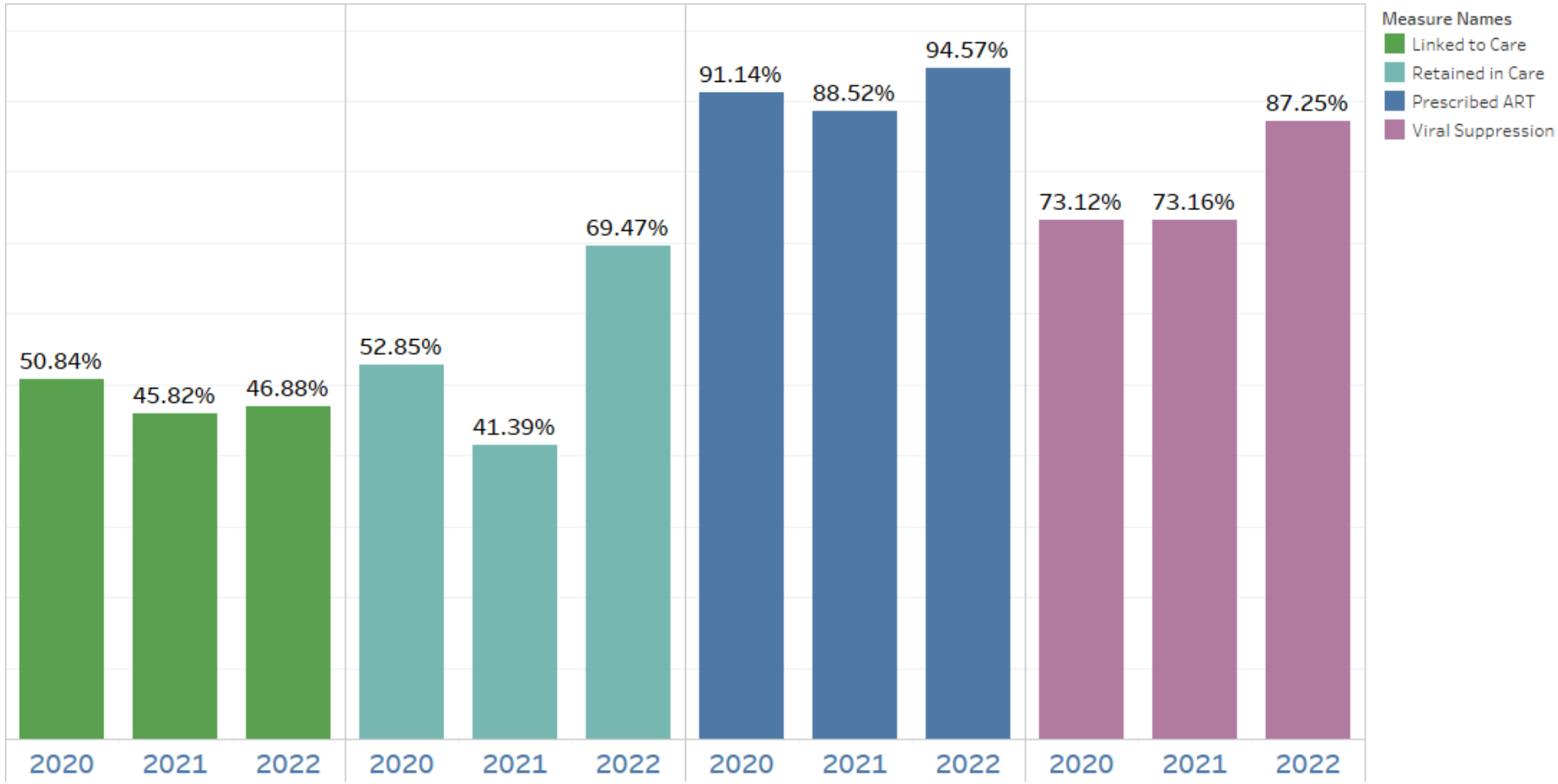
Maryland Continuum of Care, 2020 - 2022



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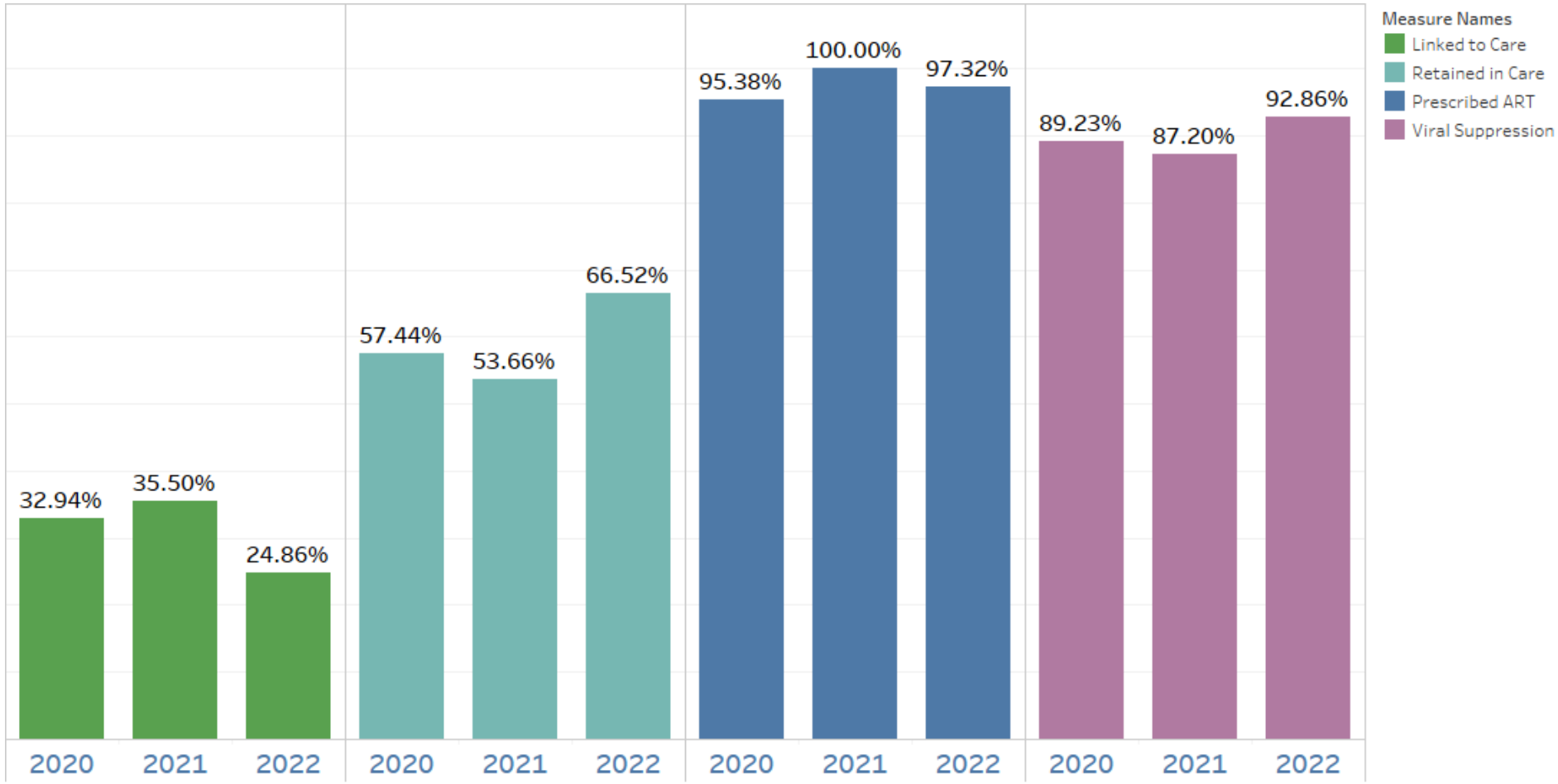
Virginia Continuum of Care, 2020 - 2022



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Key Takeaways

- EMA Total customers: 13,272 reflecting a 9% increase from 2021 report.
- DC has demonstrated a noteworthy 29% increase compared to the 2021 report, whereas MD has experienced a modest decline of 3.4%.
- In EMA 36% of the customers were 45 years old or older, whereas in WVA, a significant 67% fell into the 45 years old or older category.
- The percentage of Hispanic/Latinx in VA has risen by 7% compared to the data from 2021.
- Core Service category
  - EIS: highest proportion of unique customers.
  - EIS, MCM, & OAHS: highest proportion of service units.
- Support Service category
  - NMCM, & EFA : highest proportion of unique customers.
  - Food Bank/ Home-delivered meal: highest proportion of service units.

Key Takeaways (continued)

- Continuum of Care:
  - The proportion of VLS in EMA has increased slightly.
  - Among the jurisdictions, VA exhibited the highest proportion of ART. prescriptions and VLS; yet recorded the lowest proportion in Linkage to Care (LTC).
  - DC has the highest proportion of Reengaged in Care (RTC) as compared to the other Jurisdictions.
  - The VLS proportion in MD has surged from 72% in 2021 to an impressive 87% by 2022.

Questions?

Email: jose.delao.hernandez@dc.gov

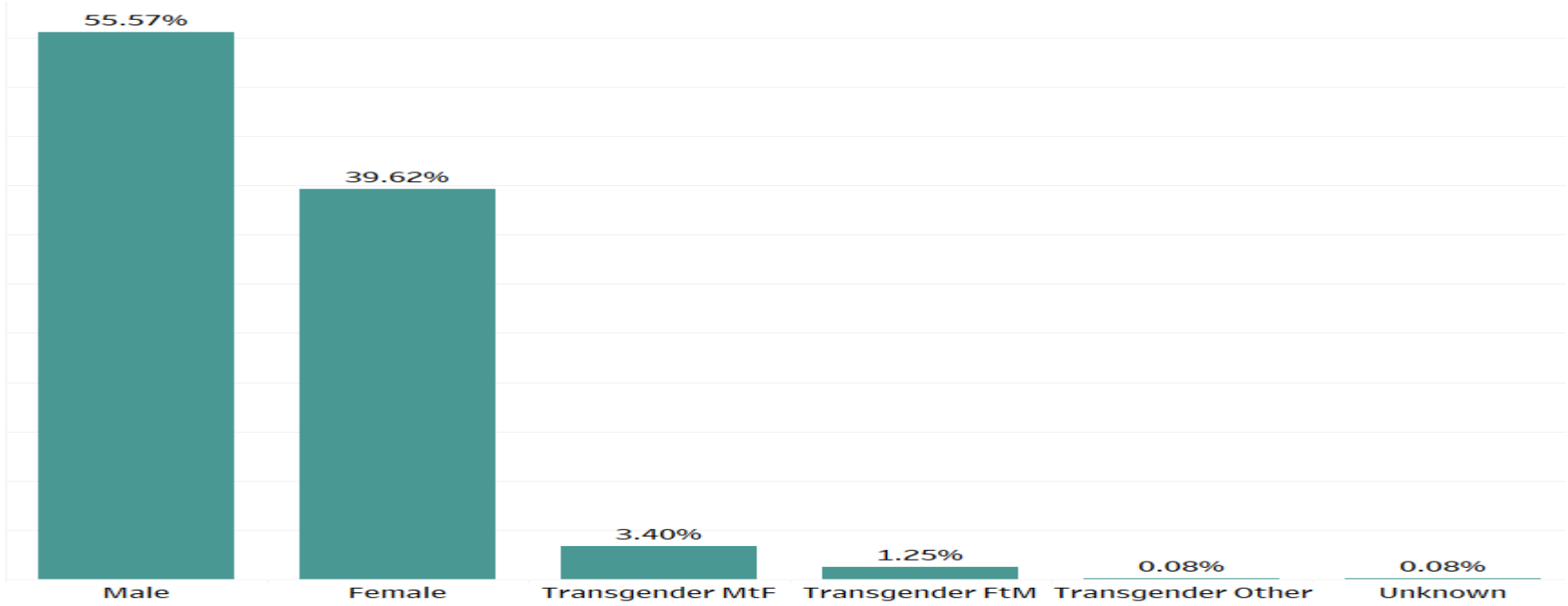
Characteristics of Customers Using RW Services in District of Columbia (DC)

Total Customers Using RW Services in DC, 2022

- Total number of RW customers in DC is 6,320
- It has shown a 21% increase from the 2021 report.

DC Customers Served in 2022 by Gender (N= 6,320)

- 40% of the DC customers identify as Female, signifying a 6% increase from the 2021 report.
- 5% of the DC customers identify as Transgender



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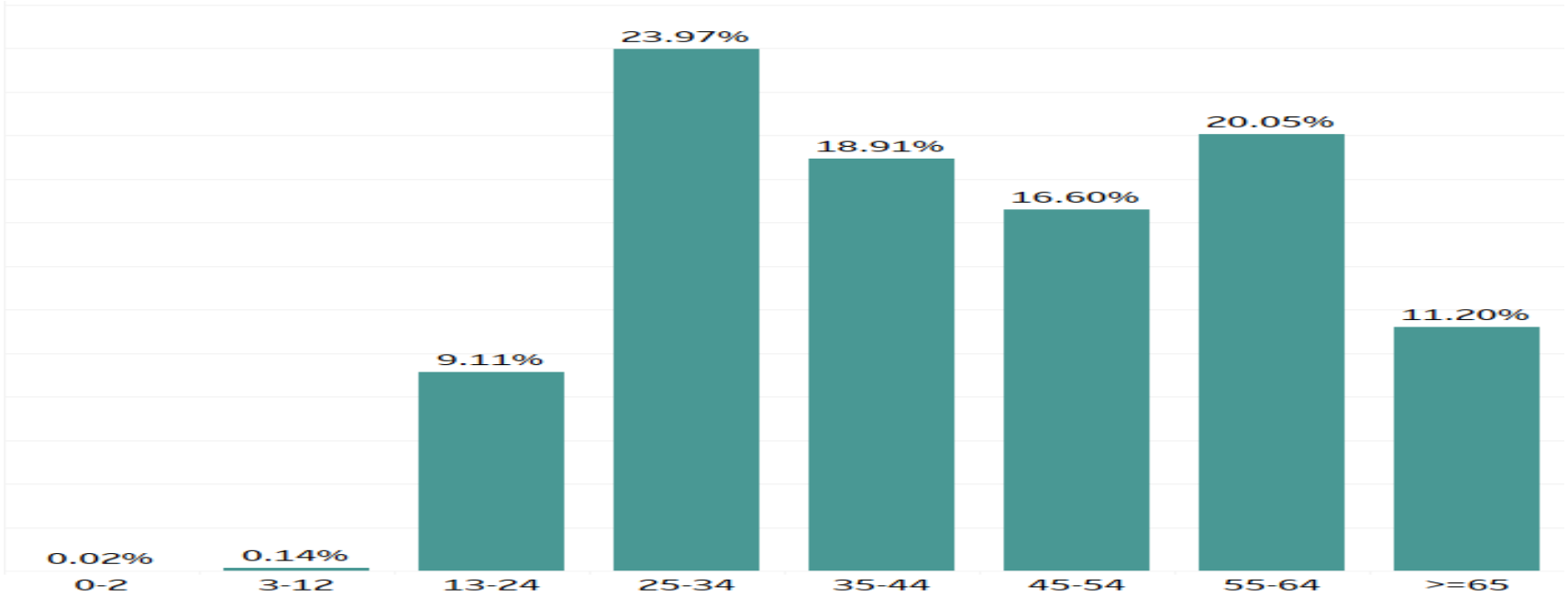
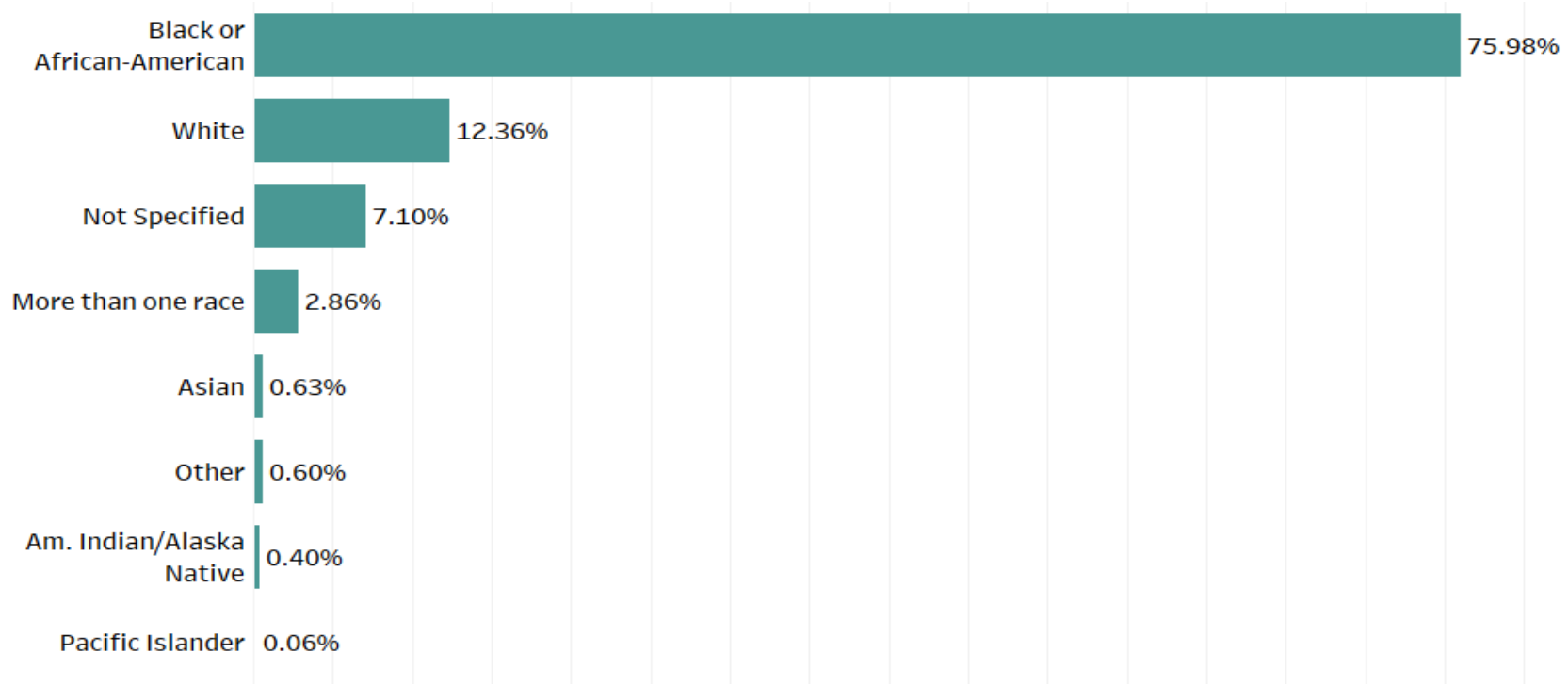
DC Customers Served in 2022 by Age Groups (N= 6,320)

- 24% of the DC customers were in the 25-34 age range.
- 48% were 45 years old or older, marking a 3% reduction as compared to the 2021 report.



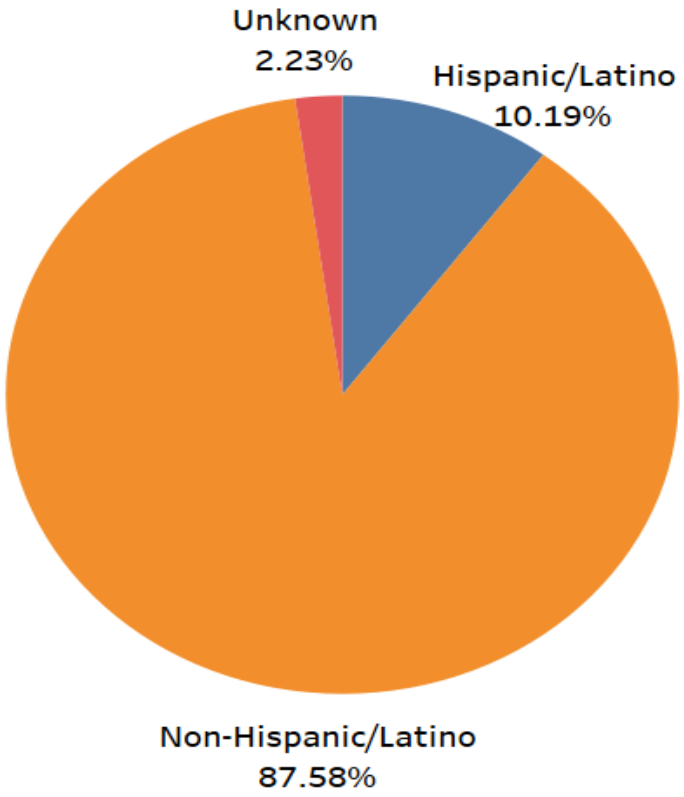
DC Customers Served in 2022 by Race (N= 6,320)

- 76% of the DC customers are African American; demonstrating a 3.0% decline from the 2021 report.



DC Customers Served in 2022 by Ethnicity (N= 6,320)

- 10% of the DC customers are Hispanic/Latino



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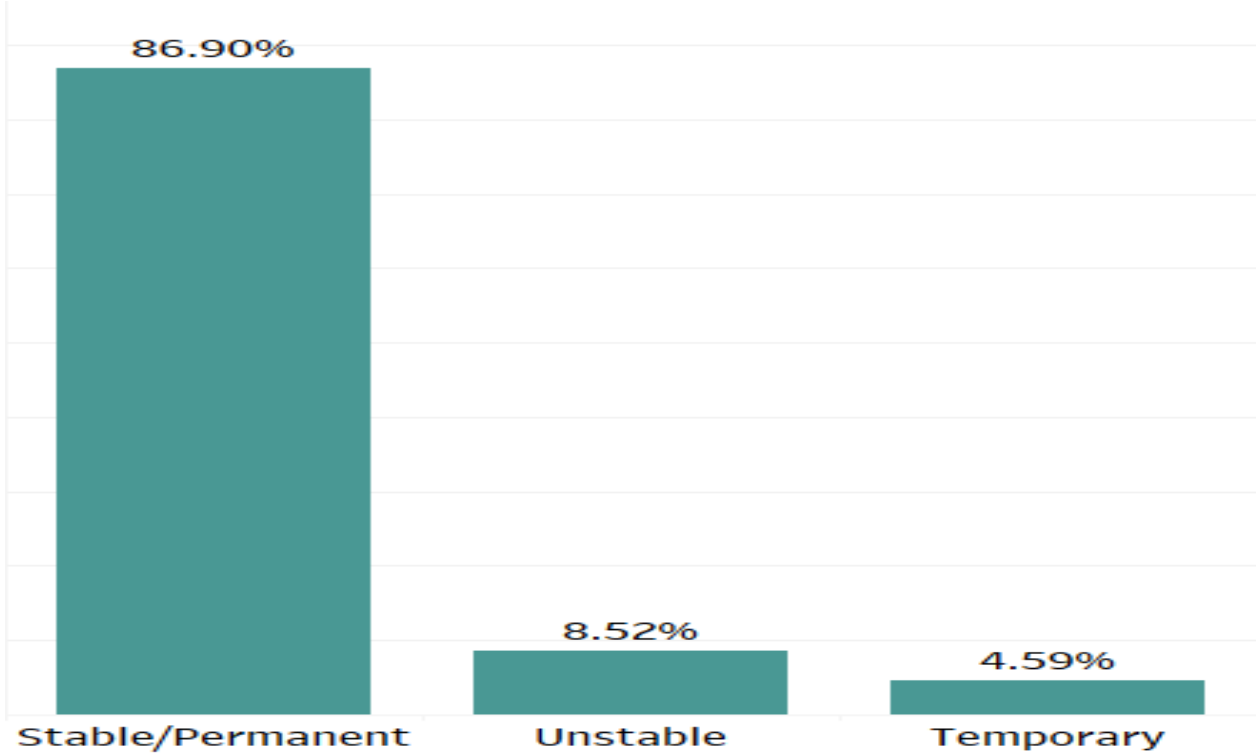
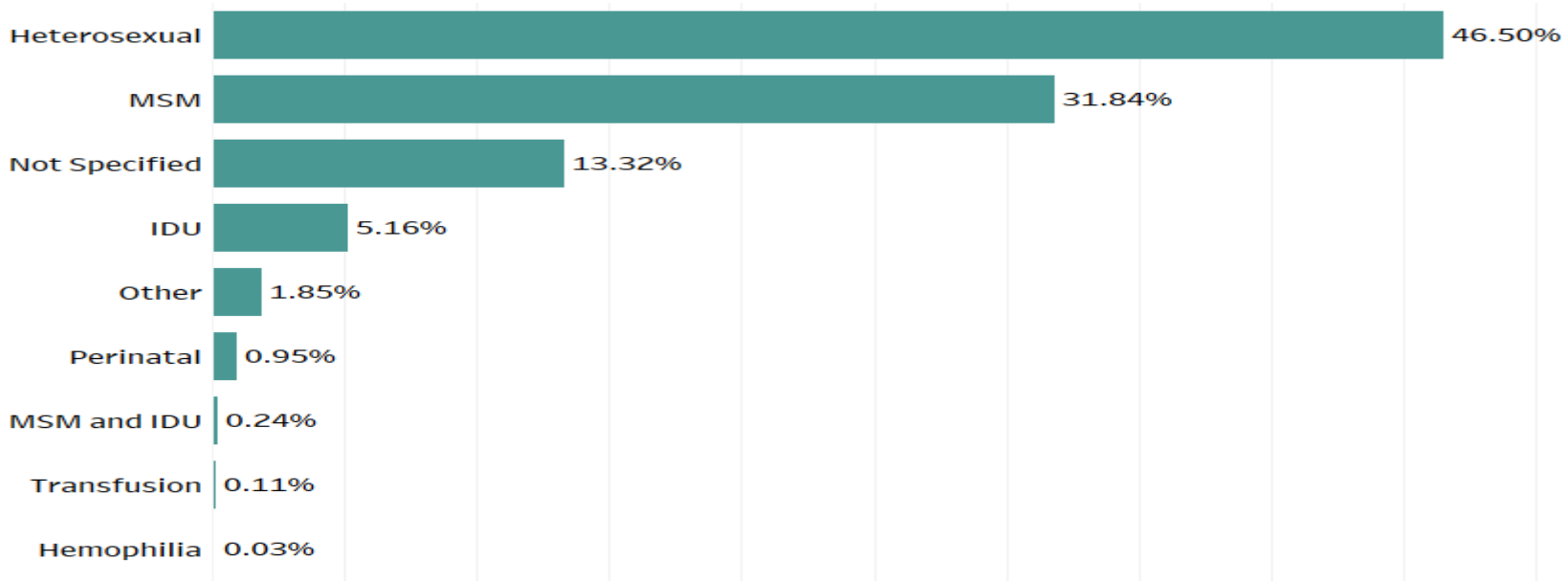
DC Customers Served in 2022 by Known Housing Status (N= 4,121)

- 9% of the DC customers had unstable housing, reflecting a 2.5 % downturn from the 2021 figures.



DC Customers Served in 2022 by Risk Factor (N= 6,320)

- Heterosexual contact constitute 47% of the identified risk factors, while Men having Sex with Men (MSM) make up 32%.
- MSM as a risk factor has exhibited a 5% decrease from 2021



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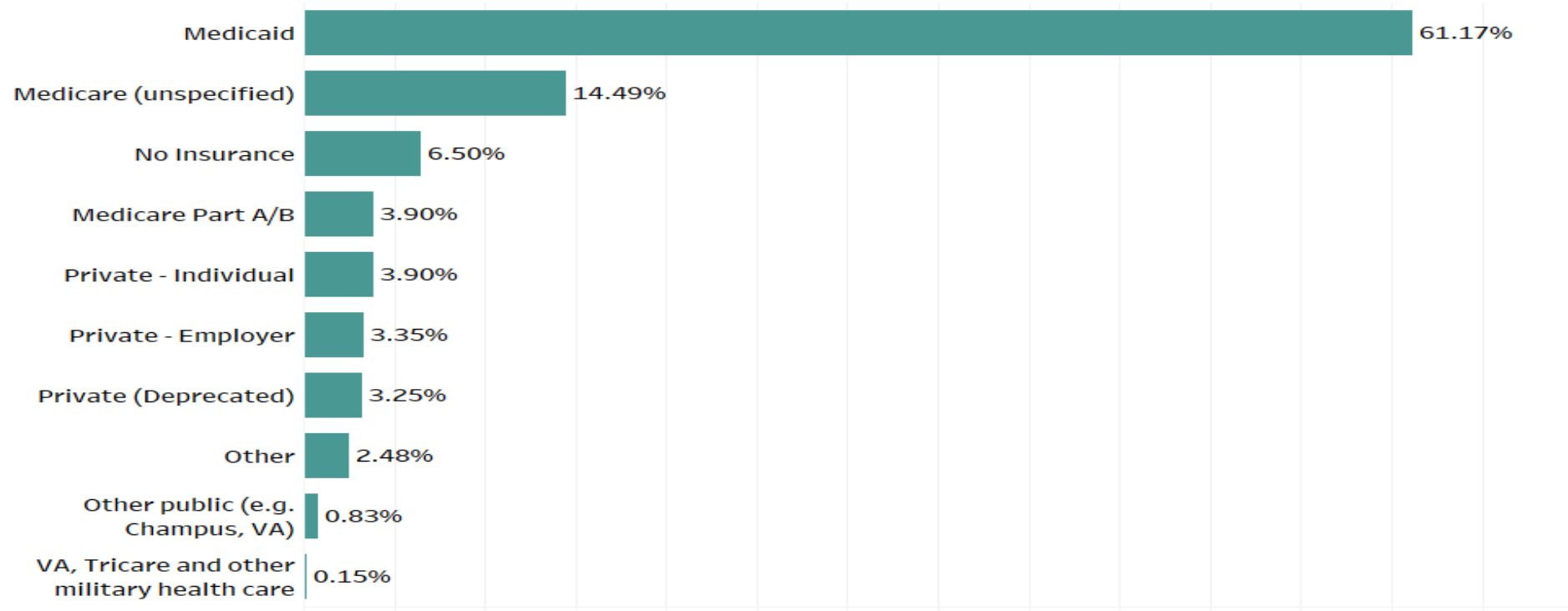
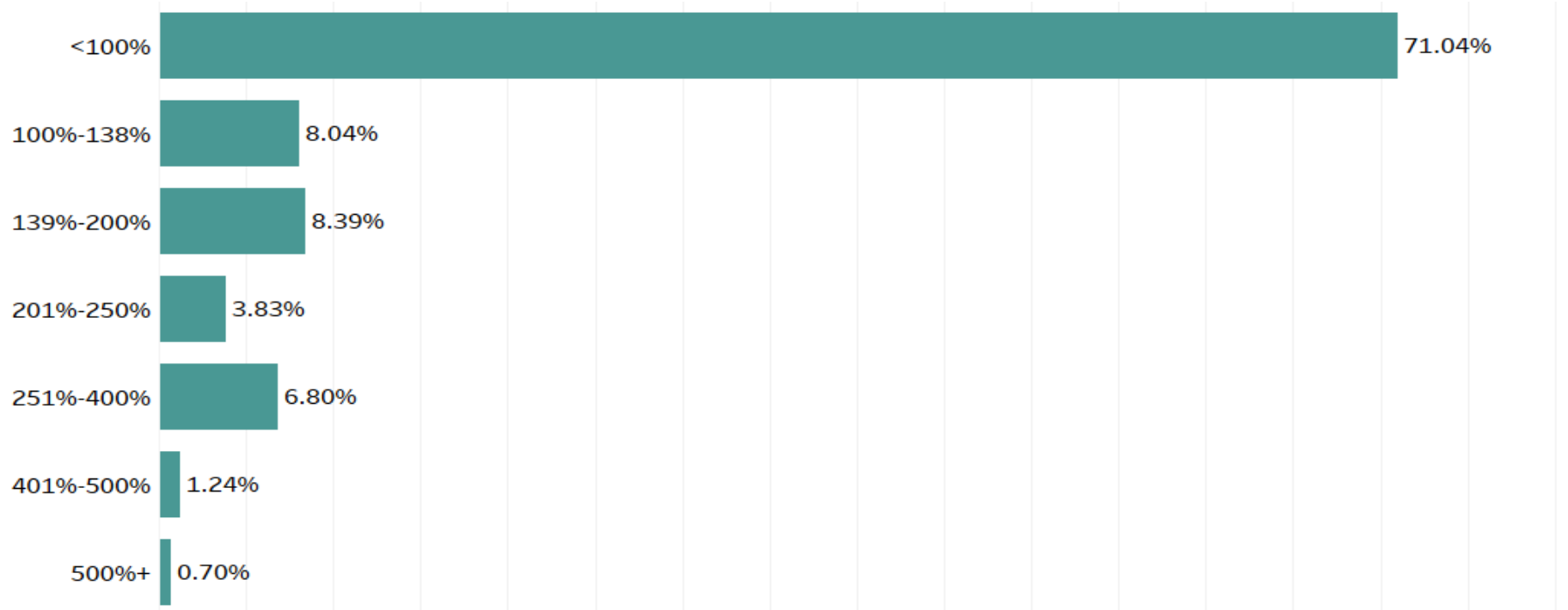
DC Customers Served in 2022 by Known Medical Insurance (N= 3,997)

- 61% of the customers were Medicaid recipients.
- 7% of the customers had no medical insurance



DC Customers Served in 2022 by Known FPL (N= 3,708)

- 71% of the DC customers were living at or below 100% FPL, noting 4.4% decrease from the 2021 data.



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Characteristics of Customers Using RW Services in Maryland (MD)

Total Customers Using RW Services in MD, 2022

- Total number of RW customers in MD is 4,437
- It has exhibited 1.8% decrease from the 2021 data.

MD Customers Served in 2022 by Gender (N= 4,437)

- 37% of the MD customers identify as Female, indicating a 1.2% decrease from the 2021 report.

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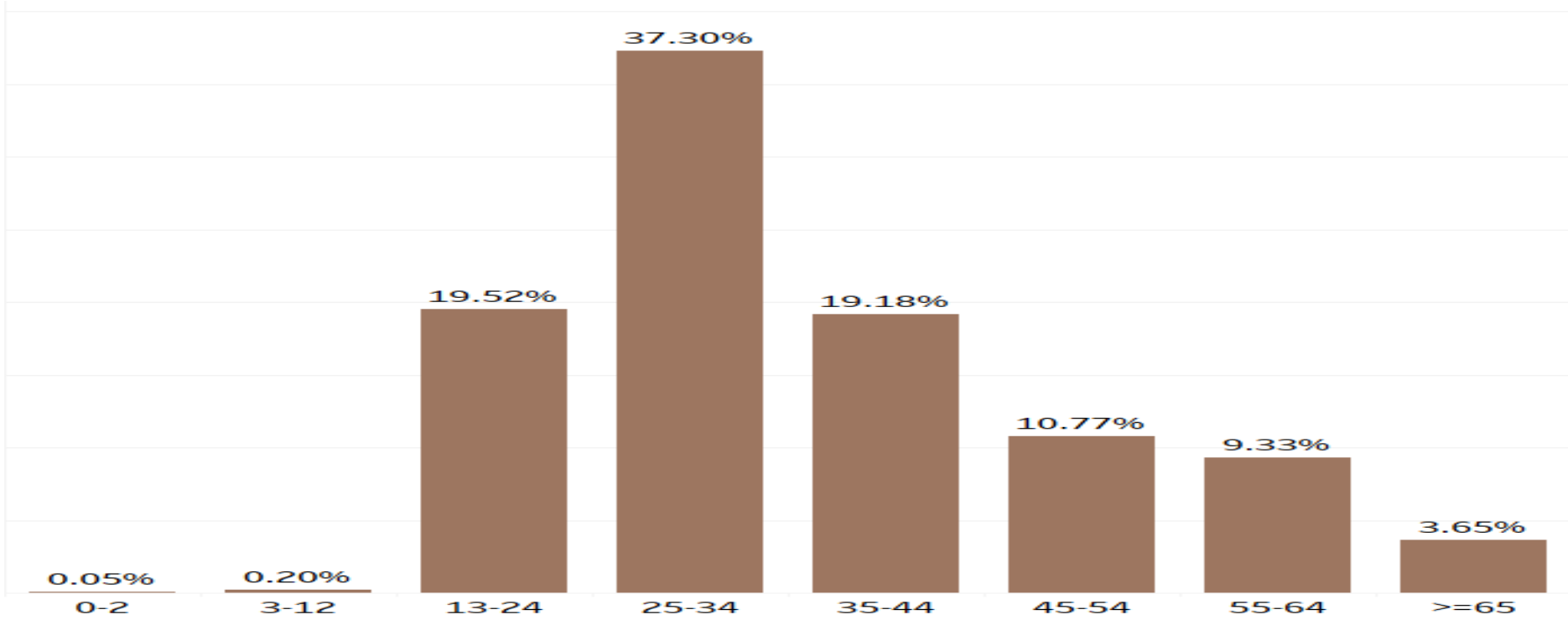
MD Customers Served in 2022 by Age Groups (N= 4,437)

- 37% of the MD customers were in the 25-34 age range.
- 24% were 45 years old or older.



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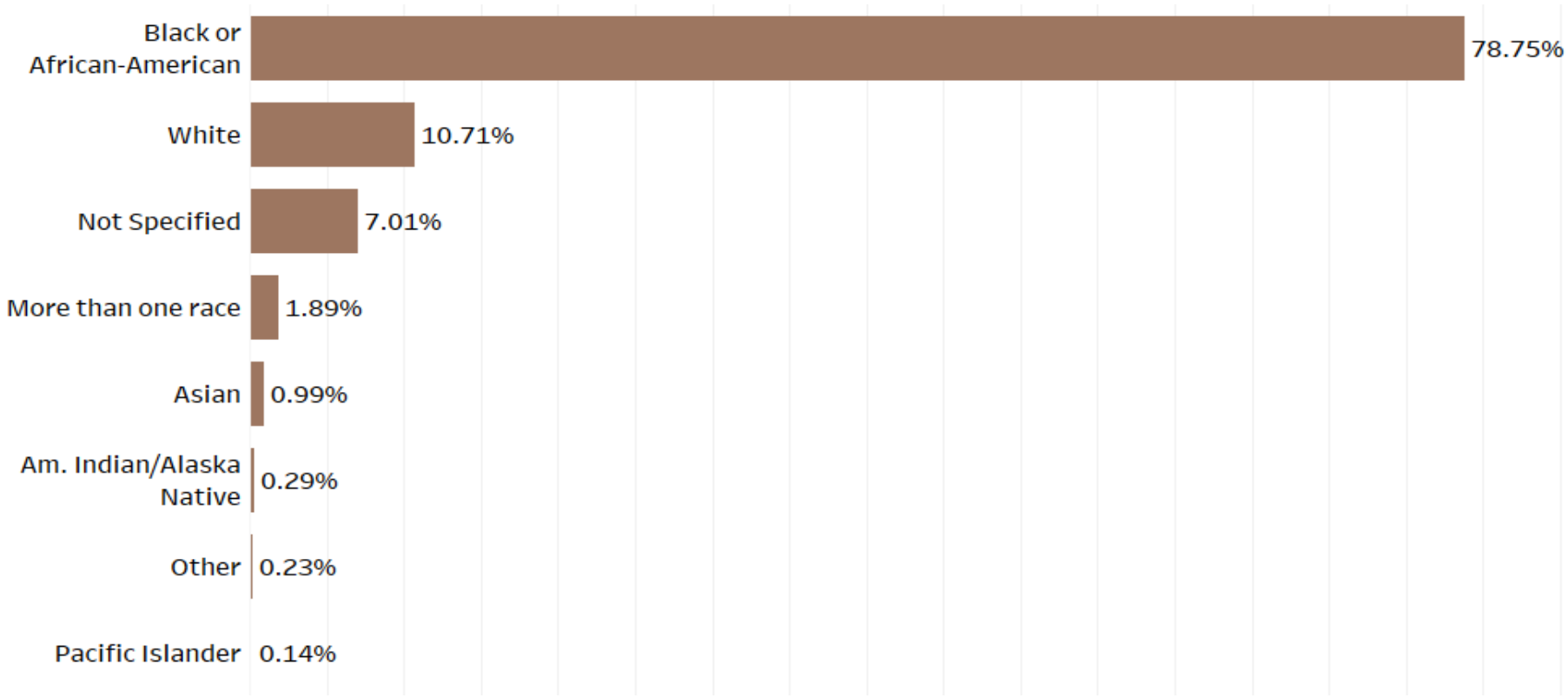
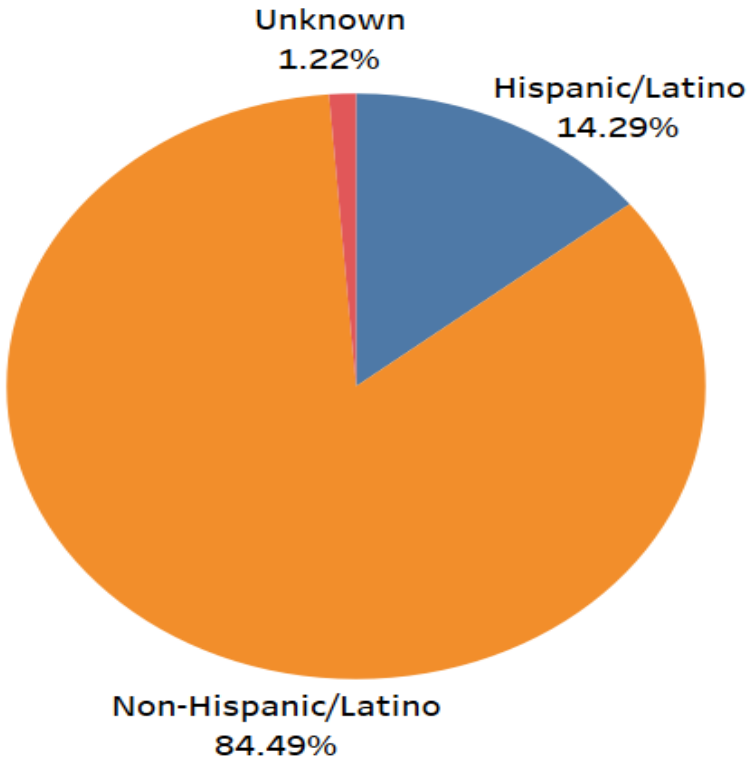
MD Customers Served in 2022 by Race (N= 4,437)

- 79% of the MD customers are African American; demonstrating a 1.3% decline from the 2021 report



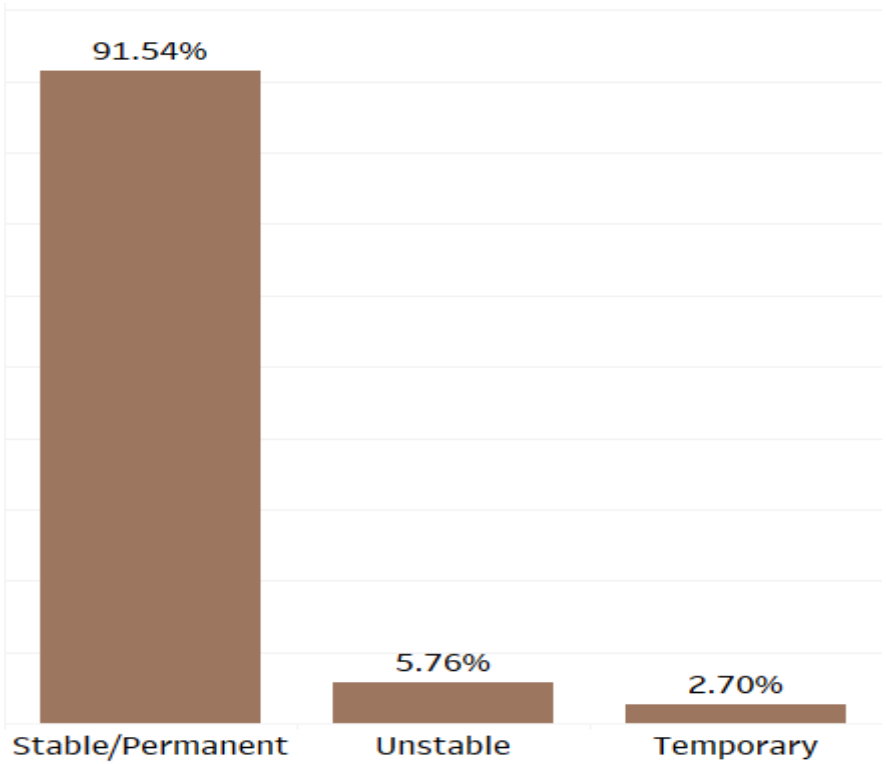
MD Customers Served in 2022 by Ethnicity (N= 4,437)

- 14% of the MD customers are Hispanic/Latino, displaying a 2.4% increment relative to the 2021 Report



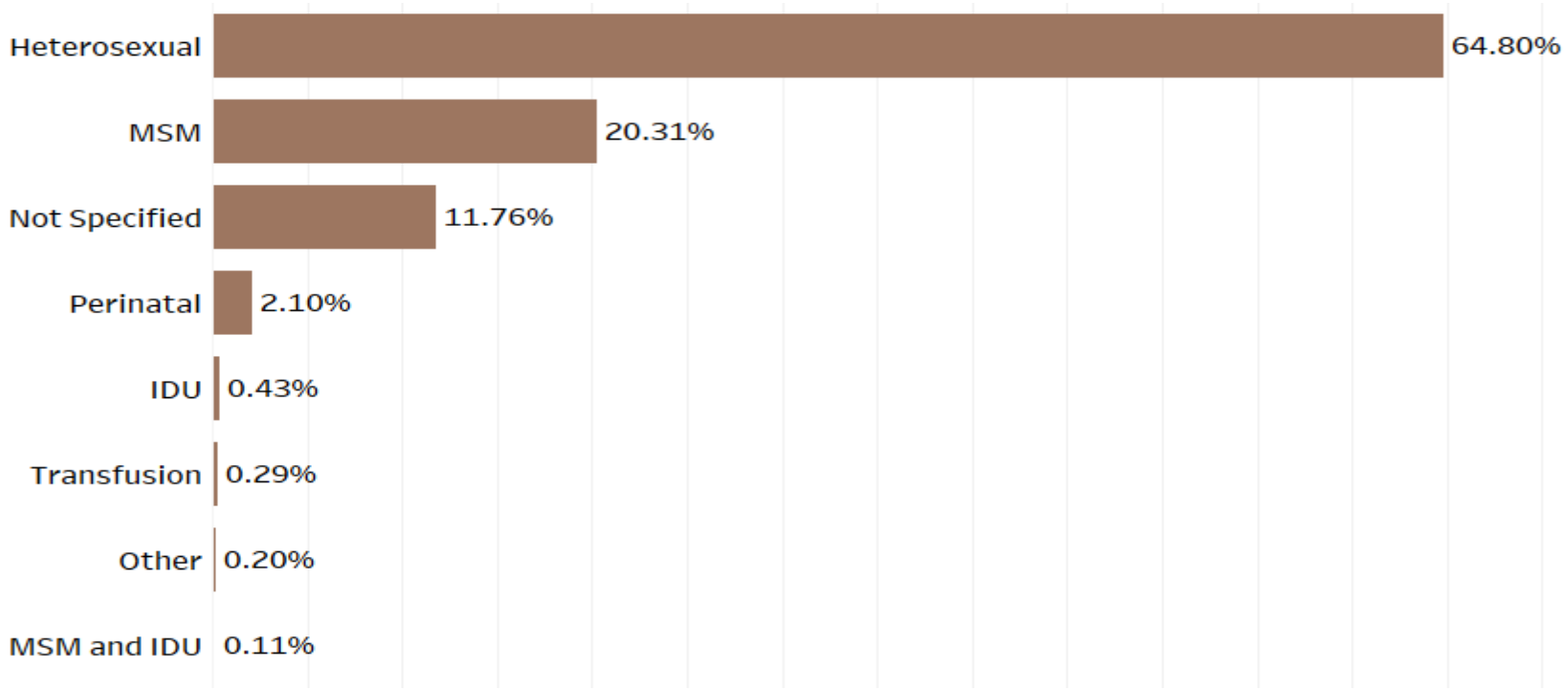
MD Customers Served in 2022 by Known Housing Status (N= 1,406)

- 6% of the MD customers had unstable housing.



MD Customers Served in 2022 by Risk Factor (N= 4,437)

- Heterosexual contact constitute 65% of the identified risk factors while Men having Sex with Men (MSM) make up 20%.
- MSM as a risk factor has exhibited a 3% increase from 2021 data.



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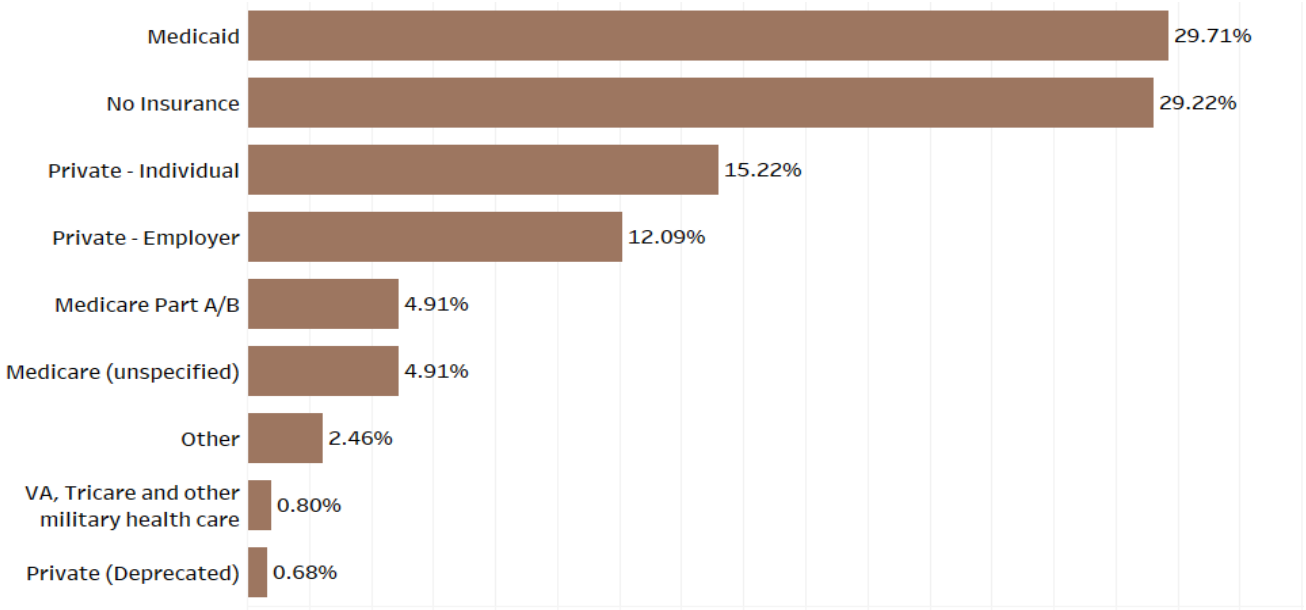
MD Customers Served in 2022 by Known Medical Insurance (N= 1,629)

- 29.7% of the customers were Medicaid recipients, noting 8 % decrease from the 2021 data
- 29.2% of the customers had no medical insurance, noting 3% decrease from the 2021 data



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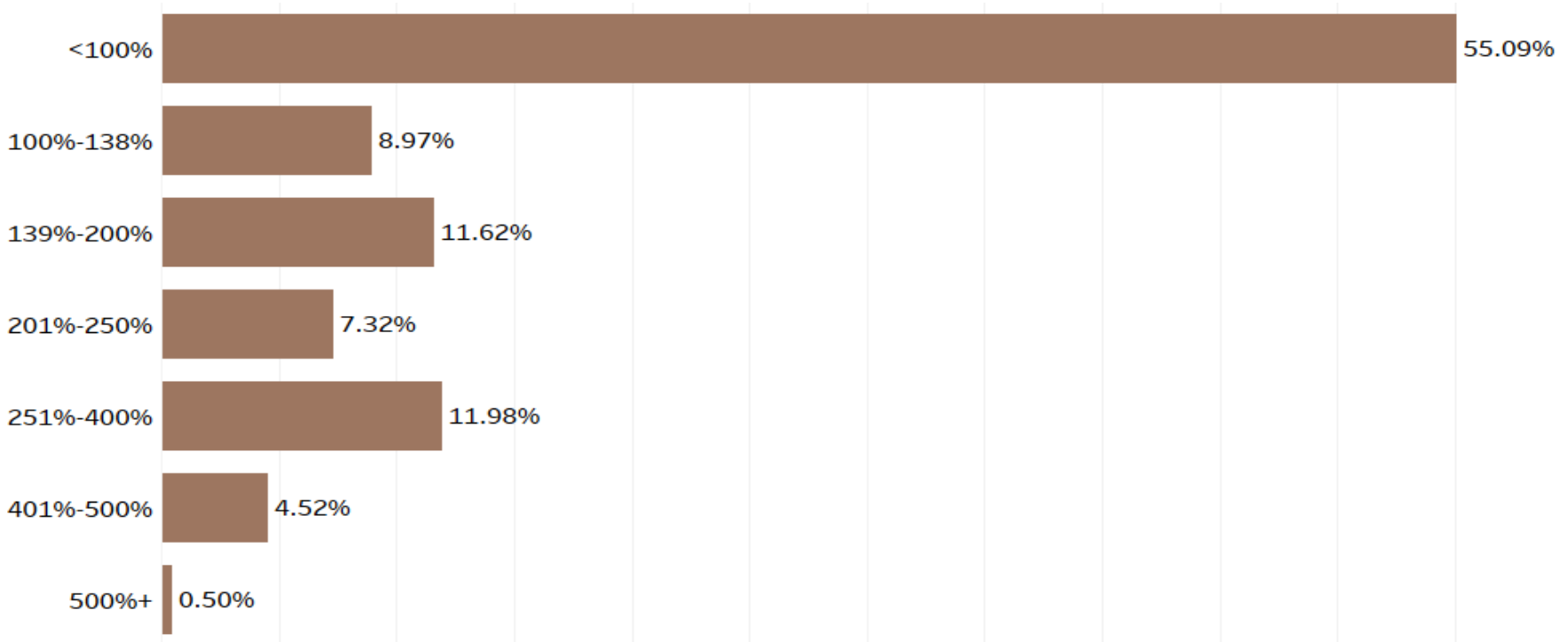
MD Customers Served in 2022 by Known FPL (N= 1394)

- 55% of the MD customers were living at or below 100% FPL, marking a 2% reduction as compared to the 2021 report.



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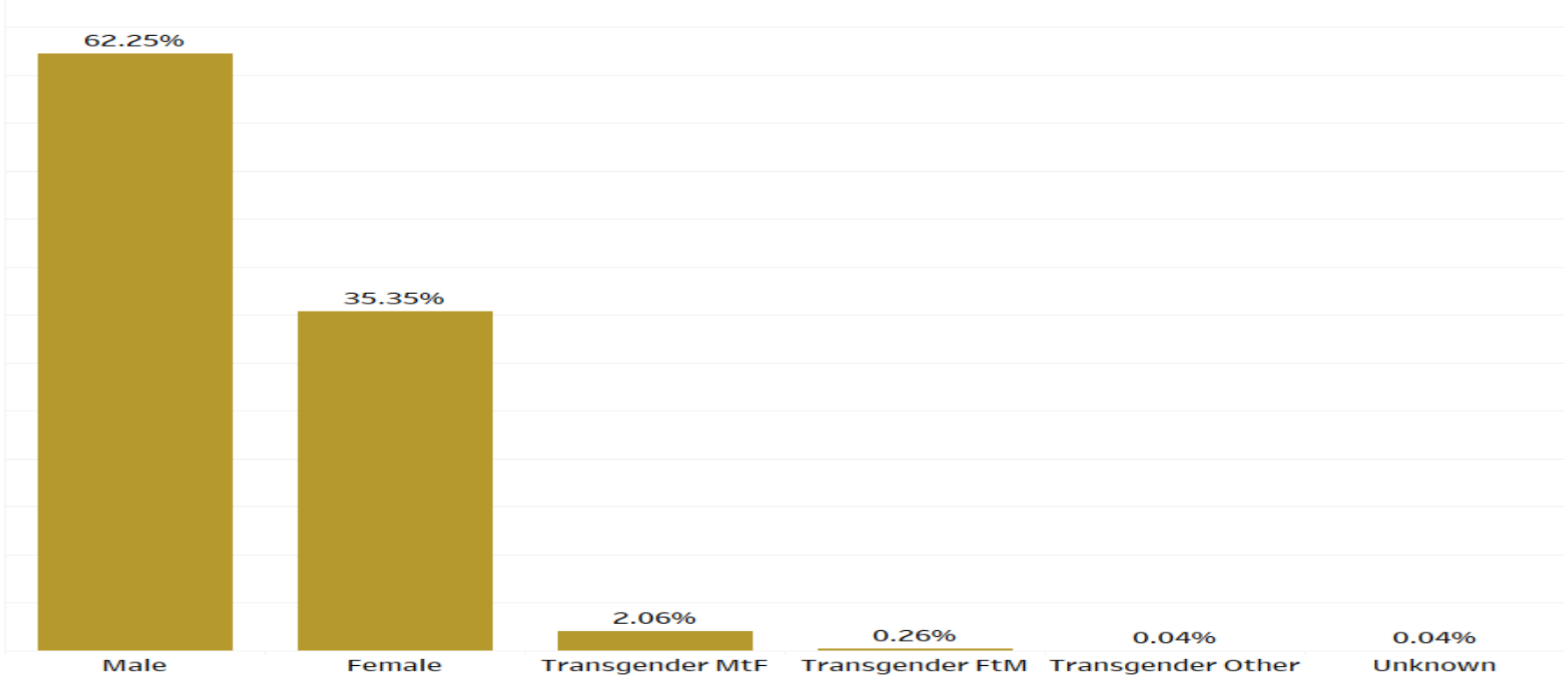
Characteristics of Customers Using RW Services in Virginia (VA)

Total Customers Using RW Services in VA, 2022

- Total number of RW customers in VA is 2,334
- It has shown a 3% increase from the 2021 report.

VA Customers Served in 2022 by Gender (N= 2,334)

- 35% of the VA customers identify as Female



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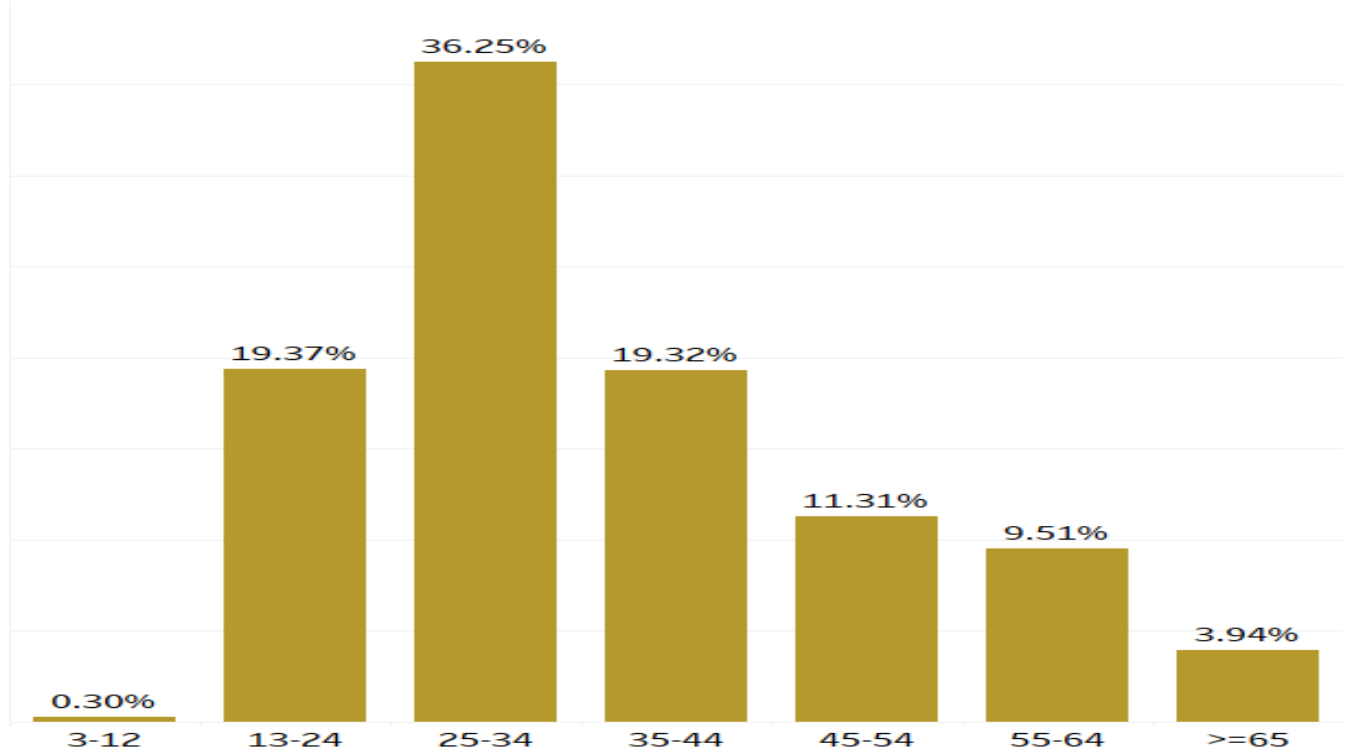
VA Customers Served in 2022 by Age Groups (N= 2,334)

- 36% of the VA customers were in the 25-34 age range.
- 25% were 45 years old or older.



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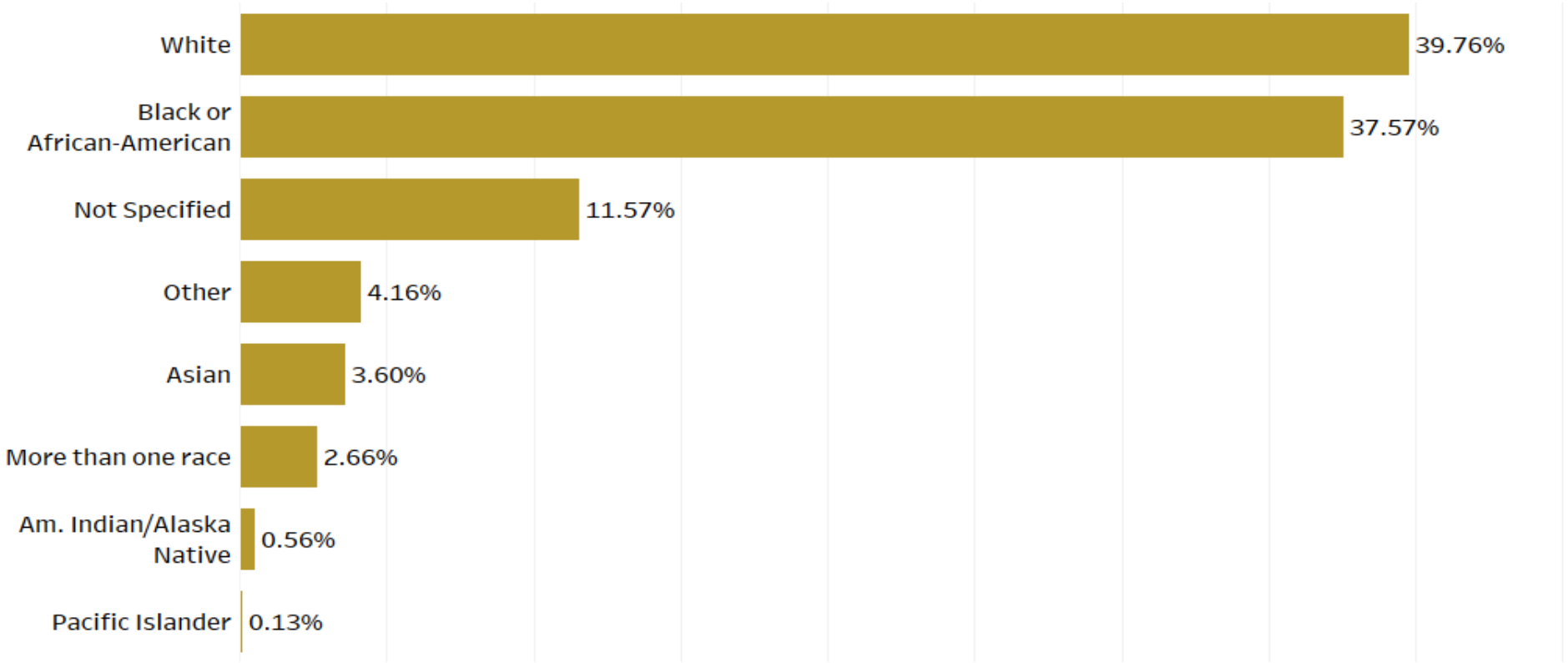
VA Customers Served in 2022 by Race (N= 2,334)

- 38% of the VA customers are African American



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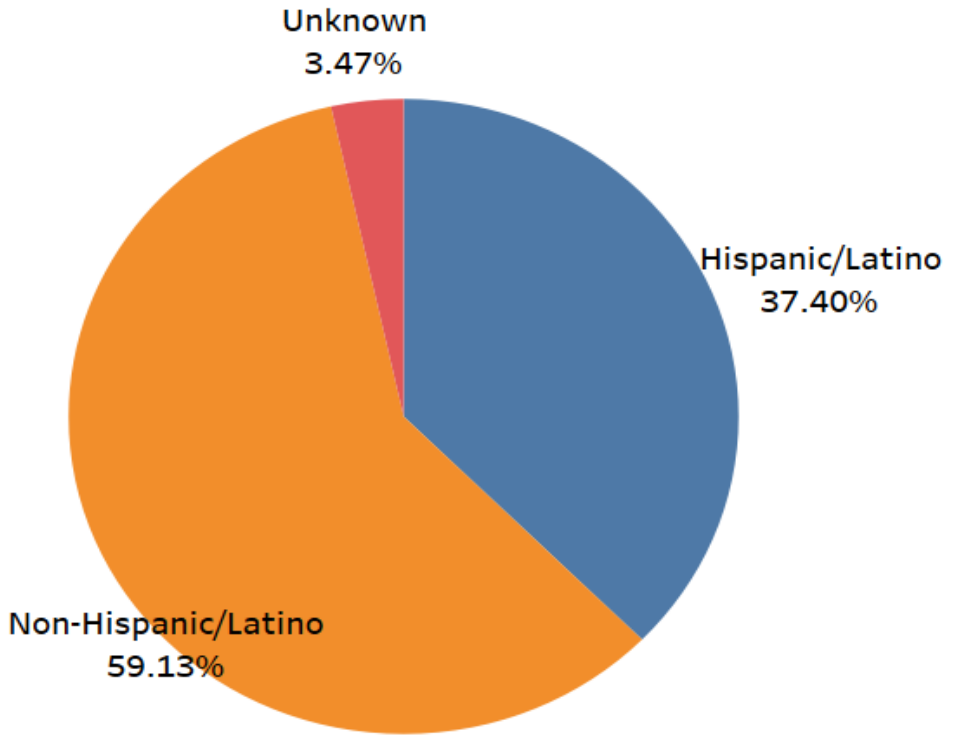
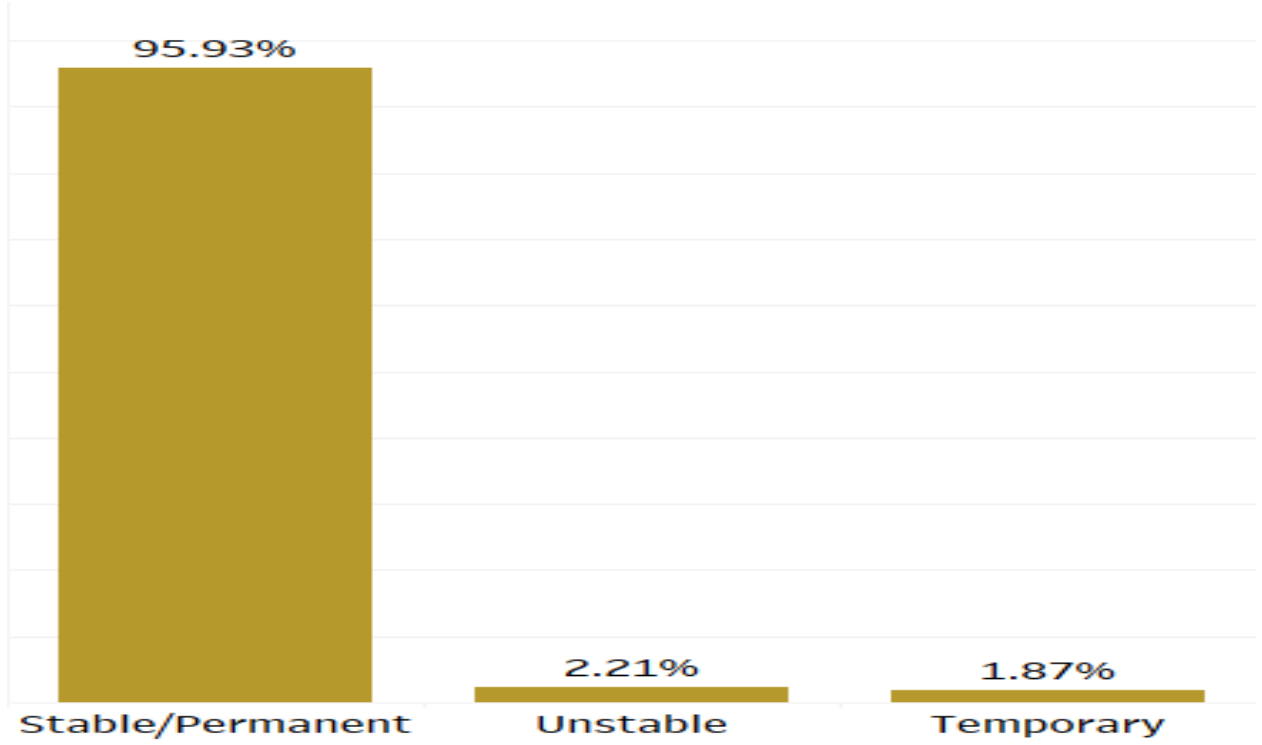
VA Customers Served in 2022 by Ethnicity (N= 2,334)

- 37% of the VA customers are Hispanic/Latino, signifying a 7% rise from 2021 figures.



VA Customers Served in 2022 by Known Housing Status (N= 589)

- 2% of the VA customers had unstable housing



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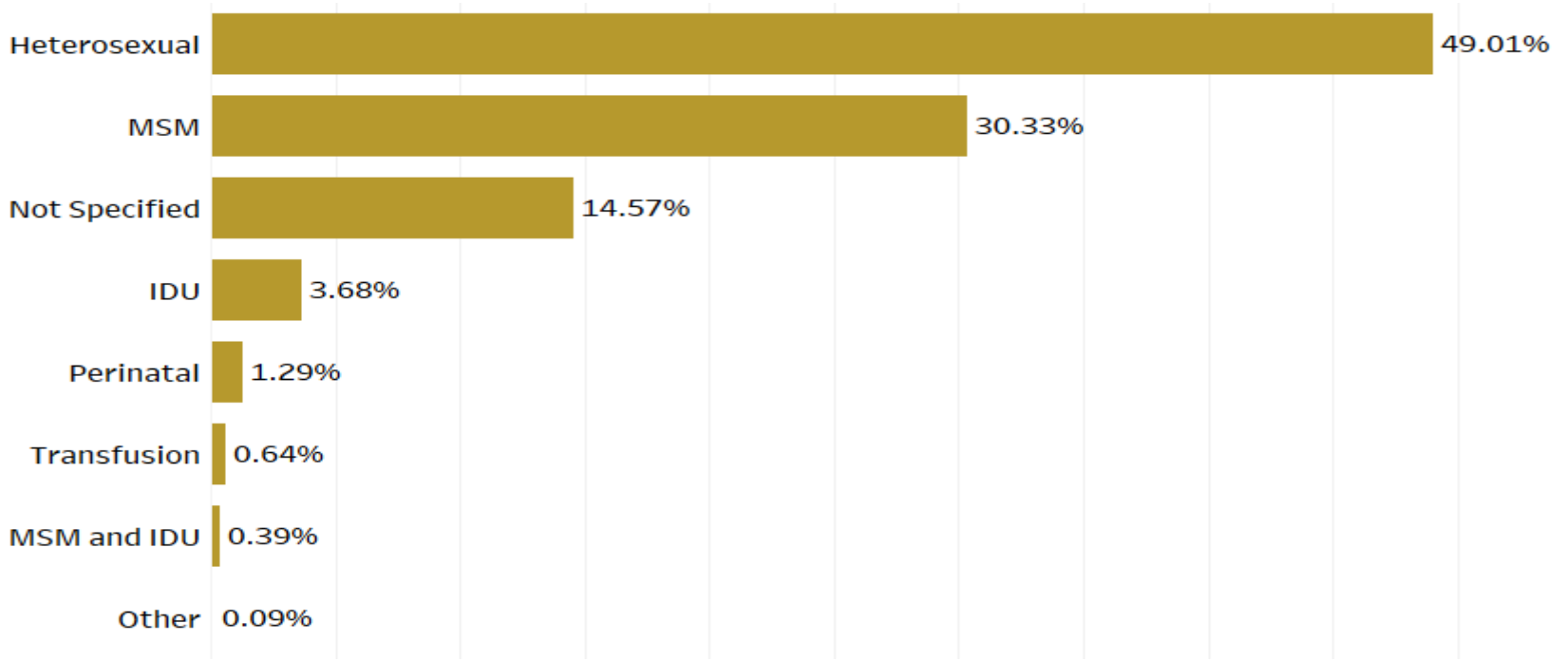
VA Customers Served in 2022 by Risk Factor (N= 2,334)

- Heterosexual contact constitute 49% of the identified risk factors while Men having Sex with Men (MSM) make up 30%.
- MSM as a risk factor has exhibited a 5% increase from 2021 data.



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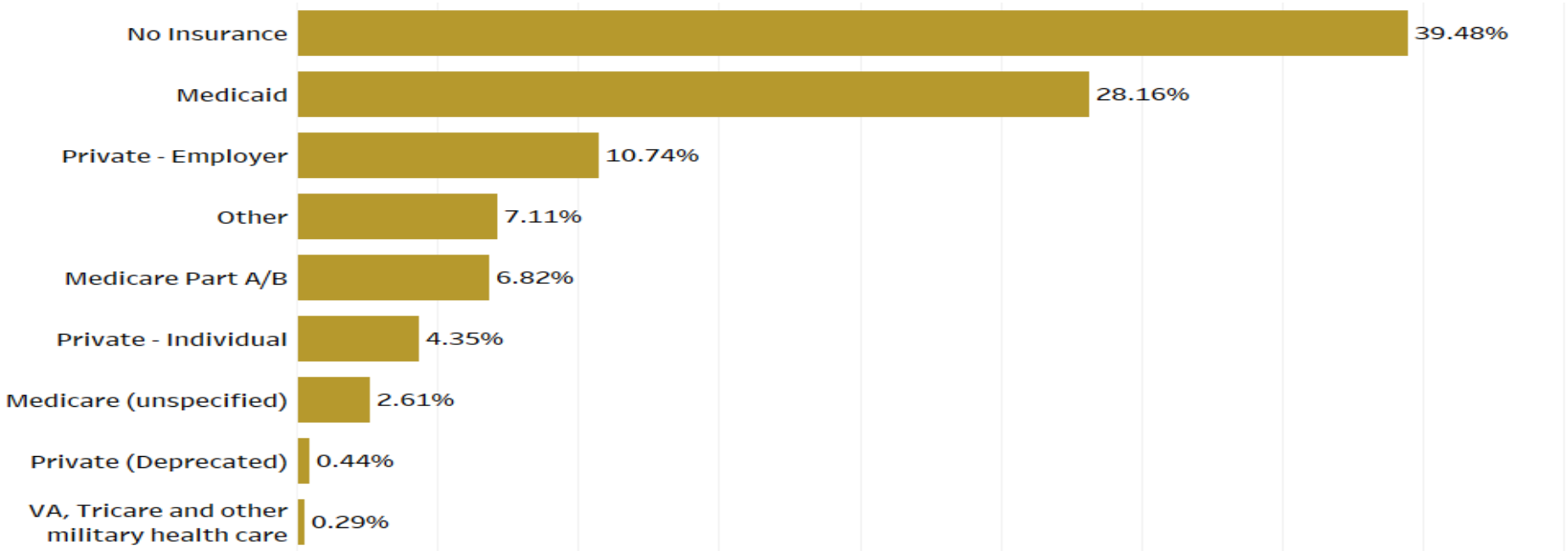
VA Customers Served in 2022 by Known Medical Insurance (N= 689)

- 40% of the customers had no medical insurance, noting 5% decrease from the 2021 data.
- 28% of the customers were Medicaid recipients. reflecting 5% increase from the 2021 data.



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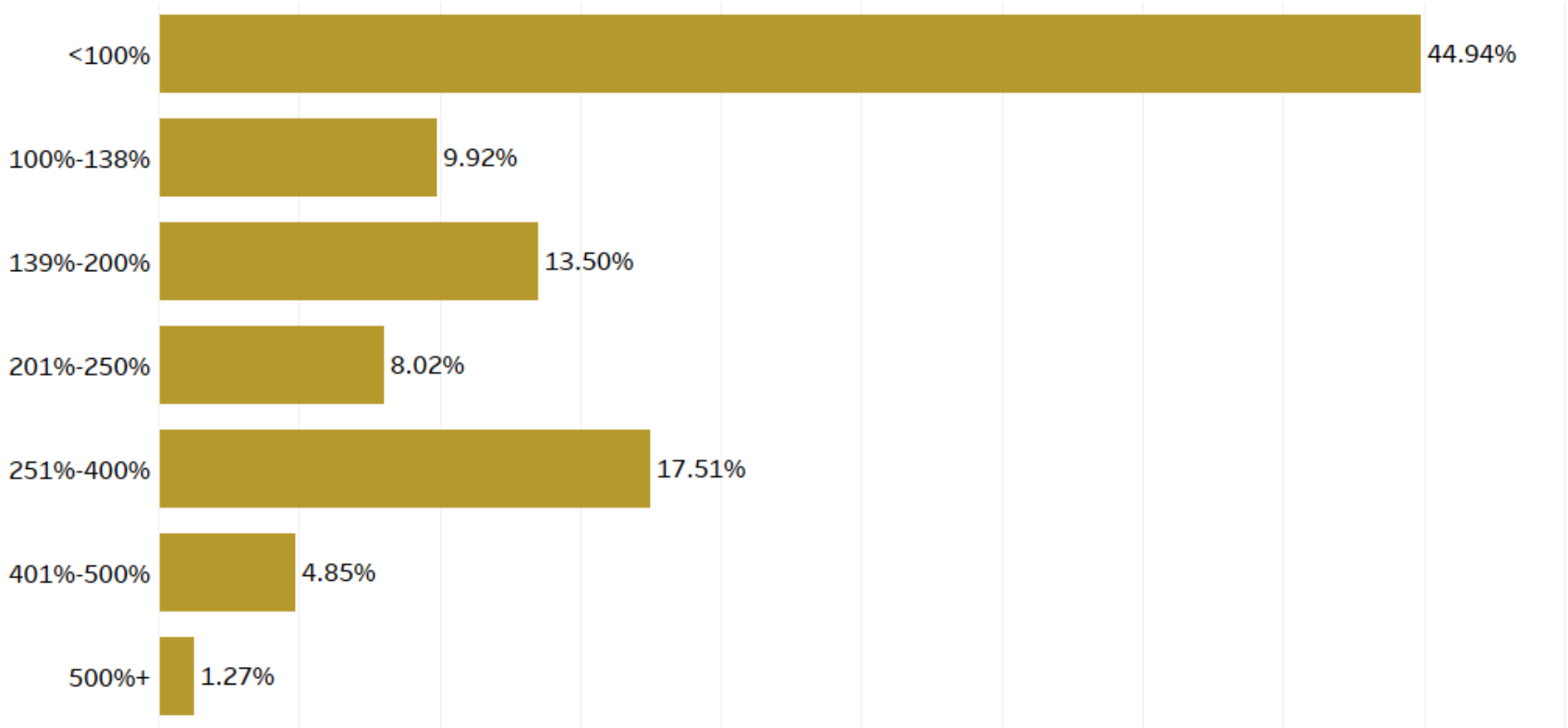
VA Customers Served in 2022 by Known FPL (N= 474)

- 45% of the DC customers were living at or below 100% FPL, demonstrating a 2% decline from the 2021 report



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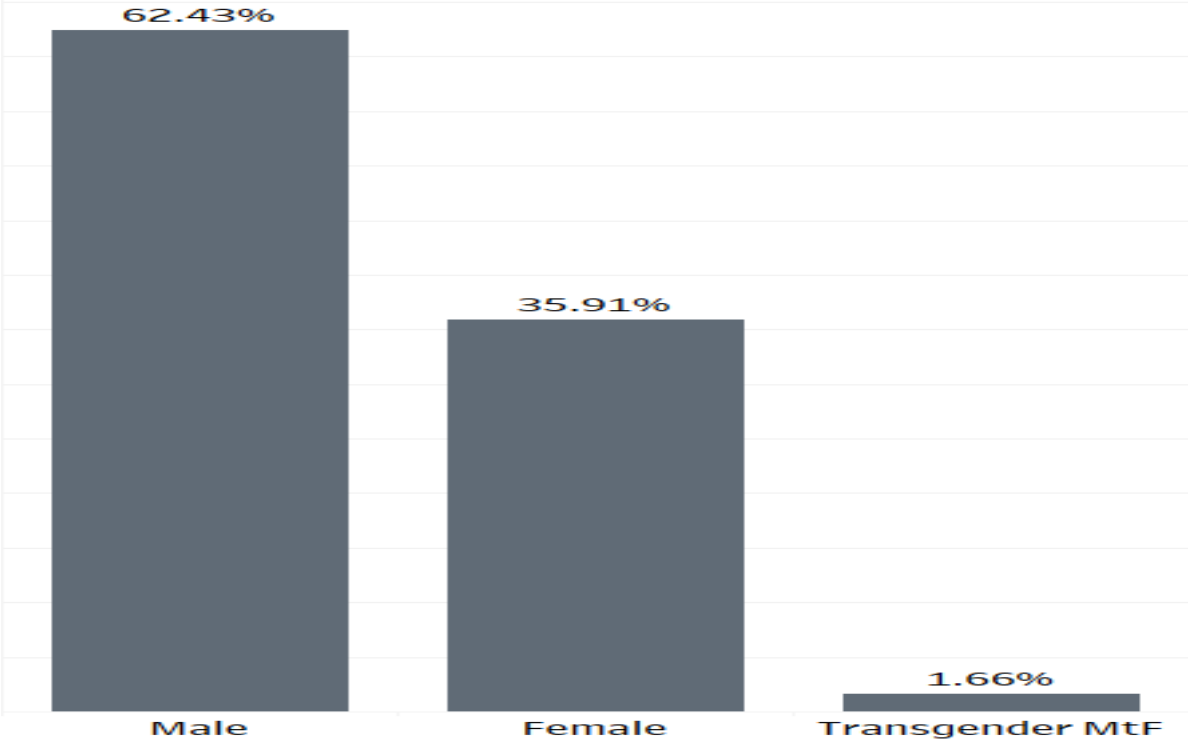
Characteristics of Customers Using RW Services in West Virginia (WVA)

Total Customers Using RW Services in WVA, 2022

- Total number of RW customers in WVA is 181
- It has shown a 5.2% increase from the 2021 report.

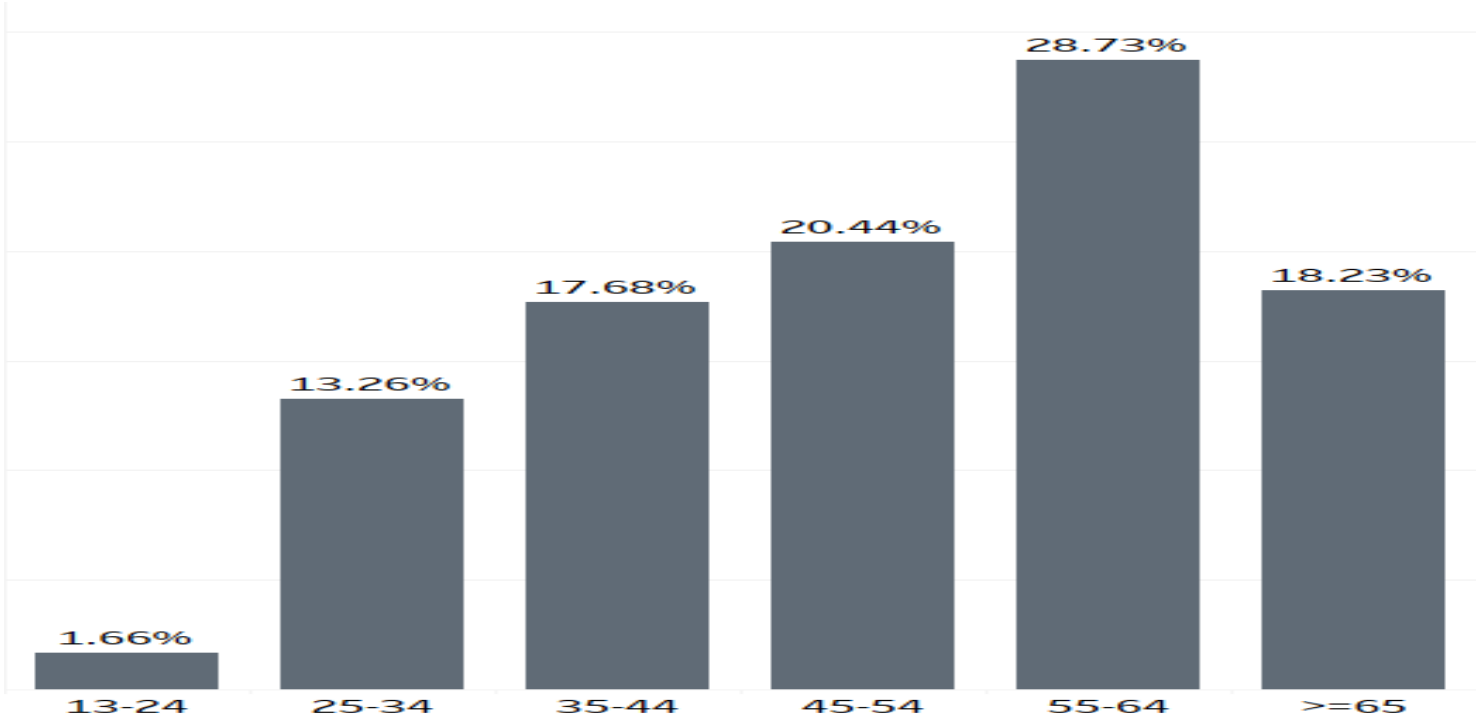
WVA Customers Served in 2022 by Gender (N= 181)

- 36% of the WVA customers identify as Female, indicating a 4% increase from the 2021 report.



WVA Customers Served in 2022 by Age Groups (N= 181)

- 29% of the WVA customers were in the 55-64 age range.
- 67% were 45 years old or older.



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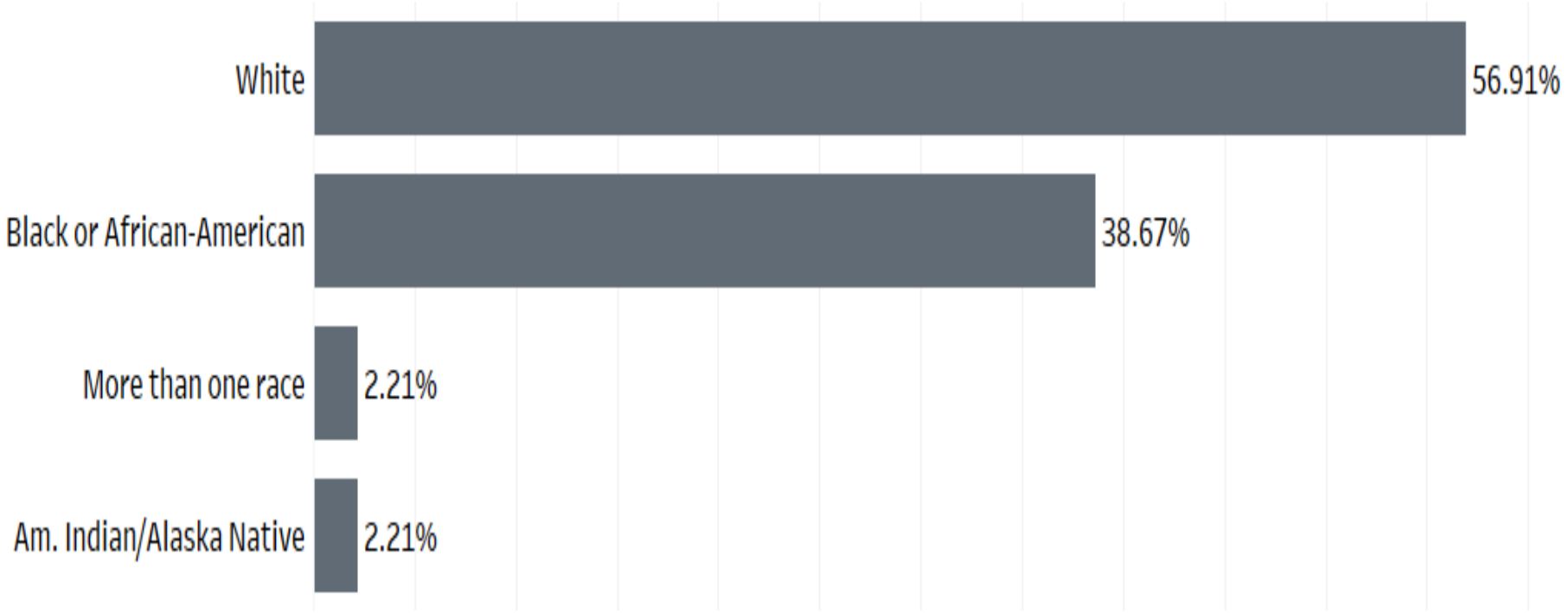
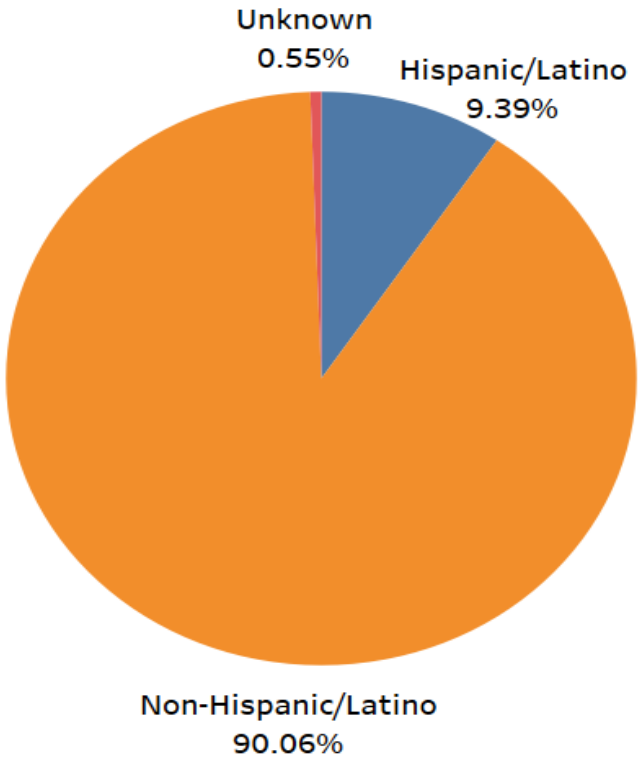
WVA Customers Served in 2022 by Race (N= 181)

- 39% of the WVA customers are African American; indicating a 2% decrease from 2021



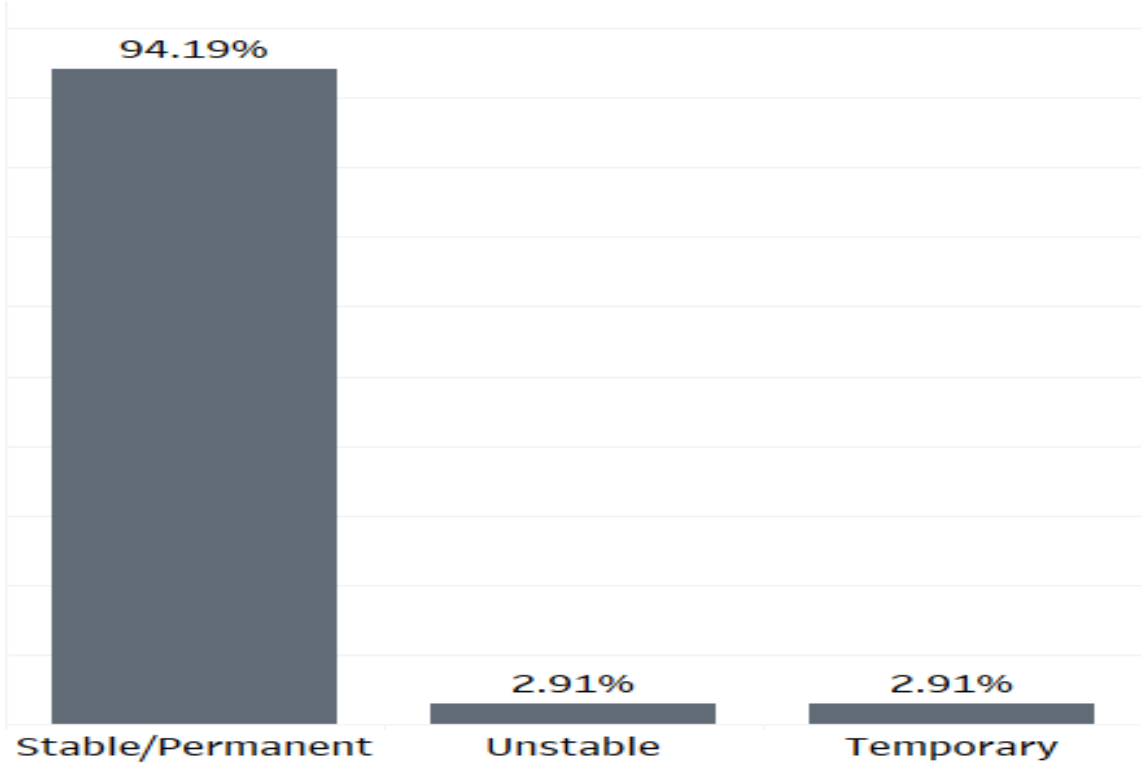
WVA Customers Served in 2022 by Ethnicity (N= 181)

- 9% of the WVA customers are Hispanic/Latino.



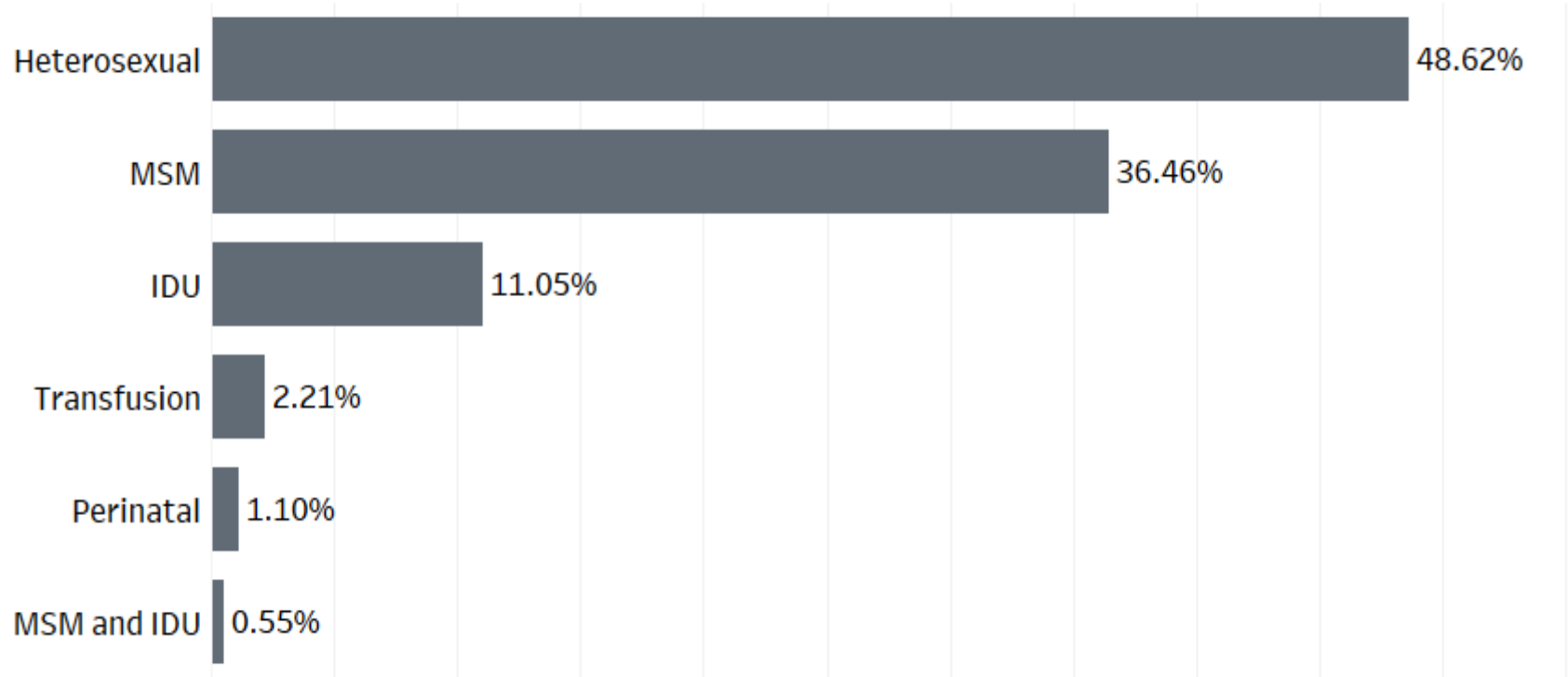
WVA Customers Served in 2022 by Known Housing Status (N= 172)

- 3% of the WVA customers had unstable housing, signifying a 2.3% increase from the 2021 report.



WVA Customers Served in 2022 by Risk Factor (N= 181)

- Heterosexual contact constitute 49% of the identified risk factors, while Men having Sex with Men (MSM) make up 36%.



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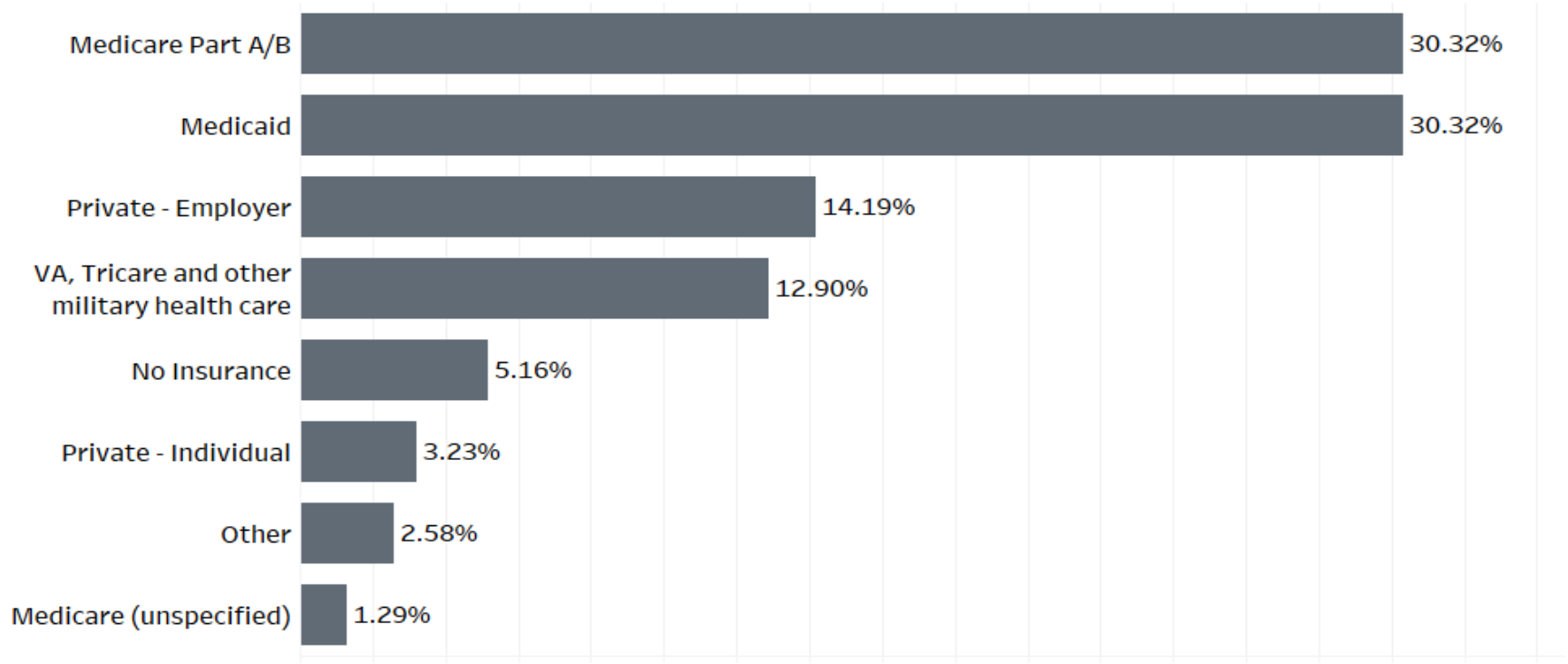
WVA Customers Served in 2022 by Known Medical Insurance (N= 155)

- 30% were Medicaid recipients, while an equal 30% were Medicare recipients.
- 5% of the customers had no medical insurance



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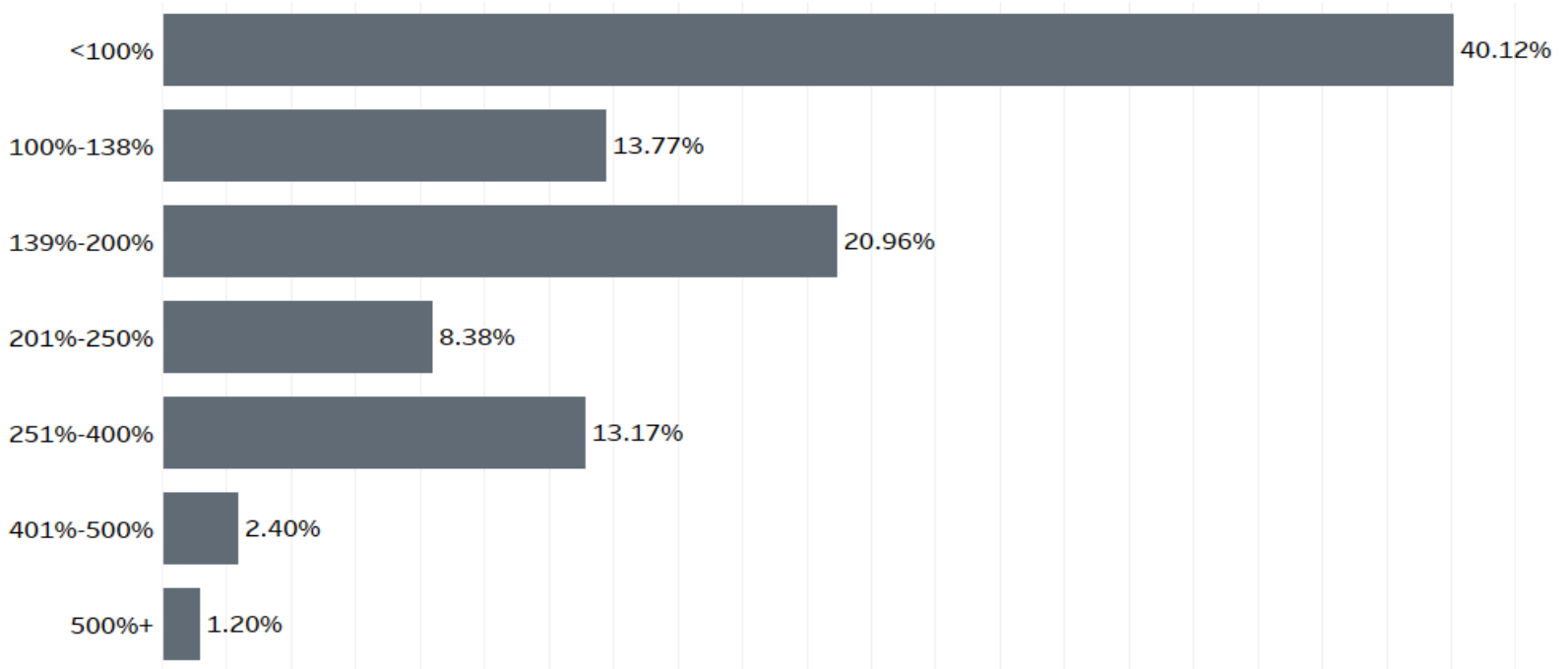
WVA Customers Served in 2022 by Known FPL (N= 167)

- 40% of the DC customers were living at or below 100% FPL, demonstrating a 6% decline from the 2021 report



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This table is an HIV resource inventory which includes public and private funding sources for HIV prevention, care, and treatment services in the DC EMA; the dollar ($) amount of available funds from that source; and allocations across each of the four jurisdictions in the EMA. Data are for the most recent fiscal year available, as indicated. When an organization has a primary focus on a specific population, that is indicated in parentheses. **Because of variations in fiscal year as well as multiple other limitations (as indicated), this should be considered an estimate rather than a precise accounting.**

(1)(a) Jurisdiction	(1)(b) Funding Amount ($) from (1)(a)	Agencies	Notes
Ryan White Part A			
DC	$16,682,784	AIDS Healthcare Foundation, Children's National Medical Center, Community Family Life Services, Damien Ministries, Family & Medical Counseling Services, Food and Friends, Homes for Hope, Housing Counseling Services, Howard University/CIDMAR, Joseph's House, La Clinica del Pueblo, Metro Health, Terrific Inc, The Women's Collective, Unity Health Care, Us Helping Us, Washington Health Institute, Whitman-Walker Health	FY23 allocations to providers Includes MAI.
MD	$3,879,279	AIDS Healthcare Foundation, Children's National Medical Center, Greater Baden Medical Services, Heart to Hand, La Clinica del Pueblo, Medstar Health Research Institute, Montgomery County Health Department, Prince George's County Health Department, SLK Health Services, Us Helping Us	FY23 allocations to providers ($3,879,279).
VA	$2,143,904	Fredericksburg Area HIV/AIDS Support Services, INOVA, Neighborhood Health, NovaSalud, Inc., Virginia Health Options	FY23 allocations to providers Includes MAI.
WV	$402,454	Shenandoah Valley Medical System	FY23
Fee for value/value enhancement	$5,375,352		Funds available across EMA
RW Part A EMA Total	**$28,483,773**		
Ryan White Part B - excluding ADAP			
DC	$2,455,870	Children's National Medical Center, Family & Medical Counseling Services, Howard University/CIDMAR, Metro Health, Unity Health Care, Us Helping Us, Washington Health Institute, Whitman-Walker Health	GY33 allocations to subgrantees
MD	$1,445,770	Charles County Health Department, Children's National Medical Center, Frederick County Health Department, Montgomery County Health Department, Us Helping Us	SFY24 Part B base and MAI allocations to EMA ($1,445,770); plus prorated share of state MADAP (state total $47,470,361)
VA	$7,072,329	Fredericksburg Area HIV/AIDS Support Services, INOVA, Legal Services of Virginia, Mary Washington Healthcare, Neighborhood Health, Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC), NovaSalud, Inc., Virginia Health Options (VHO)	GY23 Part B allocations: $7,072,329 (incl Rapid Start). VA does not receive MAI
WV	$105,101	AIDS Task Force	4/1/22-3/31/23. WV does not receive MAI. Incl $43,993 Dental $10,525 food $15,075 MCM $31,298 Out-patient Ambulatory Care $4,210 bus passes
RW Part B EMA Total	**$11,079,070**		

Ryan White ADAP			
DC	$10,758,401		4/1/23-3/31/24 total ADAP award
MD	$19,615,094		Prorated share of state MADAP (state total $47,470,361)
VA	$5,321,582		GY23 ADAP for EMA: $5,321,582.
WV	$384,620		4/1/22-3/31/23.
RW Part ADAP Total	**$36,079,697**		
Ryan White Part C EIS and Capacity Development			
DC	$2,248,879	Family & Medical Counseling Services, Howard University/CIDMAR, Unity Health Care, Whitman-Walker Health	FY22 (last full fiscal year available on Taggs)
MD	$683,380	Daydream Sunshine Initiative, Medstar Health Research Institute	FY22 last full fiscal year available on Taggs)
VA	$741,777	INOVA, Mary Washington Healthcare	FY22 last full fiscal year available on Taggs)
WV			
RW Part C EMA Total	**$3,674,036**		
Ryan White Part D			
DC			
MD	$368,266	Medstar Health Research Institute	FY23
VA	$585,866	INOVA	FY23
WV			
RW Part D Total	**$954,132**		
RW EMA TOTAL	**$80,270,708**		
EtE Awards to HDs (HRSA and CDC combined)			
DC	$4,068,127	DC DOH, DHCF	FY23. Incl $3,755,939 from HRSA for EMA minus $2,312,690 to Mont & PG Counties; plus $2,624,878 from CDC for DC DHCF
MD	$5,354,274	Montgomery County Health Department, Prince George's County Health Department	FY23. $2,312,690 HRSA via DC EMA; plus $3,041,584 CDC EHE via MDH
VA	$0		not EtE jurisdiction
WV	$0		not EtE jurisdiction
EtE HDs EMA total	**$9,422,401**		
EtE TOTAL	**$9,422,401**		
CDC HIV Prevention and Surveillance			

DC	$10,050,462	Family Medical Counseling Services, HealthHIV, HBI-DC, HIPS, La Clinica Del Pueblo, Latin American Youth Center, The Women's Collective, Us Helping Us, Washington Health Institute, Whitman-Walker Health	FY23. Includes Integrated Surveillance and Prevention; and de-duplication at DOH, plus Community to Care surv at Whitman-Walker
MD	$1,904,733		State FY24, allocations to EMA
VA	$1,167,690	Chris Atwood Foundation, Fredericksburg Area HIV/AIDS Support Services, INOVA Health System, NovaSalud, Fairfax Health District	$763,301 prevention grants, plus $316,851 testing grants, plus surveillance prorated to EMA
WV	$146,279		FY23 award to state prorated to EMA
CDC Prevention and Surveillance EMA Total	**$13,269,164**		
CDC HIV CBOs			
DC	$883,249	La Clinica del Pueblo, Whitman-Walker	FY23
MD			
VA	$400,000	INOVA	FY23. Mary Washington Hosp./Medicorp Health
WV			
CDC CBOs EMA Total	**$1,283,249**		
CDC HIV School Health			
DC	$467,500	Components One and Two School-Based HIV/STI Prevention Program; YRBS	FY23. $380,000 to DC Board of Ed; $87,500 re YRBS to DC Gov
MD	$41,194		FY23 award to state prorated to EMA
VA	$33,194		FY23 award to state prorated to EMA
WV	$11,352		FY22 award to state prorated to EMA
CDC schools EMA Total	**$553,241**		
CDC EMA Total	**$15,105,653**		
SAMHSA Direct Awards			
DC	$775,000	La Clinica del Pueblo, for Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities and for TCE-HIV: High-Risk Populations	FY22 awards
MD	$0		
VA	$0		
WV	$0		
SAMHSA block grant EMA Total	**$775,000**		
SAMHSA Block Grant Set Aside			
DC	$376,515		FY23 set aside total

MD	$710,056	County Health Departments	FY22 set aside ($1,718,401)prorated to EMA
VA	$0		no set aside in state
WV	$0		no set aside in state
SAMHSA block grant EMA Total	**$1,086,571**		
HOPWA Formula			
DC	$6,902,719	Community Family Life Services, Homes for Hope, Housing Counseling Services, DC Housing Authority (also covers Montgomery County and Prince George's County in Maryland)	FY23 allocation
MD	$4,052,142	Prince George's, Calvert, Charles, Frederick, and Montgomery Counties	State FY24 allocation from Maryland $1,852,142 plus $2,200,000 from DC
VA	$2,600,000	Arlington County, Fredericksburg Area HIV/AIDS Support Services, Homestretch (homeless families), Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC)	FY23 allocation to NVRC from DC
WV	$153,306	Community Networks, Inc.	FY23 from WV to Berkeley and Jefferson $98,306 + $55,000 from DC EMSA
HOPWA EMA	**$13,708,167**		
HRSA Bureau of Primary Health Care (times HIV prevalence among patients)			
DC	$1,852,891	Bread for the City, Community of Hope, Elaine Ellis Center of Health, Family & Medical Counseling Services, La Clinica del Pueblo, Mary's Center, Unity Health Care, Whitman-Walker Health	2023 awards (most recent avail) times clinic HIV prevalence levels in 2021 (most recent available).
MD	$77,256	Mobile Medical Care, City of Frederick, Greater Baden Medical Services, Community Clinc	see above
VA	$79,387	Greater Prince William Community Health Center, Loudoun Community Health Center, Neighborhood Health	see above
WV	$37,021	Shenandoah Valley Medical System	see above
BPHC EMA Total	**$2,046,555**		
Other Federal Grant EMA Total	**$16,841,293**		
State appropriations plus special funds			
DC	$8,883,000		Budget FY2023 tables: HAHSTA local (dedicated taxes) minus TB and STD specific lines = $3,883,000 https://app.box.com/s/cqxt49zq0uvvmgggpxmpavbsiat2rsn8/file/1261871536896 Plus $5M "federal payment"
Maryland	$9,430,304		SFY24 Ryan White Part B state special funds
VA	$0		
West Virginia	$0		
State Funding EMA Total	**$18,313,304**		
Medicaid			

DC	$265,806,982		DHCF FY17 expenditures, FFS ($139,733,965.16) +
MD	$106,441,809		Using April 2017 enrollment and capitation figures with 2018 EMA prev data; no update available.
VA	$17,517,645		FY2013 (most recent avail) KFF state estimate ($56,511,167) prorated by cases within the EMA
WV	$544,929		No update available 2018. Statewide (2015; most recent): $3,707,000, prorated to EMA
Medicaid EMA Total	**$390,311,365**		
DC Alliance and Immigrant Kids			
	$2,847,301		DHCF FY17.
Alliance and Immigrant Kids Total	**$2,847,301**		
Medicare			
Medicare	**$363,699,808**		$11,300B Medicare Spending for HIV/AIDS in US in FY2022 (most recent
Medicare EMA Total	**$363,699,808**		
Veterans Health Administration			
VHA	$49,586,406	Based on 2013 enrollment and 2019 expenditure data.	ROUGH ESTIMATE based on proportion of national VHA clients receiving HIV care in DC and total VA HIV
VHA EMA Total	**$49,586,406**		
EMA INSURANCE AND VHA Total	**$806,444,880**		
TOTAL EMA FUNDING	**$946,398,240**		

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Washington DC EMA Financial Inventory: 2023 Update

Naomi Seiler
Greg Dwyer
Washington DC COHAH

August 24, 2023

Thank you

DC HIV/AIDS, Hepatitis, STD and TB Administration:

- Julie Orban, HIV Services Planner

Maryland Department of Health:

- Peter DeMartino
- Bruno Benavides, Center Chief, Center for HIV Prevention and Health Services
- Ashley Price, Public Health Analyst, Care and Treatment Division
- Hope Cassidy-Stewart, Ending the HIV Epidemic Director

Virginia Department of Health:

- Ashley Yocum, Care Services Planner, Division of Disease Prevention

West Virginia Department of Health and Human Resources:

- Jay Adams, HIV Care Coordinator
- Henry Hatfield, Housing Programs Manager

Outline

- Why create this inventory?
- Overview of inventory
- Key visualizations
- Questions

Impetus for inventory

HRSA/CDC Integrated plan required “financial inventory” of:

(1) public and private funding sources for HIV prevention, care, and treatment services in the jurisdiction,

(2) the dollar amount and the percentage of the total available funds in fiscal year (FY) 2016 for each funding source;

(3) how the resources are being used (i.e., services delivered); and

(4) which components of HIV prevention programming and/or steps of the HIV Care Continuum is (are) impacted

“While it may be a challenge to capture all public and private investments in HIV prevention and care services in the service area, planners should make reasonable efforts to identify existing resources in the jurisdiction.”

https://hab.hrsa.gov/sites/default/files/hab/Global/hivpreventionplan062015.pdf

Updated Inventory

- HAHSTA has requested annual updates since, both for the Part A application and, when helpful, to inform PSRA process

Inventory contents - federal

- Ryan White (by Part)
- EtE (from HRSA and from CDC)
- CDC
  - Prevention and Surveillance
  - Direct funding to CBOs
  - School Health
- SAMHSA
  - Direct grants
  - Block grant HIV set-aside
- HOPWA
- HRSA Bureau of Primary Health Care

Inventory contents - additional

- State dollars
  - Appropriations
  - “Special funds” (Maryland)
- Medicaid and related programs (old, rough estimate)
- Medicare (rough estimate)
- VA (rough estimate)

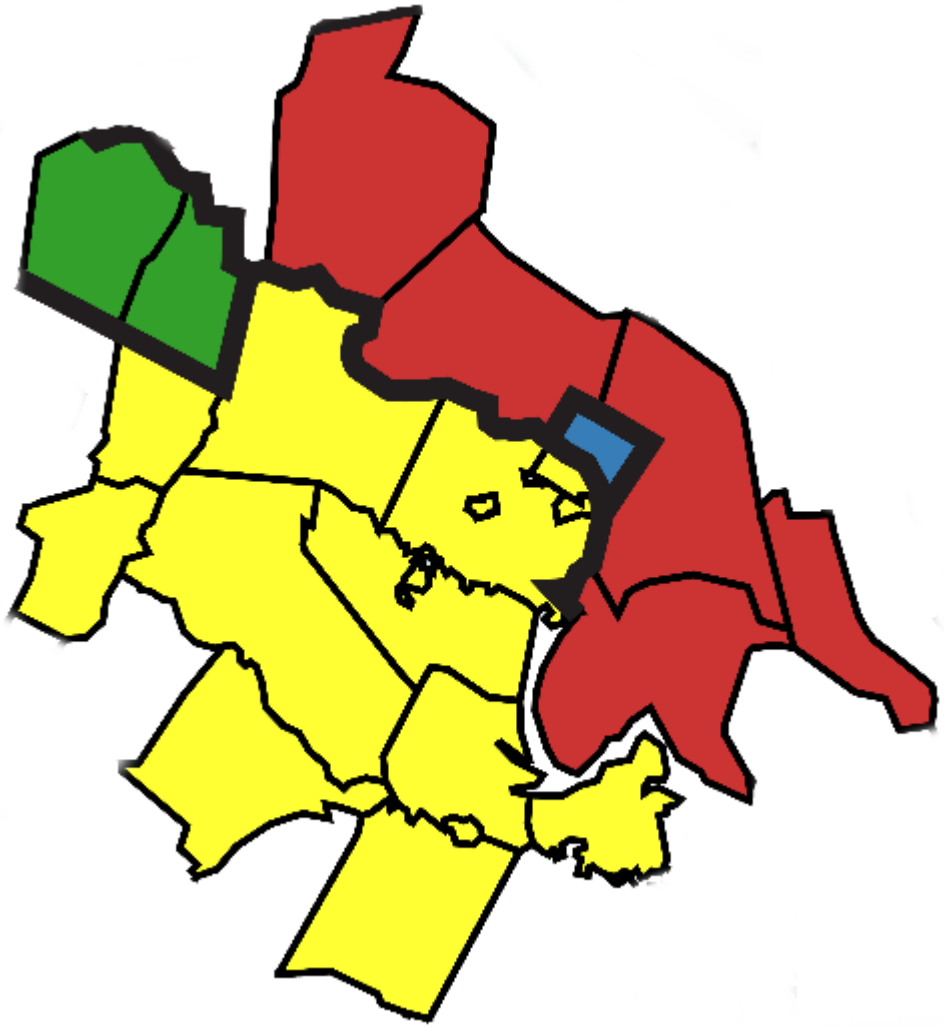
Scope and limitations

- GW attempted to identify all funding for HIV prevention, care or treatment in the EMA
- Some could be allocated by county; other required rough estimates
- Different categories use different years (fiscal, calendar, etc.) and different types of figures (awards, expenditures)
- Not all FY23 figures are available yet
- Some large but important categories unavailable (e.g. private insurance).

This information reflects a general overview of resources available, not an exact accounting.

←THIS

NOT
THAT→



DC EMA

Proportion of PLWH Who Reside in EMA, FY22

State	EMA Cases	State Cases	Proportion living in EMA
Maryland	13,059	31,604	**41.3%**
Virginia	8,360	26,969	**31.0%**
West Virginia	279	2,089	**13.4%**

Where only statewide funding was available, EMA-level estimates were calculated by multiplying statewide funding by the proportion of PLWH in the state who reside in the EMA.

Example from Inventory: RW Part A

(1)(a) Jurisdiction	(1)(b) Funding Amount ($) from (1)(a)	Agencies	Notes
Ryan White Part A			
DC	$16,682,784	AIDS Healthcare Foundation, Children's National Medical Center, Community Family Life Services, Damien Ministries, Family & Medical Counseling Services, Food and Friends, Homes for Hope, Housing Counseling Services, Howard University/CIDMAR, Joseph's House, La Clinica del Pueblo, Metro Health, Terrific Inc, The Women's Collective, Unity Health Care, Us Helping Us, Washington Health Institute, Whitman-Walker Health	FY23 allocations to providers Includes MAI.
MD	$3,879,279	AIDS Healthcare Foundation, Children's National Medical Center, Greater Baden Medical Services, Heart to Hand, La Clinica del Pueblo, Medstar Health Research Institute, Montgomery County Health Department, Prince George's County Health Department, SLK Health Services, Us Helping Us	FY23 allocations to providers ($3,879,279).
VA	$2,143,904	Fredericksburg Area HIV/AIDS Support Services, INOVA, Neighborhood Health, NovaSalud, Inc., Virginia Health Options	FY23 allocations to providers Includes MAI.
WV	$402,454	Shenandoah Valley Medical System	FY23
Fee for value/value enhancement	$5,375,352		Funds available across EMA
RW Part A EMA Total	**$28,483,773**		

Example: Part C and D Awards

Ryan White Part C EIS and Capacity Development			
DC	$2,248,879	Family & Medical Counseling Services, Howard University/CIDMAR, Unity Health Care, Whitman-Walker Health	FY22 (last full fiscal year available on Taggs)
MD	$683,380	Daydream Sunshine Initiative, Medstar Health Research Institute	FY22 last full fiscal year available on Taggs)
VA	$741,777	INOVA, Mary Washington Healthcare	FY22 last full fiscal year available on Taggs)
WV			
RW Part C EMA Total	**$3,674,036**		
Ryan White Part D			
DC			
MD	$368,266	Medstar Health Research Institute	FY23
VA	$585,866	INOVA	FY23
WV			
RW Part D Total	**$954,132**		

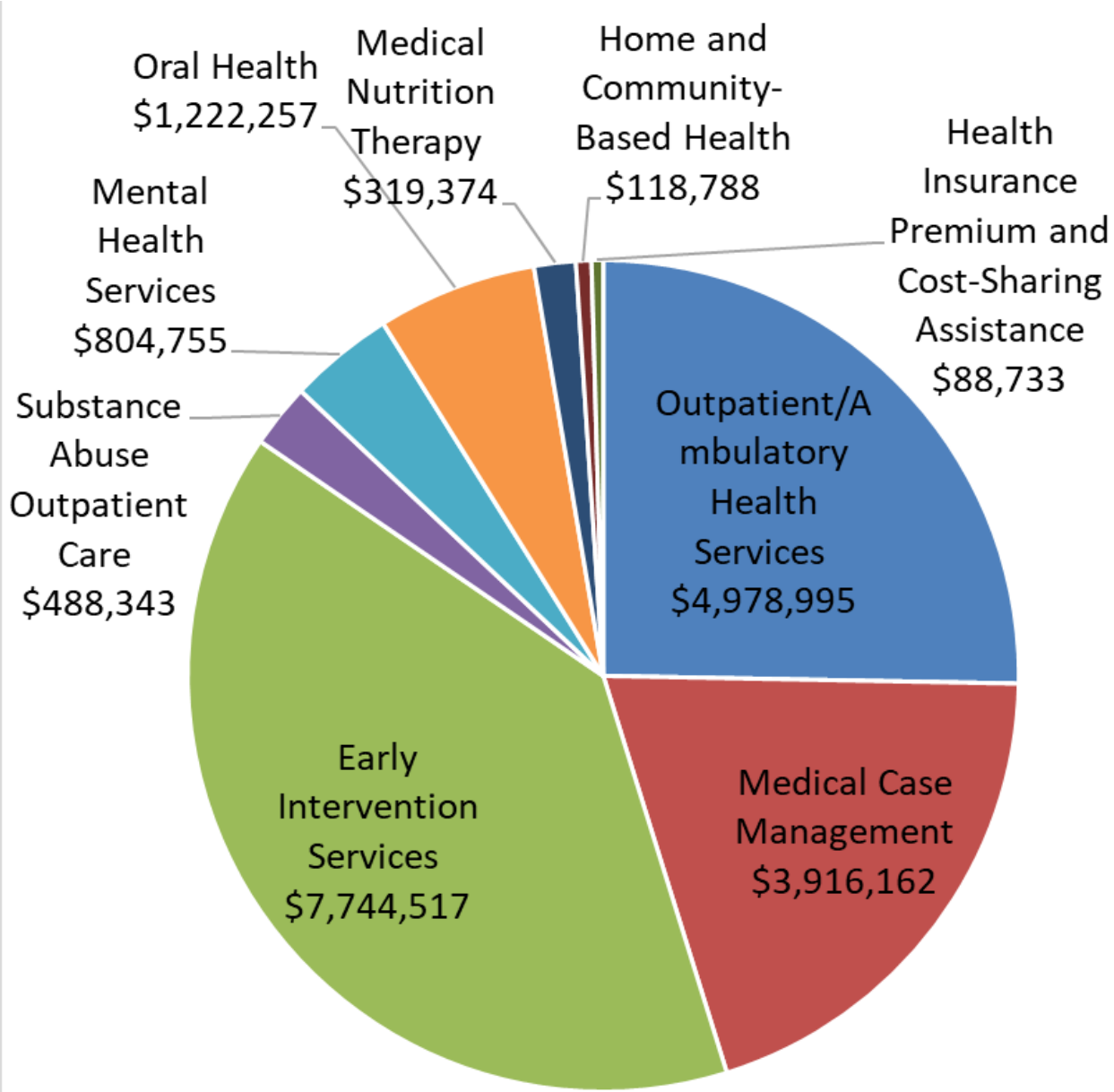
Example: SAMHSA Awards

SAMHSA Direct Awards			
DC	$775,000	La Clinica del Pueblo, for Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities and for TCE-HIV: High-Risk Populations	FY22 awards
MD	$0		
VA	$0		
WV	$0		
SAMHSA block grant EMA Total	**$775,000**		
SAMHSA Block Grant Set Aside			
DC	$376,515		FY23 set aside total
MD	$710,056	County Health Departments	FY22 set aside ($1,718,401)prorated to EMA
VA	$0		no set aside in state
WV	$0		no set aside in state
SAMHSA block grant EMA Total	**$1,086,571**		

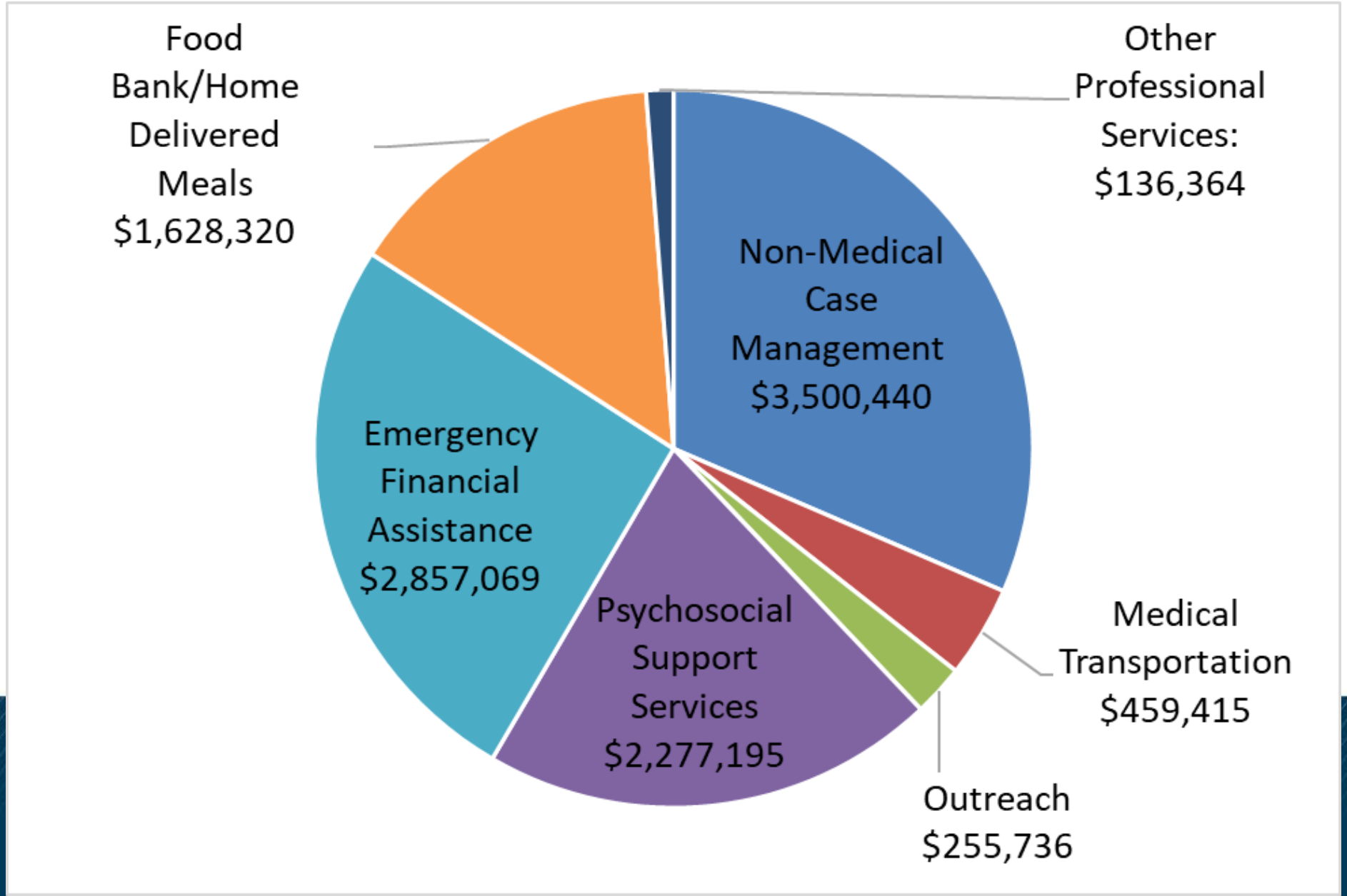
Example: HOPWA totals

HOPWA Formula			
DC	$6,902,719	Community Family Life Services, Homes for Hope, Housing Counseling Services, DC Housing Authority (also covers Montgomery County and Prince George's County in Maryland)	FY23 allocation
MD	$4,052,142	Prince George's, Calvert, Charles, Frederick, and Montgomery Counties	State FY24 allocation from Maryland $1,852,142 plus $2,200,000 from DC
VA	$2,600,000	Arlington County, Fredericksburg Area HIV/AIDS Support Services, Homestretch (homeless families), Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC)	FY23 allocation to NVRC from DC
WV	$153,306	Community Networks, Inc.	FY23 from WV to Berkeley and Jefferson $98,306 + $55,000 from DC EMSA
HOPWA EMA	**$13,708,167**		

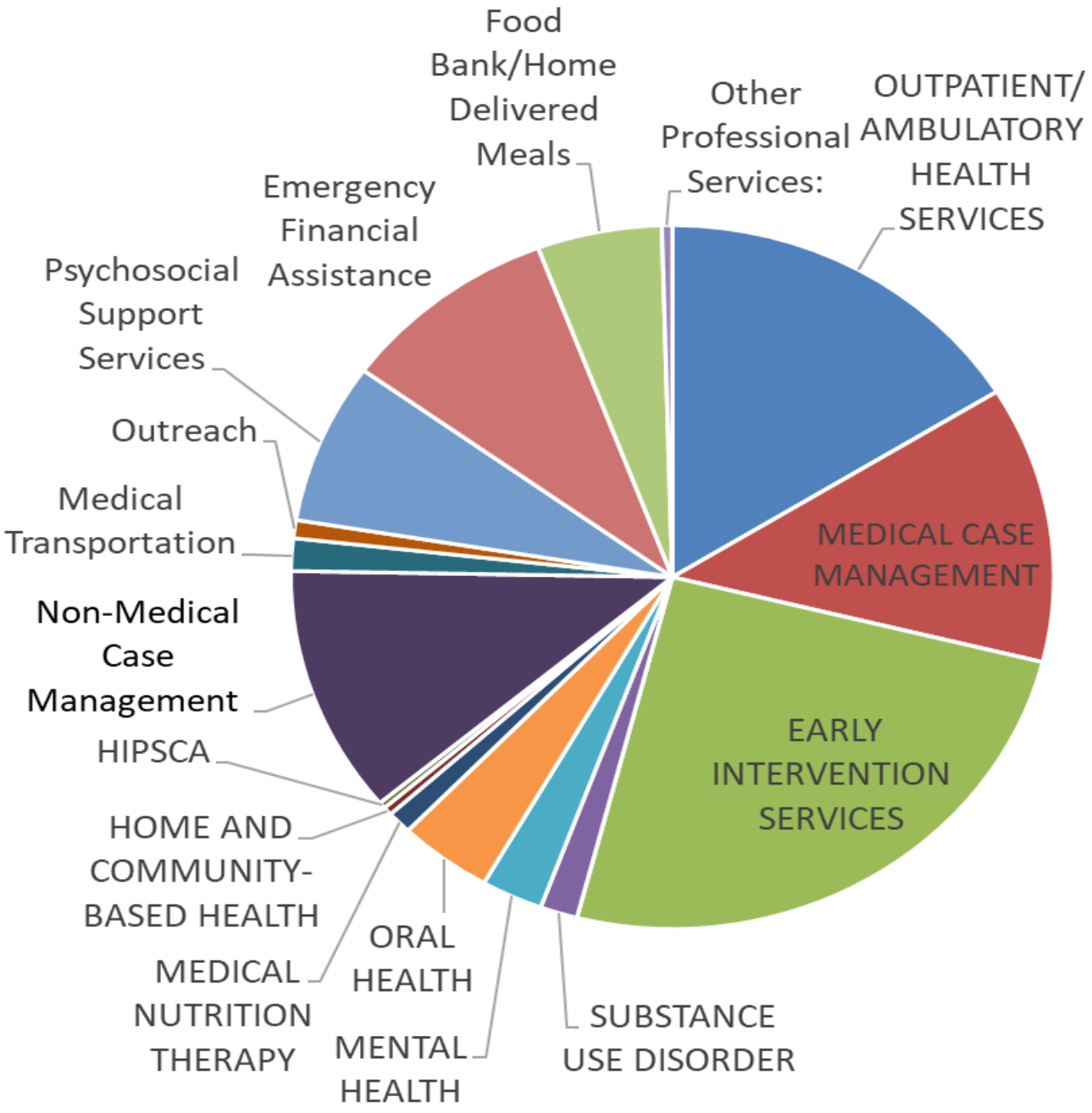
FY23 EMA Part A: Core Medical (incl HRSA EtE and MAI)



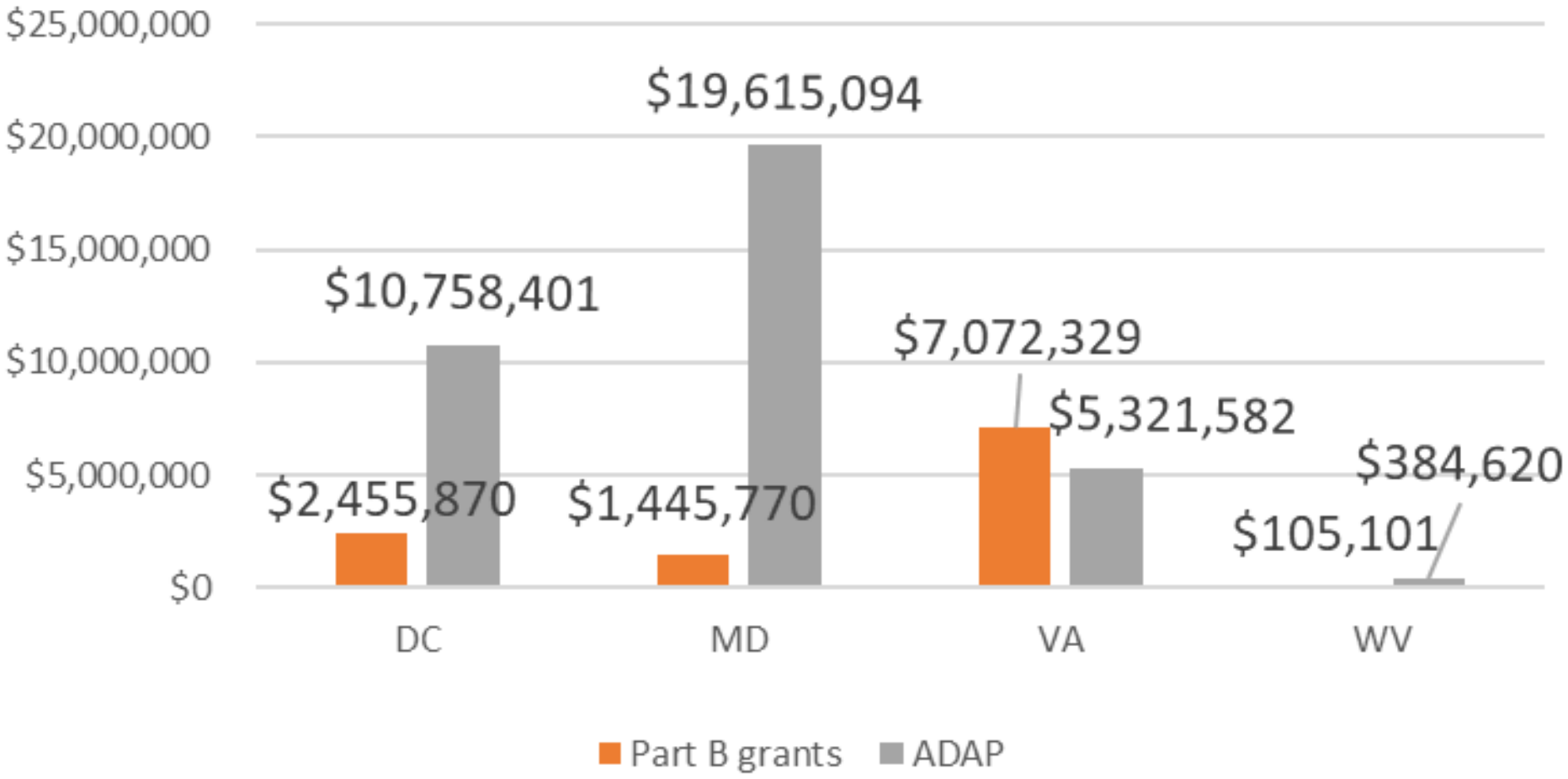
FY23 EMA Part A: Support Services (incl HRSA EtE & MAI)



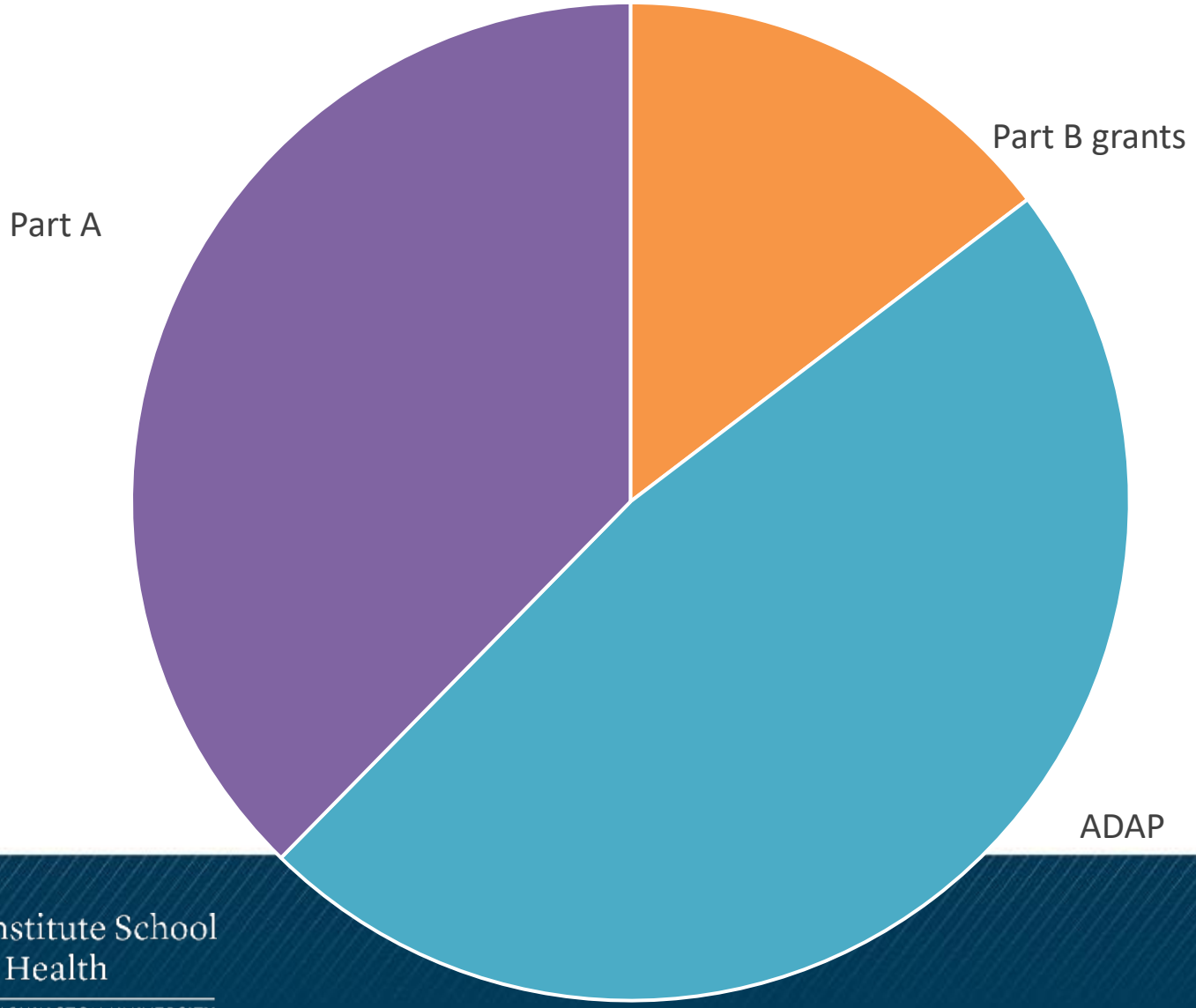
FY23 EMA Part A: Core + Support (incl HRSA EtE & MAI)



Part B funds within EMA by state

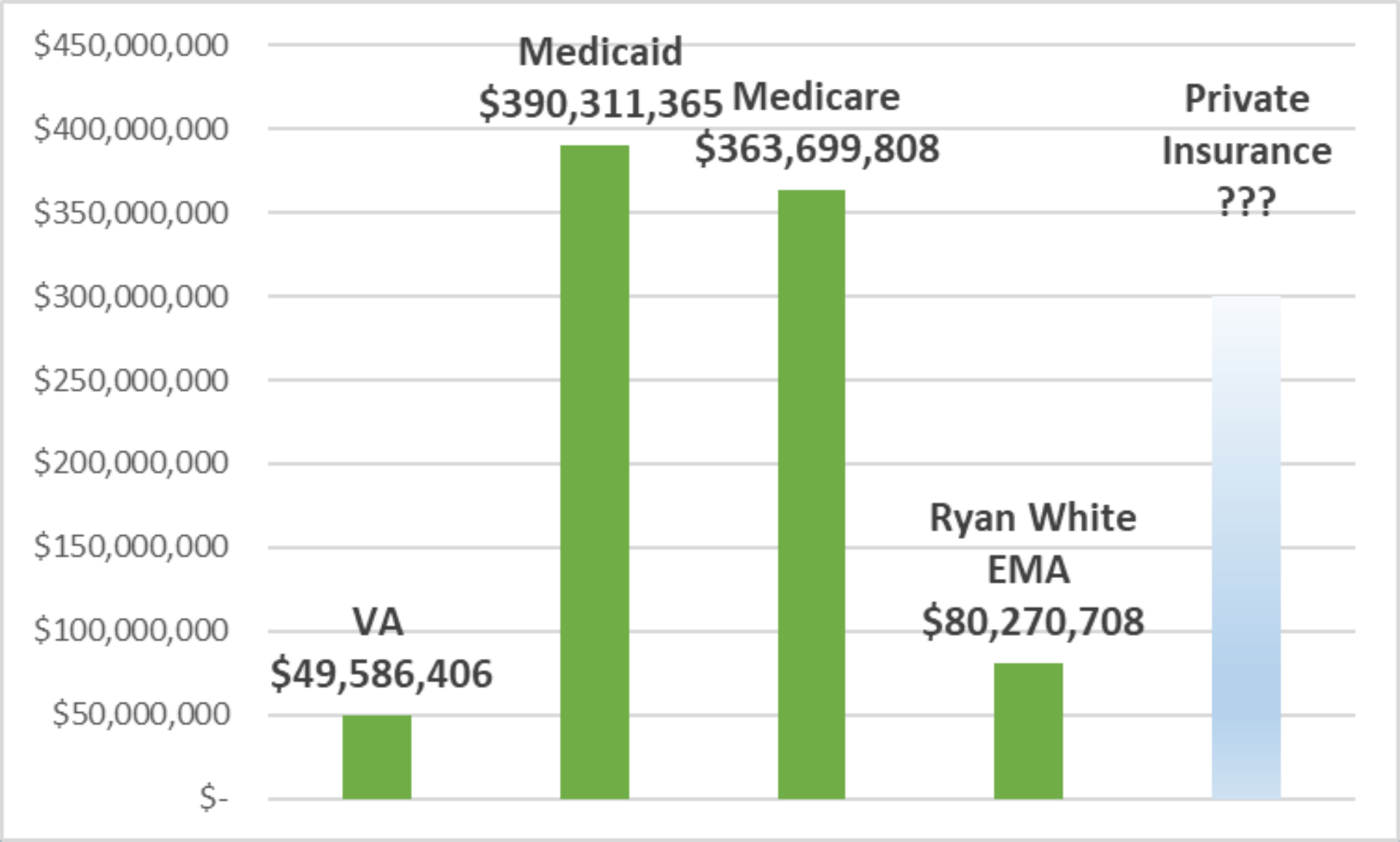


Part A, B, and ADAP in the EMA



Ryan White funding in the context of other healthcare payers (VERY rough estimates…)

Major Funding Sources – EMA-wide, est.



Questions?

Reach out anytime:

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Service System Part A Grant Year 34

Priority Setting & Resource Allocation (PSRA)

August 24, 2023

Avemaria Smith, M.ED.

AGENDA

- Service System Updates
- EMA Provider Network
- Providers & Regional Allocations
- EMA Allocations and Obligations
- Considerations for GY34
- Q & A

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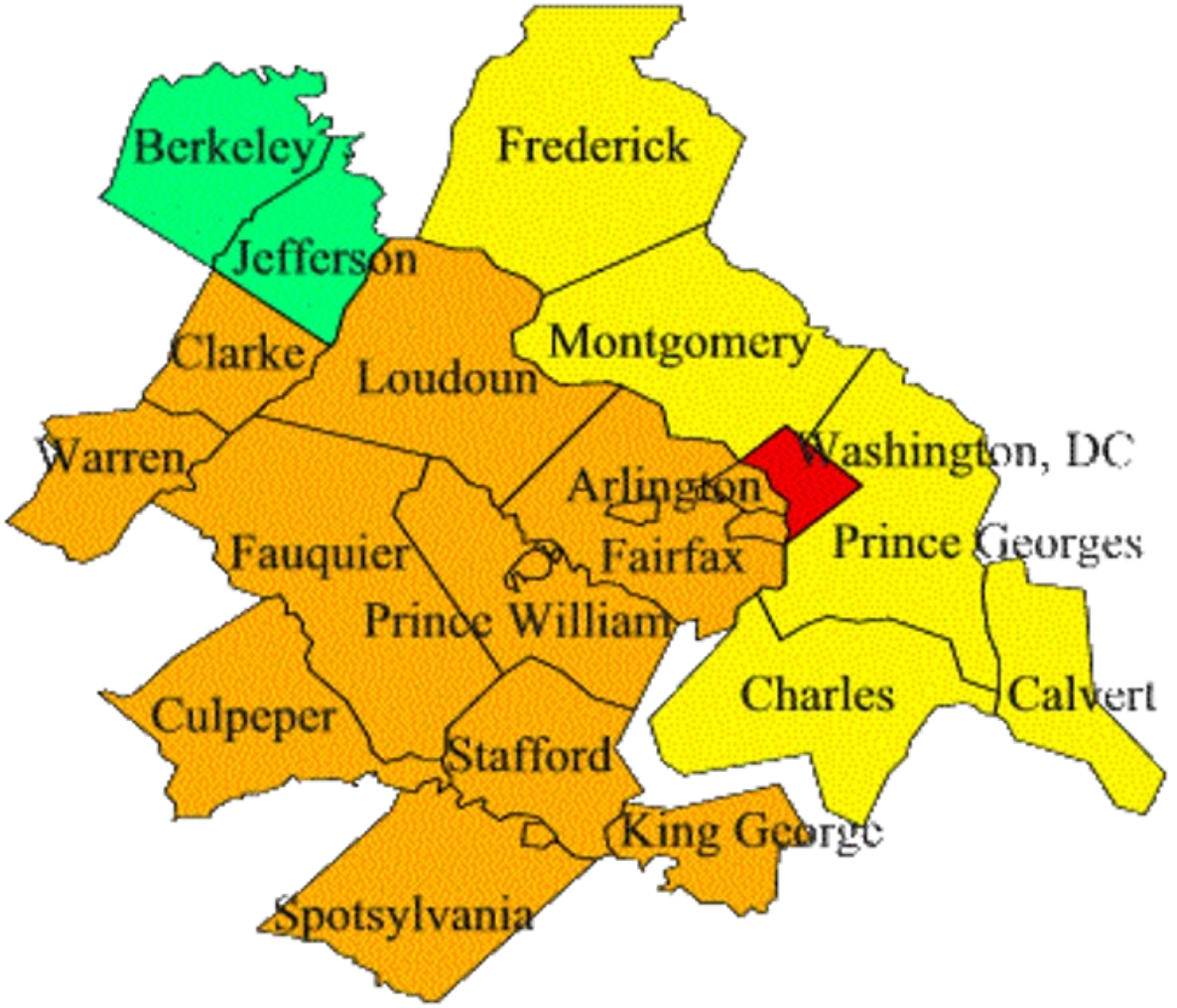
Service System Updates

WASHINGTON, DC RYAN WHITE PART A EMA



Service System Updates

Grant Year 33	Part A Formula and Supplemental	Part A MAI	Total Funds
CQM	$ 995,291		$ 995,291
Administrative	$ 2,987,774	$ 281,445	$ 3,265,219
Non- services subtotal	$ 3,979,065	$ 281,445	$ 4,260,510
Core Medical Services	$ 15,210,490	$ 2,096,459	$ 17,306,949
Support Services	$ 10,648,182	$ 436,548	$ 11,084,730
Total Service Allocations	$ 25,858,672	$ 2,533,007	$ 28,391,679
Total Allocations(Service + Non-service)	$ 29,837,737	$ 2,814,452	$ 32,652,189

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Service System Updates

Process:

- COHAH **allocates** the direct services portion of the Part A Grant
- *Allocations* are made for each RW *service category* being funded in the EMA
- HAHSTA/Recipient develops programs/packages service categories
- HAHSTA *obligates* allocated funds to facilitate service delivery through *competitive subgrants*
- HAHSTA can only expend funds when there is an *eligible* service provider that has been *awarded* to deliver services

Service System Updates

- Service Categories Funded as outlined in GY32 RFA
  - FFV Model (OAHS, MCM, NMCM, Medical Nutrition Therapy, Food Bank & HDM)
  - Service Bundles
    - Early Intervention & Retention (EIS, PSS)
    - Mental Health & Wellness (MHS, PSS)
    - Medical Care Coordination (OAHS, MCM, NMCM)
    - Non-Medical Care Coordination (MCM, NMCM)
  - Individually funded service categories

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EMA Provider Network

Provider Network

- RFA GY32 29 sub-recipients awarded
- 18 service categories allocated and solicited, 17 service categories funded (no applications received for Linguistics)
- Provider attrition past 3 years
  - RFA upsets
  - Relinquished grants (administrative burden)
  - Sub-recipient monitoring/technical assistance
- GY33 26 external providers/subgrants

Provider Network

- Several sub-recipients have multiple service locations

Jurisdiction	Number of Service Providers
Washington, DC	17
Maryland	8
Virginia	5
West Virginia	1

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Providers & Regional Allocations

Allocations and Obligations

GY33 Regional Part B Allocations:

- MDH provides a total of $8,498,901 in RW Part B funding to three local health departments in the EMA for that are not funded by DC Health's RW Part A Program.
- VDH provides a total of $ 1,125,843 in RW Part B funding to four providers in the EMA that are not funded by DC Health's RW Part A Program.

GY33 Funding by Jurisdiction

Jurisdiction	Funded Service Categories	Total Amount Allocated
DC Health	*Part A Funded Service Categories*: OAHS, MCM, OH, NMCM	$1,467,681
Maryland Department of Health (MDH)	*Part B Funded Service Categories*: OAHS, MCM, OH, FB/HDM, HIPSCA, HS, MNT, MT, SA	$2,377,173
Total		**$ 3,844,854**

- One provider is funded by both DC Health's RW Part A Program and MDH's RW Part B Program. This chart reflect the service categories and total amount for the one provider only.
- The three service categories dually funded are OAHS, MCM and OH.

GY33 Funding by Jurisdiction

Jurisdiction	Funded Service Categories	Total Amount Allocated
DC Health	*Part A Funded Service Categories:* OAHS, MCM, NMCM, OH, EIS, PSS, MT, SAOC, MH	$ 2,287,527
Virginia Department of Health (VDH)	*Part B Funded Service Categories*: OAHS, MCM, NMCM, OH, EIS, PSS, MT, SAOC, MH, HIPCSA, MNT, EFA, HE/RR (Part B MAI), LS, Outreach (Part B MAI), SA (Residential), FB/HDB	$ 5,926,443
Total		**$ 8,213,970**

- Five providers are funded by both DC Health's Ryan White Part A Program and VDH's Ryan White Part B Program. This chart reflect the service categories and total amount for these five providers only.
- The eight service categories that are dually funded are OAHS, MCM, NMCM, EIS, PSS MT, SAOC, and MH

GY33 Funding by Jurisdiction

Jurisdiction	Funded Service Categories	Total Amount Allocated
DC Health	*Part A Funded Service Categories:* OAHS, MCM, NMCM, EIS, PSS, MT, MH, SAOC, MNT, FB/HDM, OH, EFA, OPS	$16,544,880
DC Health Part B	*Part B Funded Service Categories*: OAHS, MCM, NMCM, PSS, MT, HE/RR, and MH	$ 2,903,538
Total		$19,448,418

- Eight providers are funded by both DC Health's Ryan White Part A Program and DC Health's Ryan White Part B Program . This chart reflects the service categories and total amount for these eight providers only.
- The seven service categories that are dually funded are OAHS, MCM, NMCM, PSS, MT, and MH
- Comparison isn't apples to apples. The Part B Status Neutral Care Continuum uses biomedical intervention to move HIV+ persons non-VLS along care continuum to VLS
- Several DC based providers have locations in MD and DC providers serve regional customers

Allocations and Obligations

Jurisdictional Insights:

- RWHAPs from DC Health, MDH, and VDH met in early August to discuss providers/funding overlap; funding gaps; new partnerships; and site visits. The following are highlights from the meeting:
  - No gaps in services were identified by DC Health or MDH
  - VDH identified the need for more Medicaid providers that are available for mental health and oral health
  - MDH provides funding to three community-based organizations that are not in the EMA network
  - A working group will be formed to develop a mechanism to minimize the administrative burden of site visits, and create templates for allocation/expenditure data sharing

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EMA Allocations and Obligations

Allocations and Obligations

- GY33 Allocations and obligations (grants funded) are not aligned due to:
  - *Changes in provider network*
  - *Reduced funding requests prevented full allocation of (EIS, HCBHS, FB/HDM, OS, LS)*
  - *Rightsizing of FFV awards (value enhancements made at GY33 start up w/funds returned)*
  - Unable to operationalize tax preparation services *(OPS)*
  - A portion of housing case management efforts covered under NMCM *(HS)*

Allocations and Obligations

- Recipient submitted a reprogramming request for GY33 to:
  - ensure the alignment of obligations/expenditures with established allocations
  - ensure adequate funding is allocated in all service categories to maintain service delivery levels
  - avoid lapse of funds at the end of the grant period

- **Note:** This reprogramming request will not negatively impact the provision of services throughout the EMA.

Allocations and Obligations

- Request to move $5,655,908 from the following service categories:
  - Early Intervention Services (EIS), Home and Community Based Health Services (HCBHS), Foodbank Home Delivered Meals (FB/HDM), Housing Services (HS), Outreach Services (OS), Linguistic Services (LS) and Other Professional Services (OPS)
- Funds will be reprogrammed into the following service categories:
  - Outpatient Ambulatory Health Services (OAHS), Oral Health Services (OH), Medical Case Management (MCM), Mental Health Services (MHS), Substance Abuse Outpatient Care (SAOC), Medical Nutrition Therapy (MNT), Health Insurance Premium and Cost Sharing Assistance (HIPCSA), Emergency Financial Assistance (EFA), Medical Transportation (MT), Non- Medical Case Management (NMCM), and Psychosocial Support Services (PSS)

Allocations and Obligations

- Justification *(impacted service category)*
  - Fee For Value Program *(OAHS, MCM, NMCM,MNT)*
  - Increased need for rental and food assistance due to the end of COVID 19 funding support and the moratoria on evictions *(EFA)*
  - Increase need for transportation to support medical adherence *(MT)*
  - Increase based on providing level funding to current sub-recipients*(MHS, PSS, OHS)*

Allocations and Obligations by Service Category (Core)

	Total Part A Direct		
Service Category	**Original Allocation %**	**Adjusted Allocation %**	**Justification**
Outpatient/Ambulatory Health Services	6%	12%	Increased demand for funding: Bundled service
Oral Health Care	4%	6%	Increased demand for services
Medical Case Management	10%	14%	Increased demand for funding: Bundled service
Mental Health Services	2%	2%	
Substance Abuse Outpatient Care	1%	1%	Increased demand for funding
Medical Nutrition Therapy	1%	1%	
Early Intervention Services	33%	18%	Not enough demand funding/ applications, other payors
Health Insurance Premium and Cost Sharing Assistance	0%	0%	
Home and Community Based Health Services	1%	0%	Not enough demand for funding/applications
Subtotal Core Services	58%	55%	

Allocations and Obligations by Service Category (Support)

	Total Part A Direct		
Service Category	**Original Allocation %**	**Adjusted Allocation %**	**Justification**
Emergency Financial Assistance	4%	8%	Increased demand for services /inflation
Medical Transportation	1%	1%	
Food Bank/Home Delivered Meals	11%	6%	Not enough demand for funding/applications
Non-Medical Case Management Services	10%	11%	Increased demand for funding: Bundled service
Housing Services	6%	3%	Some portions absorbed by NMCM
Outreach Services	3%	1%	Included in EIS. Not enough demand for funding/applications
Linguistic Services	1%	0%	No applications received
Psychosocial Support Services	3%	7%	Increased demand for services secondary to service bundle
Other Professional Services	3%	1%	Tax prep not operationalized
Subtotal, Support Services	42%	39%	
Unobligated Balance		6%	
TOTAL	100%	100%	

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Considerations for GY34

Considerations for GY34

Assuming approval of the GY33 reprogramming request is granted, the Recipient recommends COHAH adopt the approved allocations for GY34:

- Considerations:
  - Not enough data on impact of FFV programs, bundles.
  - Currently have active project period to support subgrants, which affords continuity of services w/o disruption
  - GY33 is last year of “PSRA lite”. In GY34, full PSRA process and new application for funding. Better position to develop and release new RFA
  - Future of HIV funding is uncertain given efforts to avoid government shut down. FY24 Appropriations bills under consideration with significant cuts to HIV funding to HHS and CDC.

Considerations for GY34

- Based on funding projections for GY34, we anticipate an unobligated balance of approx. $2M and recommend the following:

Opportunities:

- Add $200,000 to Childcare **S**ervices for a pilot program to fund four sub-recipients with a base award of $50,000 each**,** pending OSSE rulemaking decision

- HAHSTA Efforts:
  - Expansion of provider network through outreach efforts
  - Re-release GY32 RFA

Questions?
Discussion

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This presentation will answer the questions:

- Who's living with HIV in the DC EMA?
- Are there trends among newly diagnosed HIV disease cases?
- Are there trends among newly diagnosed stage 3 (AIDS) cases?
- What does the care continuum look like for people living with HIV in the DC EMA?
- Are PLWH in the EMA experiencing unmet need?

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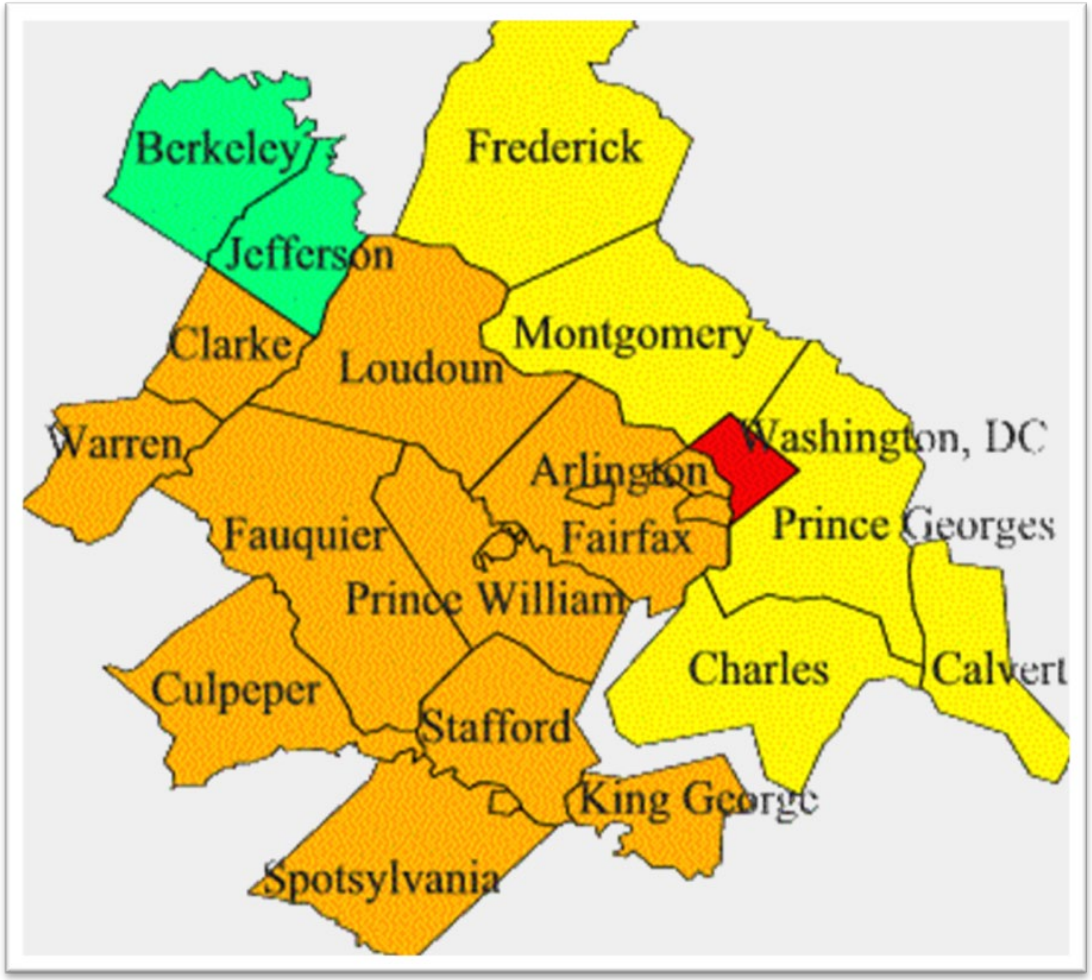
Geographic Makeup of Washington, DC EMA



The Washington, D.C. EMA consists of:

- The District of Columbia
- Northern and Northwestern Virginia (17 counties/areas)
- Suburban Maryland (five counties)
- West Virginia (two counties)

Who's living with HIV in the DC EMA?

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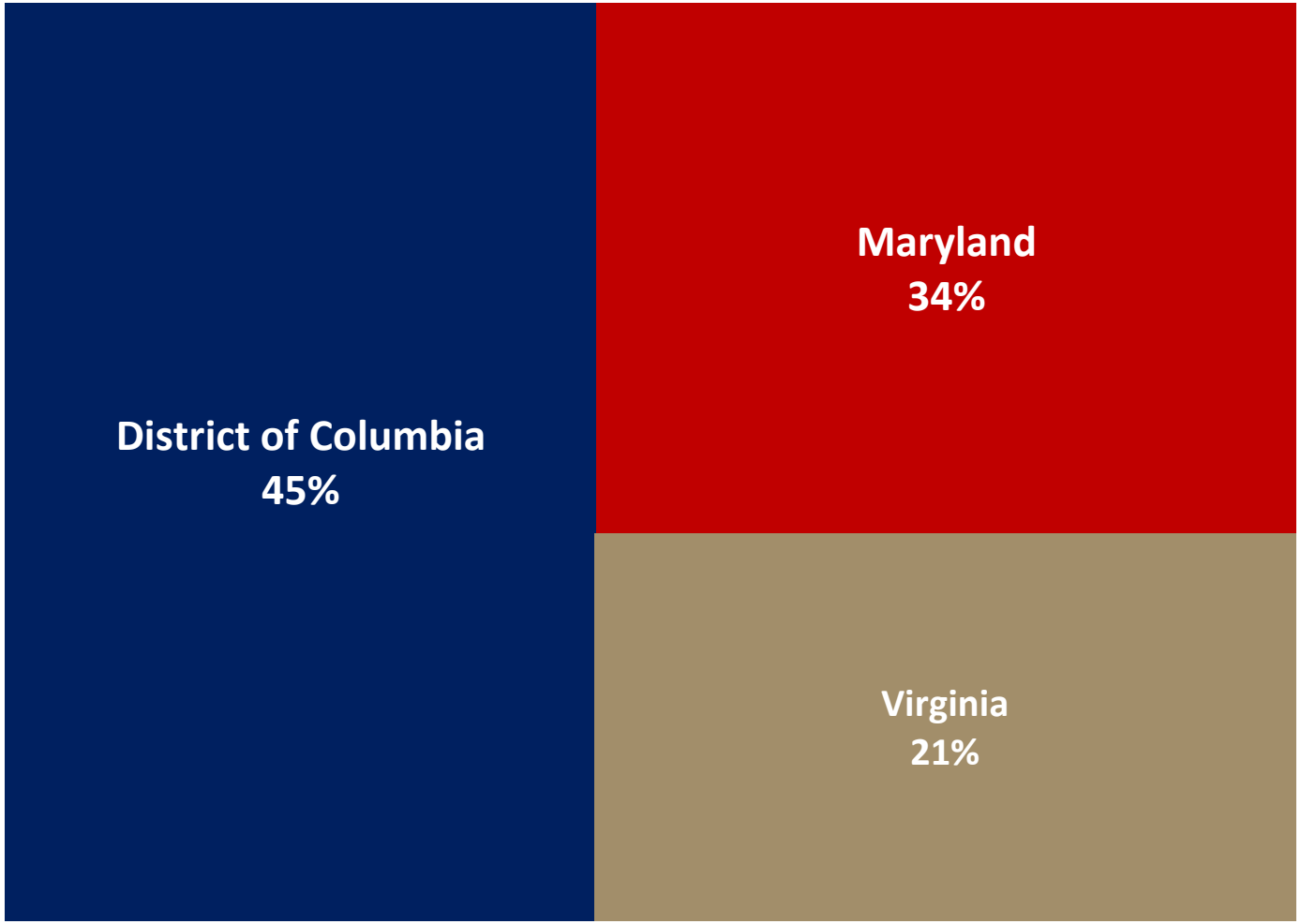
Distribution of people living with HIV in the DC EMA, 2022, by Jurisdiction N= 39,725



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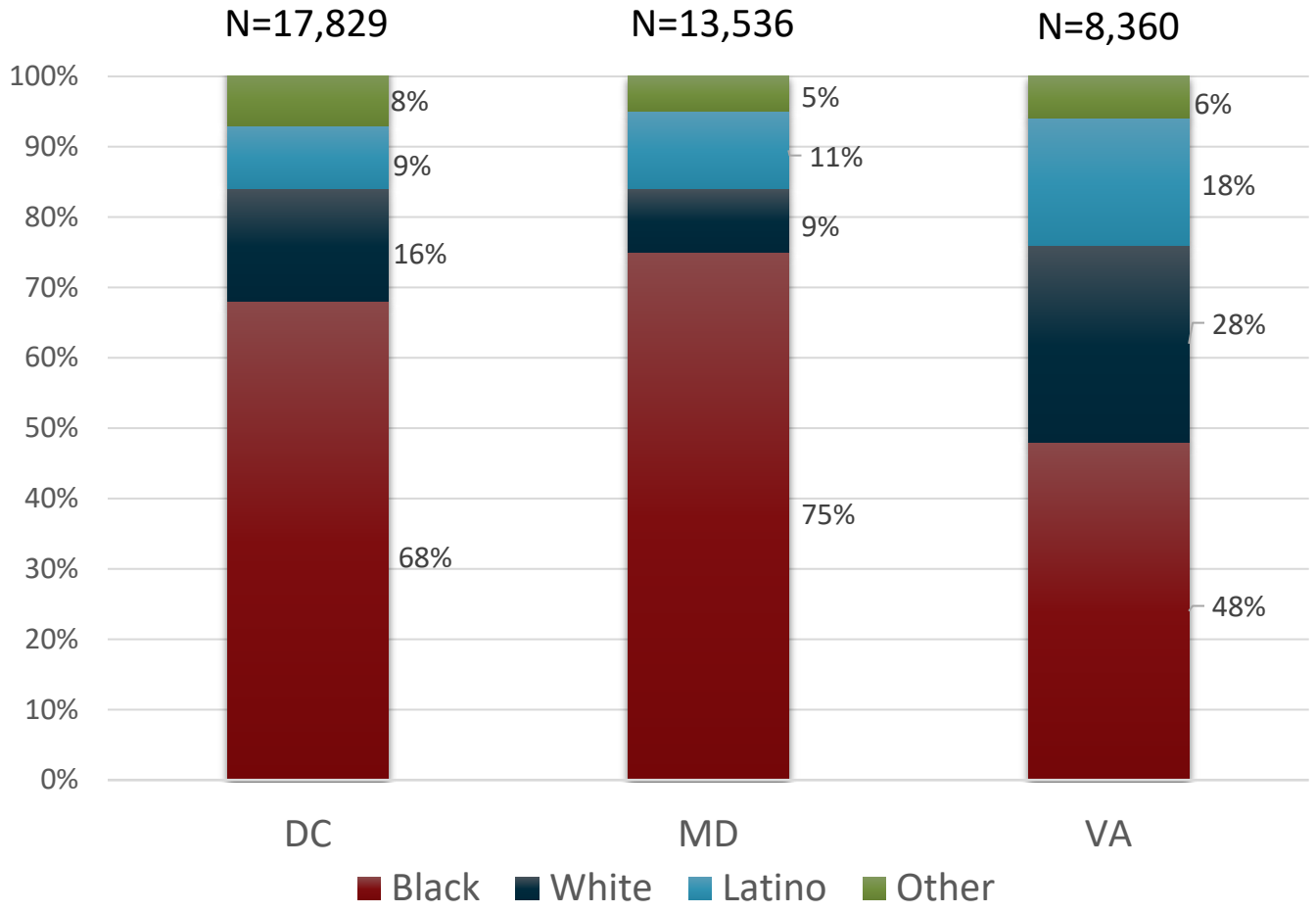
Proportion of people living with HIV, by race/ethnicity and jurisdiction, DC EMA 2022



The majority of people diagnosed were Black across all jurisdictions.

MD had the highest proportion of Black cases at 75%, followed by DC at 68%.

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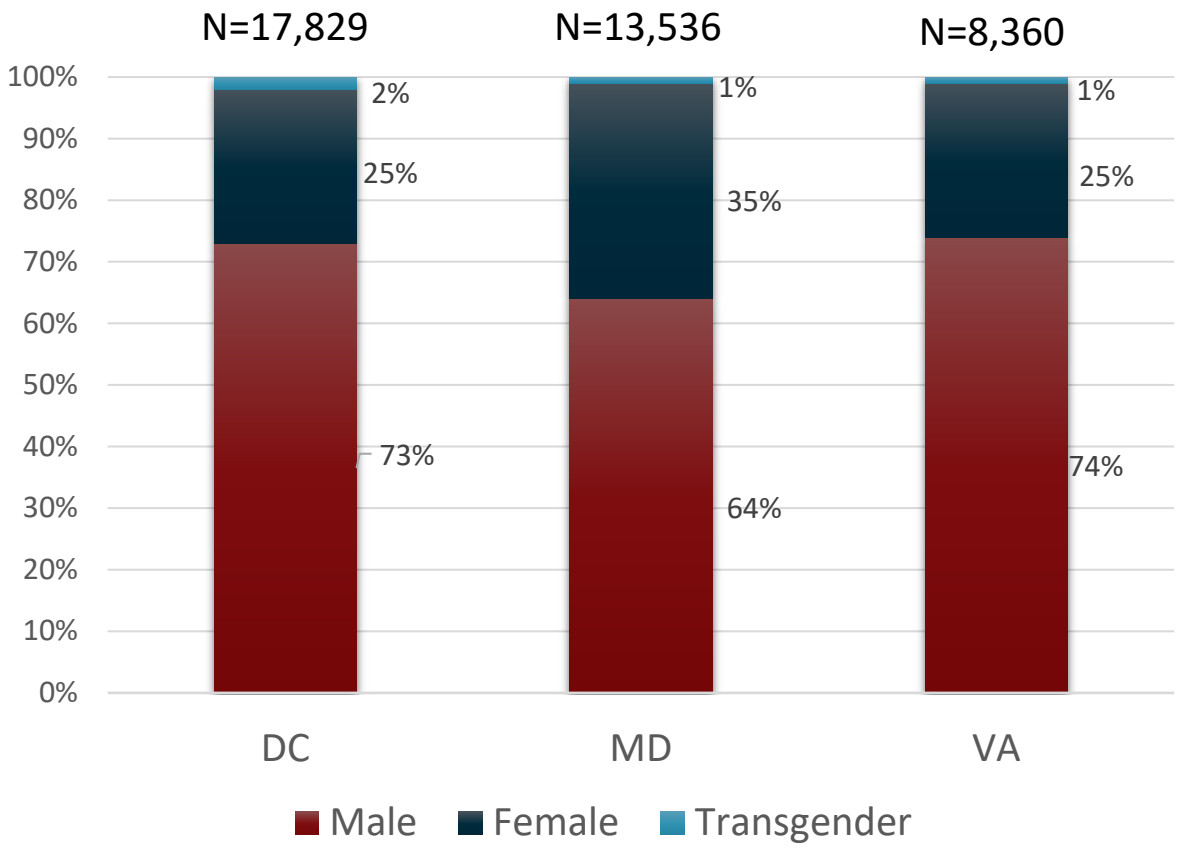
Proportion of people living with HIV, by gender identity and jurisdiction, DC EMA 2022



By jurisdiction, the majority of living HIV cases were male, with MD having the highest proportion of cases among women at 35%

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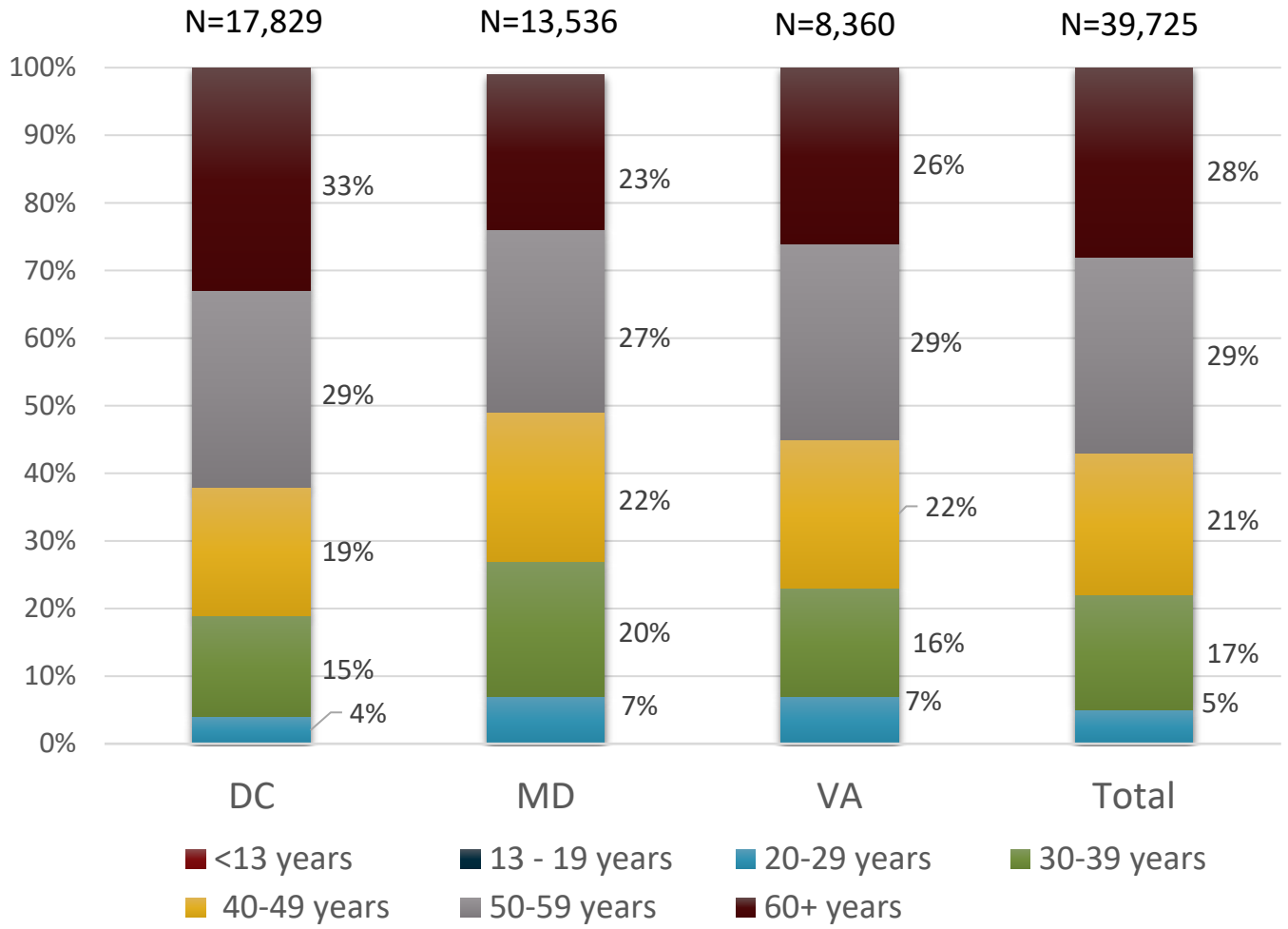
Proportion of people living with HIV, by current age and jurisdiction, DC EMA, 2022



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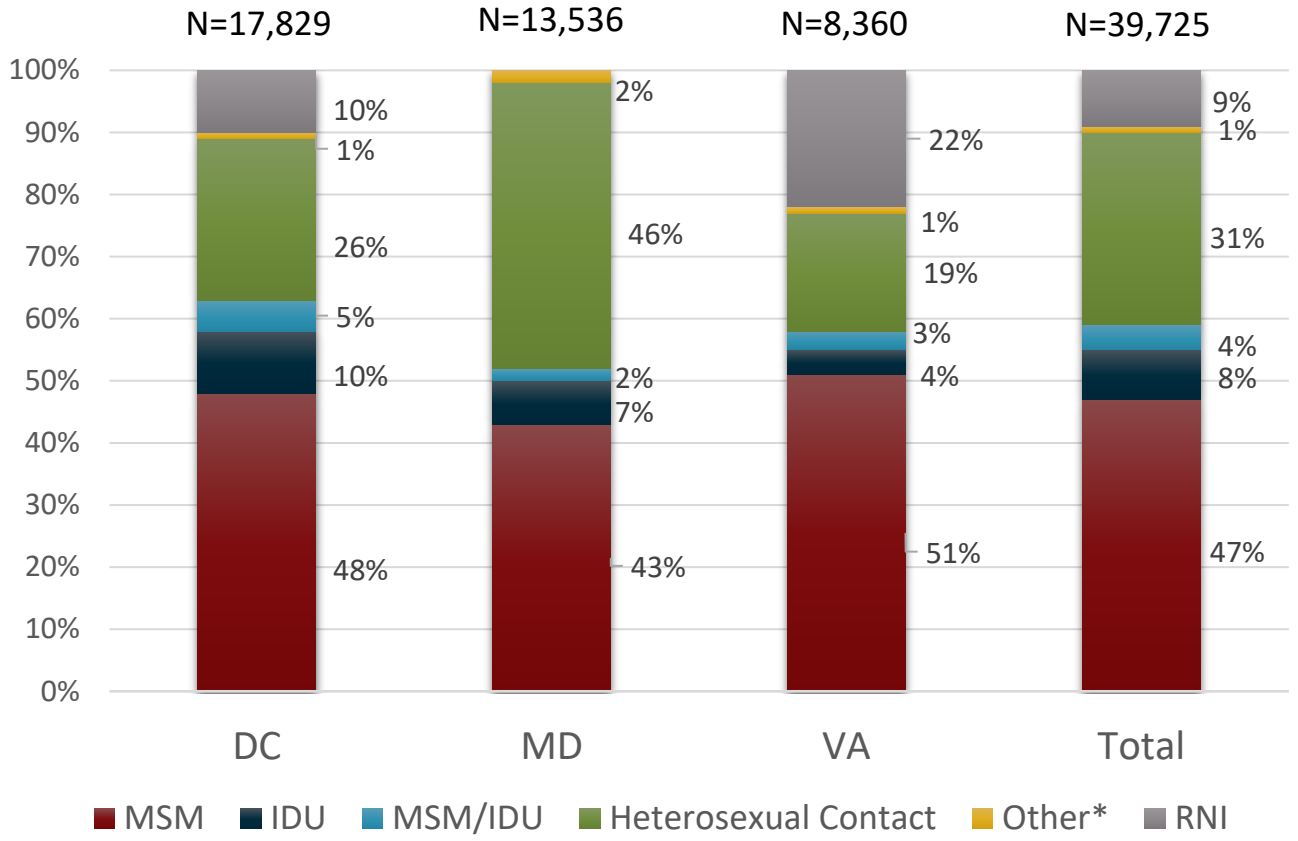
Proportion of people living with HIV, by mode of transmission and jurisdiction, DC EMA 2022



By Jurisdiction, with the exception of MD, MSM accounted for the majority of cases in the EMA, ranging from 43% (MD) to 51% (VA)

MD had the highest proportion of Heterosexual contact cases at 46%

*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

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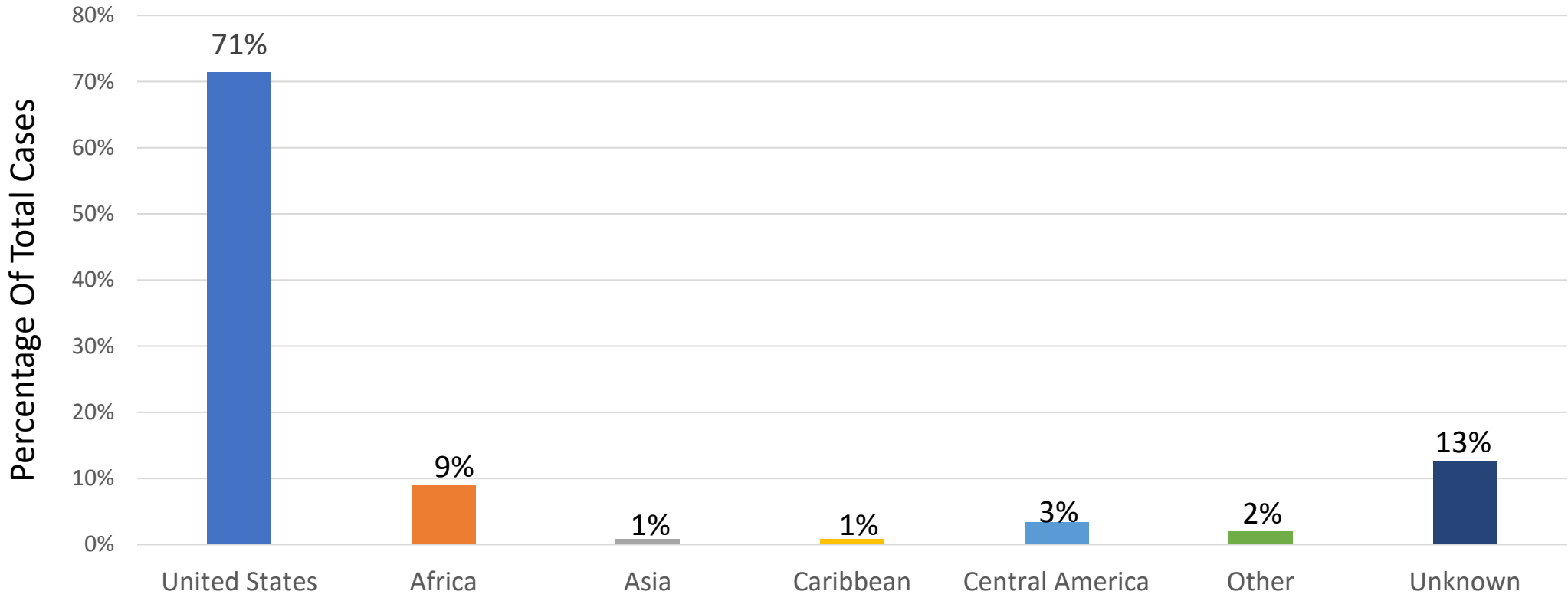
HIV prevalence by country of origin

N= 39,725



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Are there trends among newly diagnosed HIV cases?

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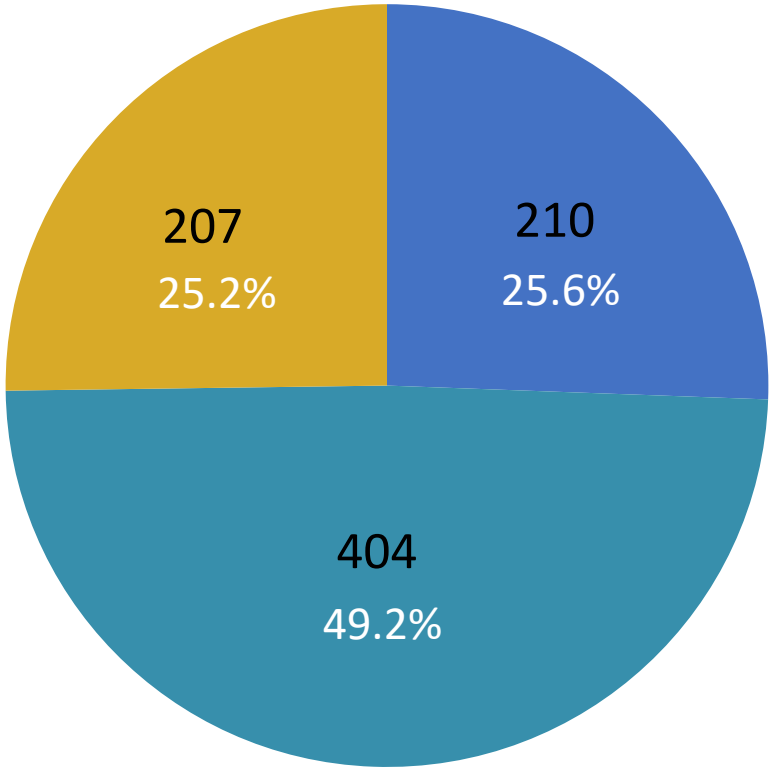
Number of new HIV infections by jurisdiction N=821

Number Of Newly Diagnosed HIV Cases



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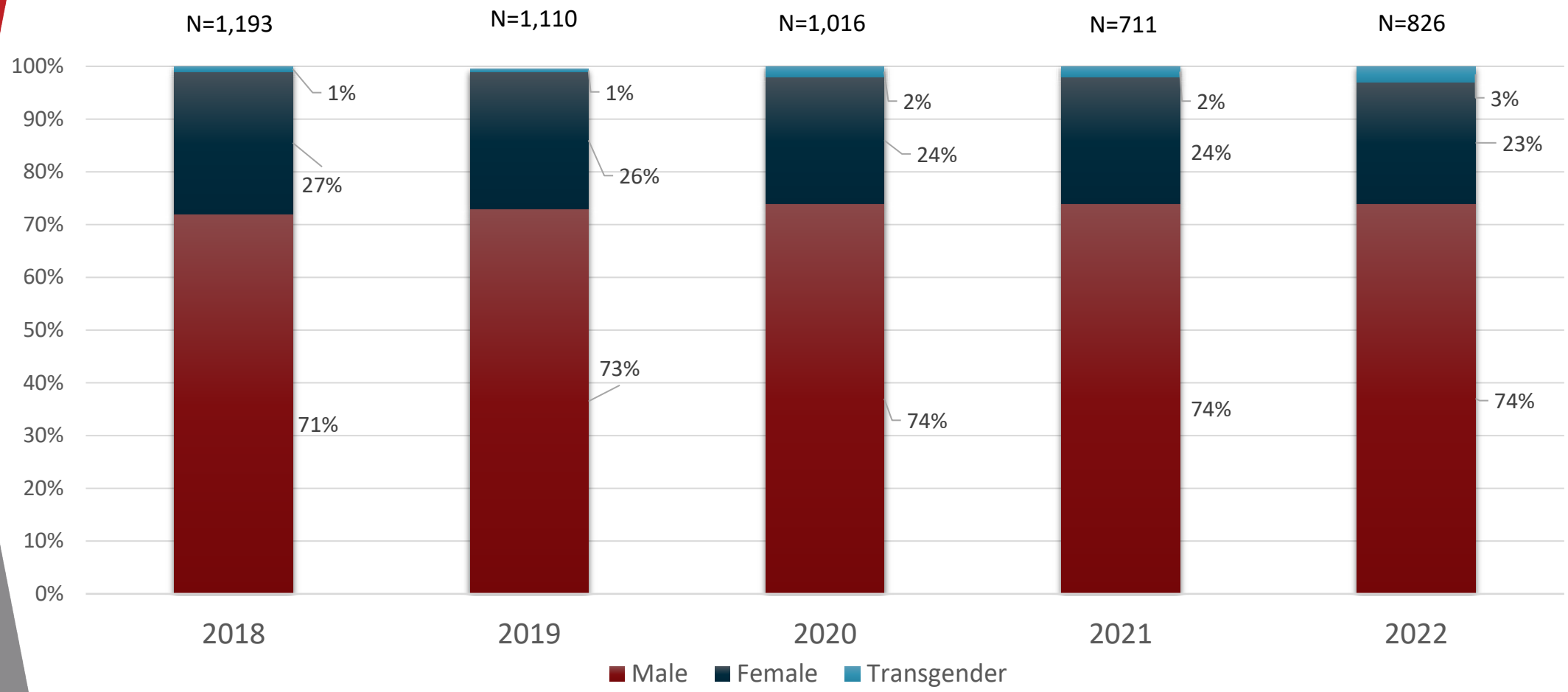
Newly diagnosed HIV by gender identity, DC EMA 2018-2022



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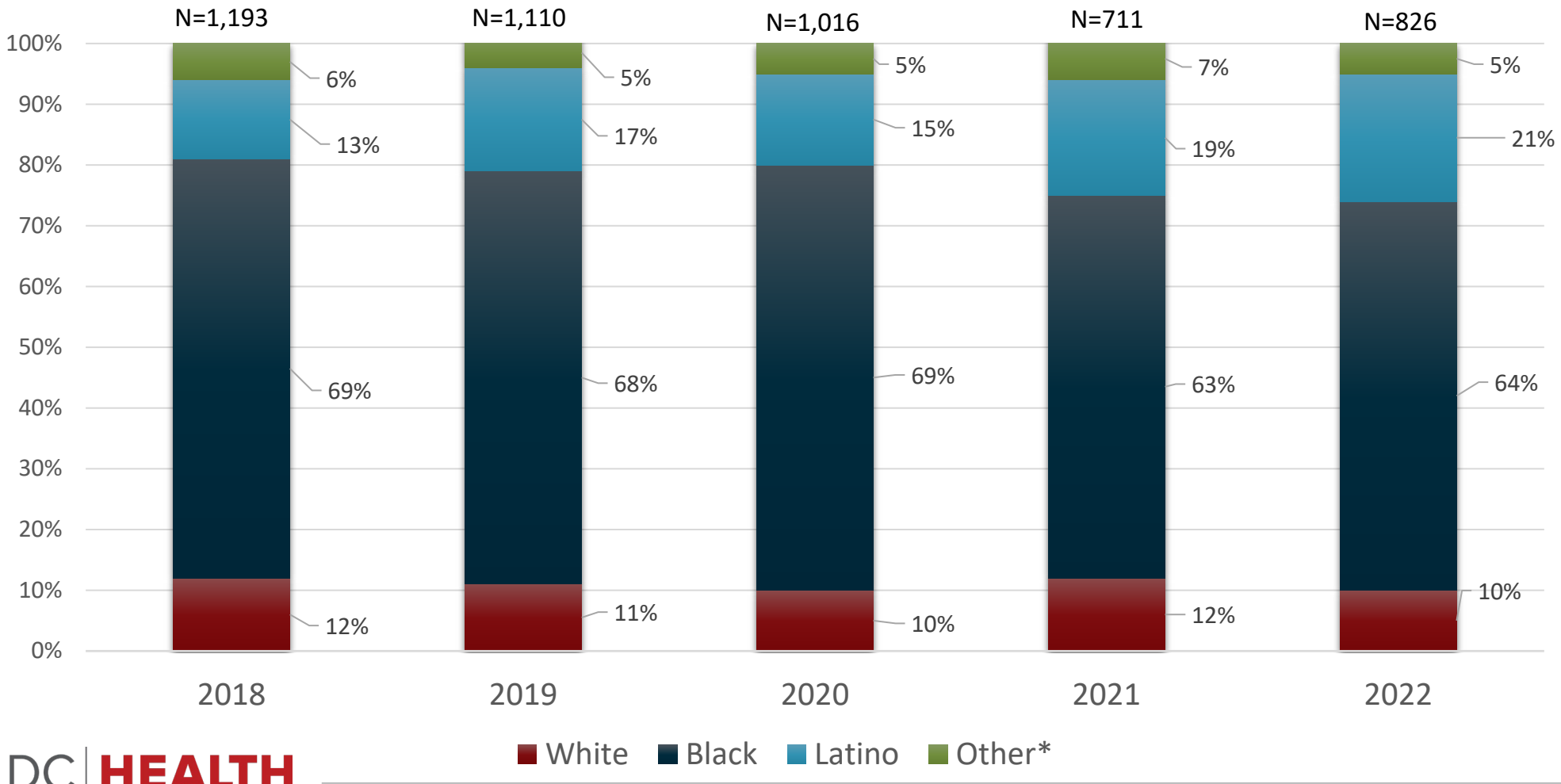
Newly diagnosed HIV by race/ethnicity, DC EMA 2018-2022

Majority of new diagnoses were among Black individuals in all EMA jurisdictions



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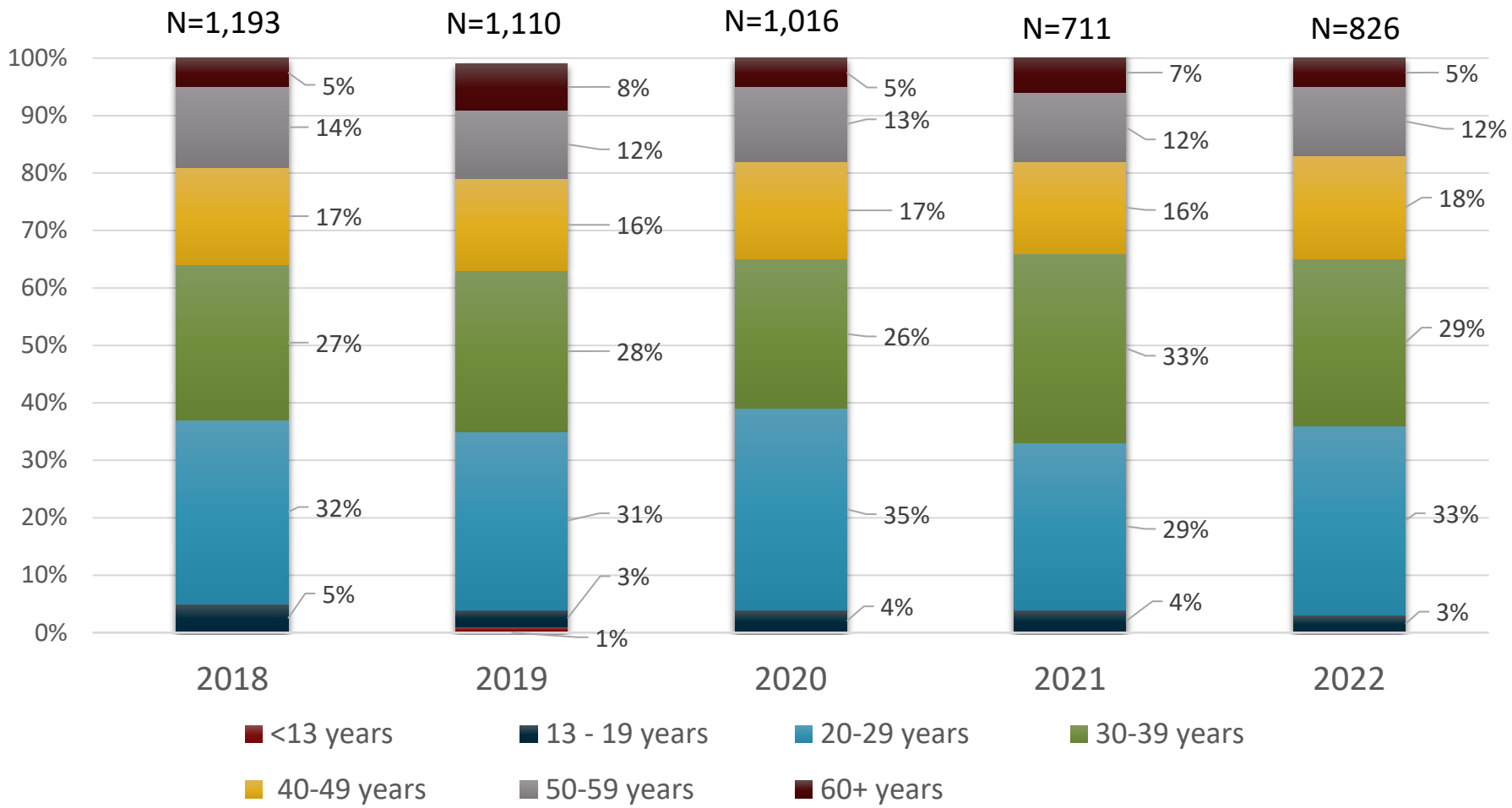
*Other race/ethnicity include Asian, Pacific Islander, Alaska Native, American Indian, Native Hawaiian and missing

Newly diagnosed HIV by age at diagnosis, DC EMA 2018-2022



Overall, the majority of new diagnoses in the EMA were among residents aged 20-29, followed by residents aged 30-39.

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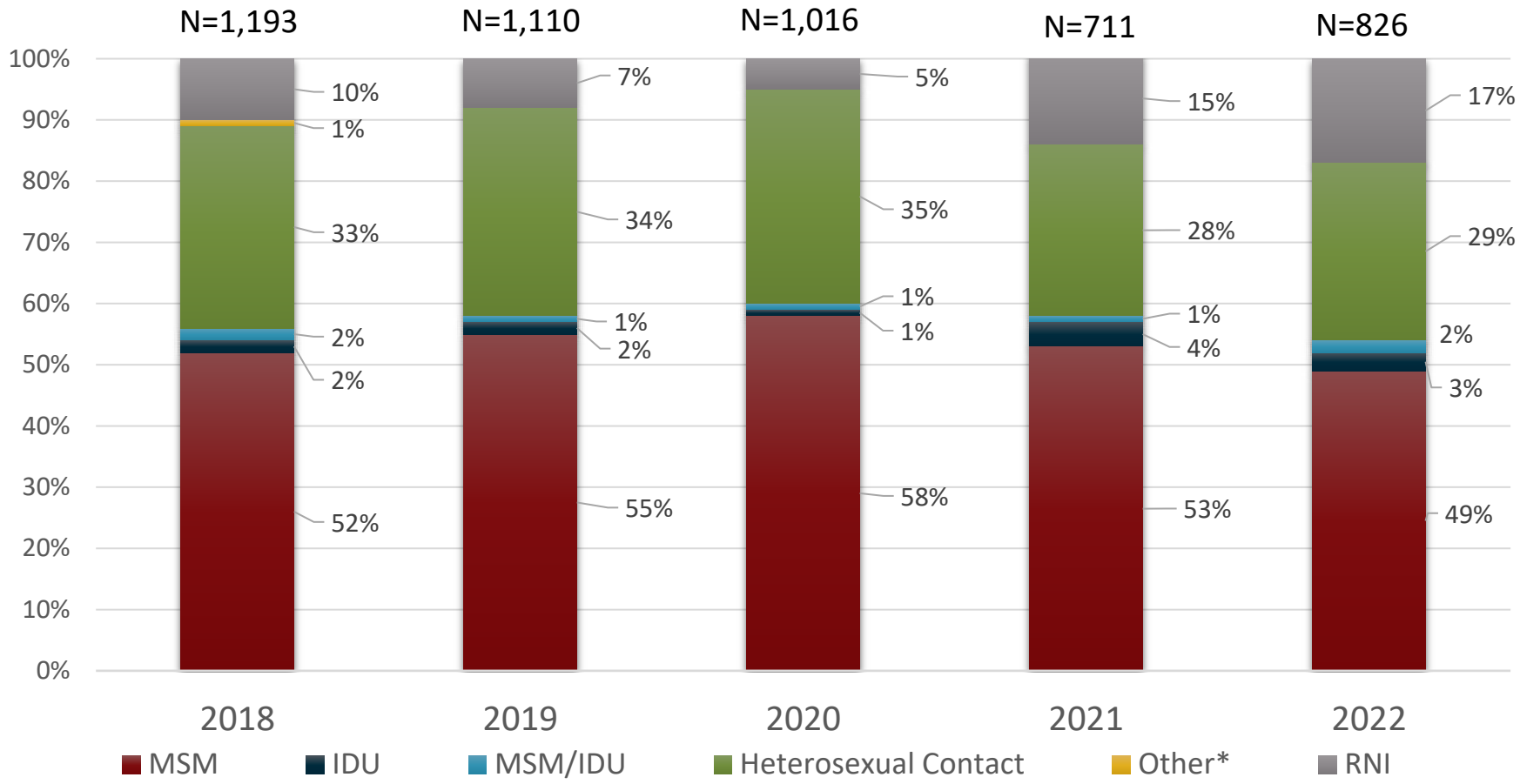
Newly diagnosed HIV by mode of transmission, DC EMA 2018-2022



Most new HIV disease diagnoses were among MSM followed by heterosexual contact. Risk not identified (RNI) was about 11% within the 5-year period.

*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

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Are there trends among newly diagnosed stage 3 (AIDS) cases?

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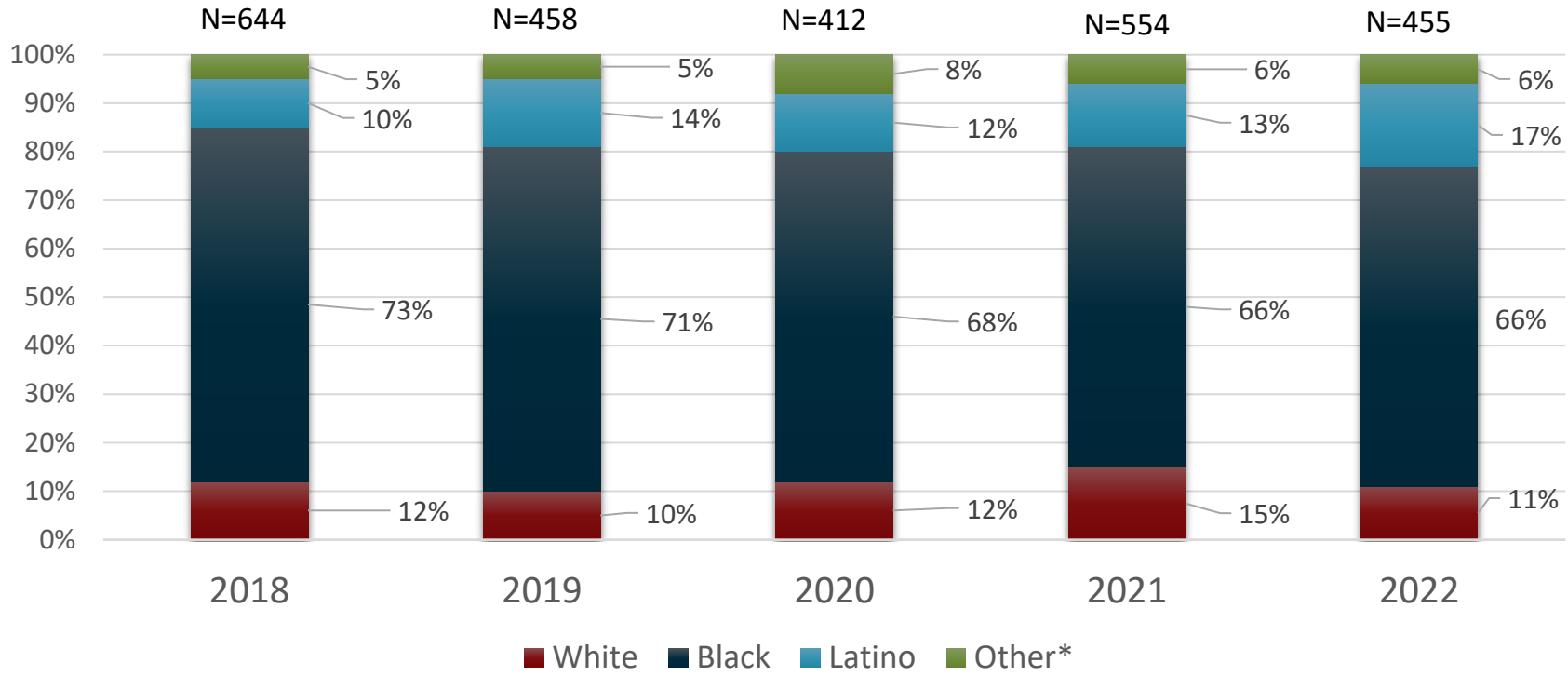
Newly diagnosed stage 3 (AIDS) diagnoses

Stage 3 (AIDS) infection signifies that a person living with HIV has a compromised immune system (i.e., CD4<200 cells/µL and/or an HIV-related opportunistic infection), thereby increasing their susceptibility to adverse health conditions and symptoms associated with infection.

- As opposed to the traditional HIV disease dichotomy of HIV-only cases and HIV positive cases with AIDS, the HIV infection staging system provides the opportunity to reclassify individual health status dependent on clinical indicators at a given point in time.

Newly diagnosed stage 3 (AIDS) diagnoses by mode of transmission, DC EMA 2018-2022



Most newly diagnosed stage 3 disease (AIDS) diagnoses were Black in the EMA and this is also true by jurisdiction.

*Other race/ethnicity include Asian, Pacific Islander, Alaska Native, American Indian, Native Hawaiian and missing

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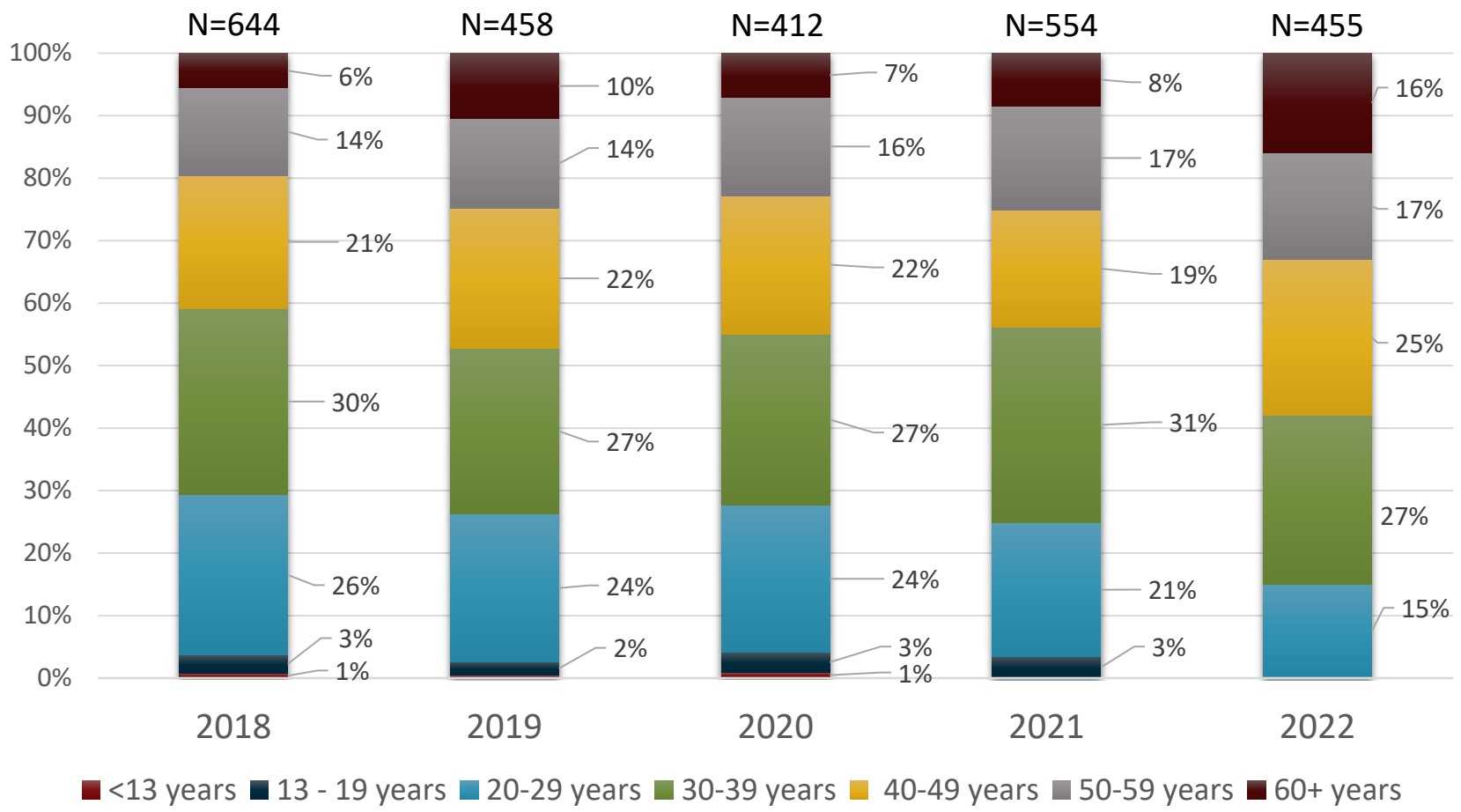
Newly diagnosed stage 3 (AIDS) diagnoses by age at diagnosis, DC EMA 2018-2022



Overall, the majority of Stage 3 diagnoses were among residents aged 30-49, with the proportion of those 20-29 decreasing over time

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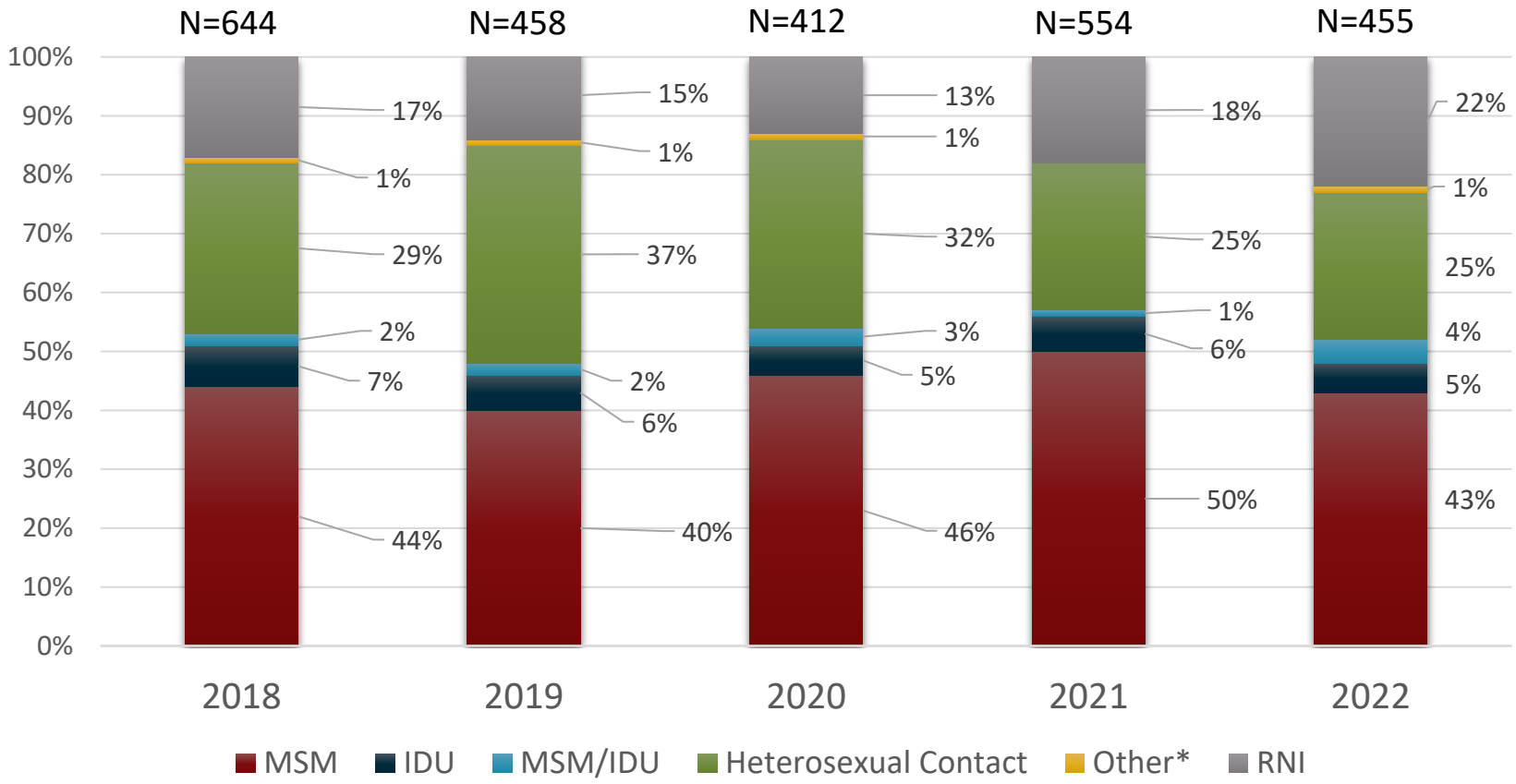
Newly diagnosed stage 3 (AIDS) diagnoses by mode of transmission, DC EMA 2018-2022



Stage 3 diagnosis by mode of HIV transmission varied by jurisdiction. With the exception of MD, the majority of stage 3 diagnoses were among MSM followed by heterosexual contact.

*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

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How should the continuum of care be used in relation to PLWH in the EMA?

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Overview of continuum of care

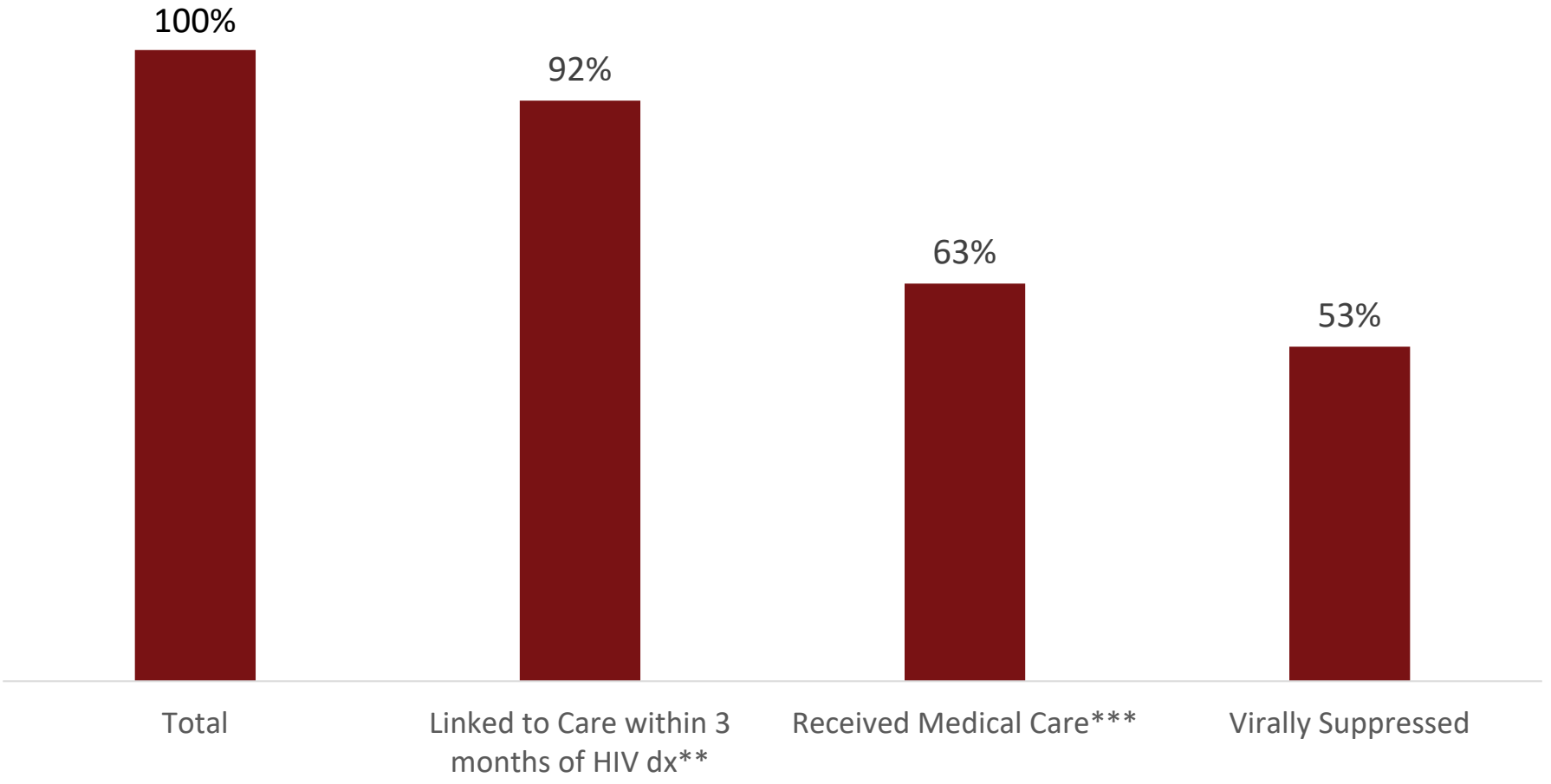
What is the continuum of care?

- A method of evaluating HIV cases from the time of diagnosis (or total estimated infected) to viral suppression
- After diagnosis, steps in the cascade include linkage to care, retention (engagement in care), ART prescription, and viral suppression

What are the limitations?

- Data systems at the national and local are different
- Increase in televisits and lingering pandemic effects may lower lab volumes
- Calculations based on lab information may differ based on completeness of lab reporting and data entry

2022 DC EMA HIV continuum of care



*The cumulative number of living cases diagnosed and reported to the local surveillance system through the end of 2022

**The number of cases diagnosed in 2022 who had evidence of a CD4 or VL test within 3 months of HIV diagnosis

‡ having a viral load of <200 copies/mL in 2022. Clients excluded if no care marker reported during time frame

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Are people living with HIV experiencing unmet need?

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What is unmet need? What is retention in care?

What is unmet need?

- Unmet Need is “the need for HIV-related health services by individuals with HIV who are aware of their HIV status but are not receiving regular primary [HIV] health care”.
- The way that it is calculated is based on surveillance data using lab information.

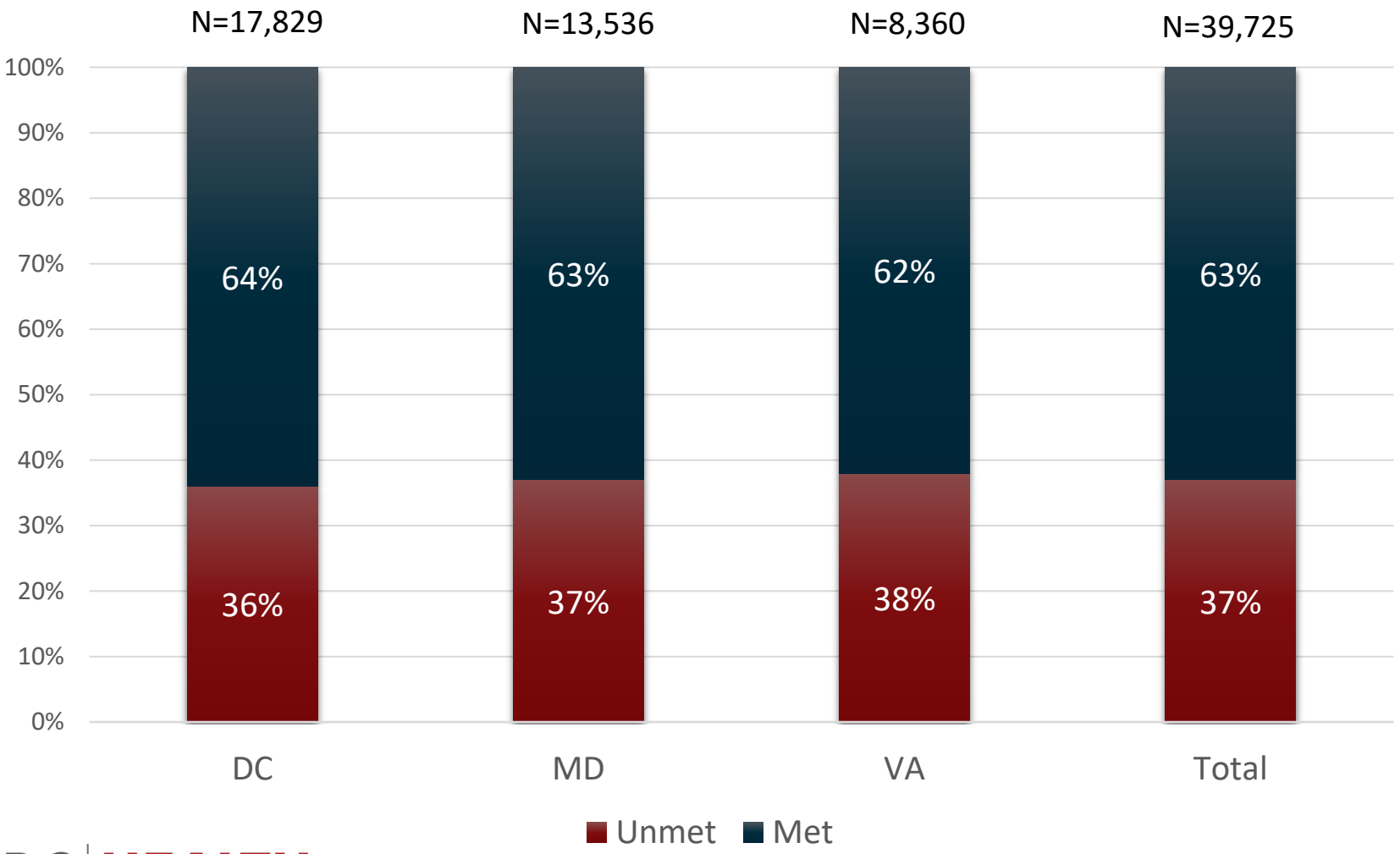
What is considered not in care?

- Having no evidence of a viral load or CD4 lab in a given 12-month period.

What’s the difference between the two measures?

- Unmet need estimates evidence of care from lab data among PLWH by residence at diagnosis, while retention in care uses only VL and CD4 labs among people living in DC.

Unmet need estimates by jurisdiction, DC EMA, 2022



Among cases diagnosed in the EMA, unmet need was 37%

By jurisdiction, unmet need remained relatively constant near 37%

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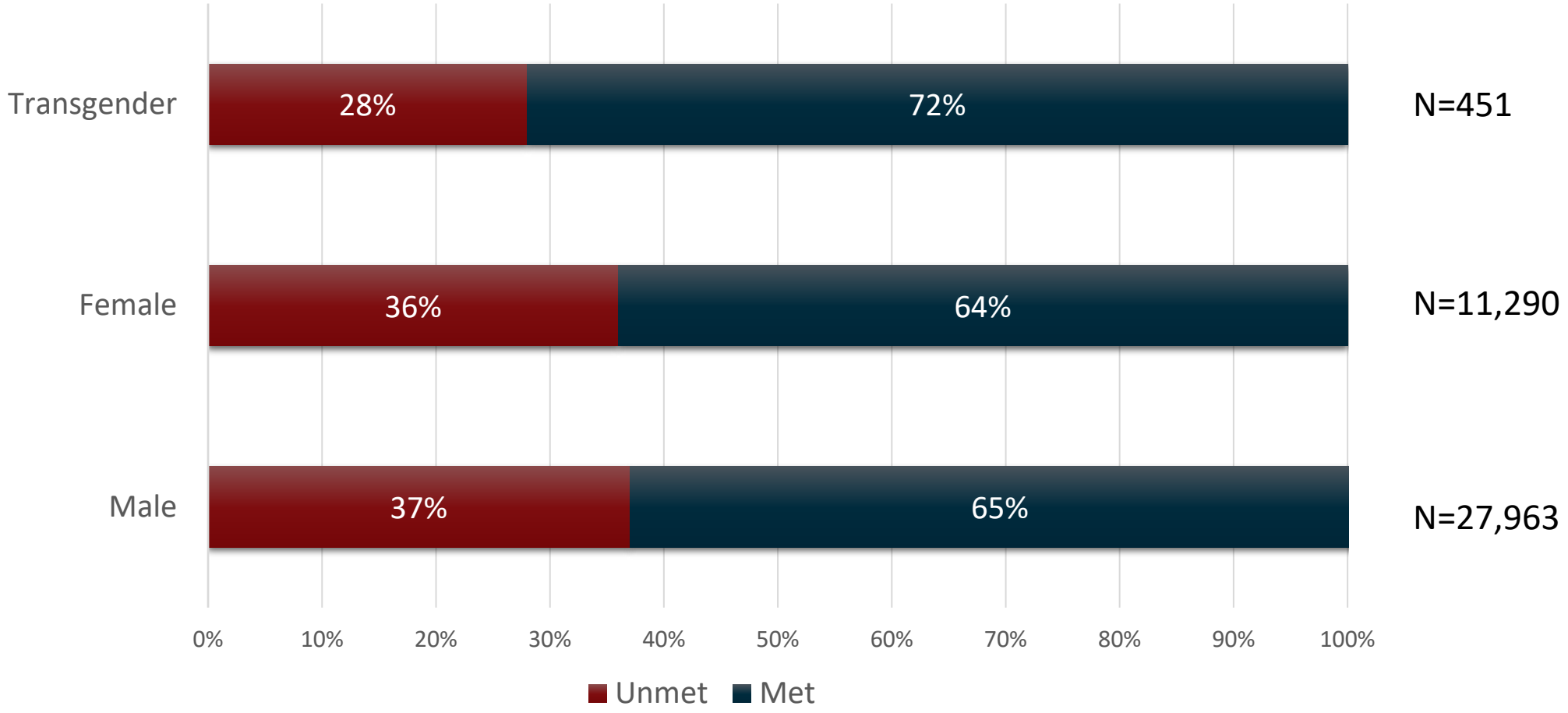
Unmet need estimates by gender identity, DC EMA, 2022, n=39,725



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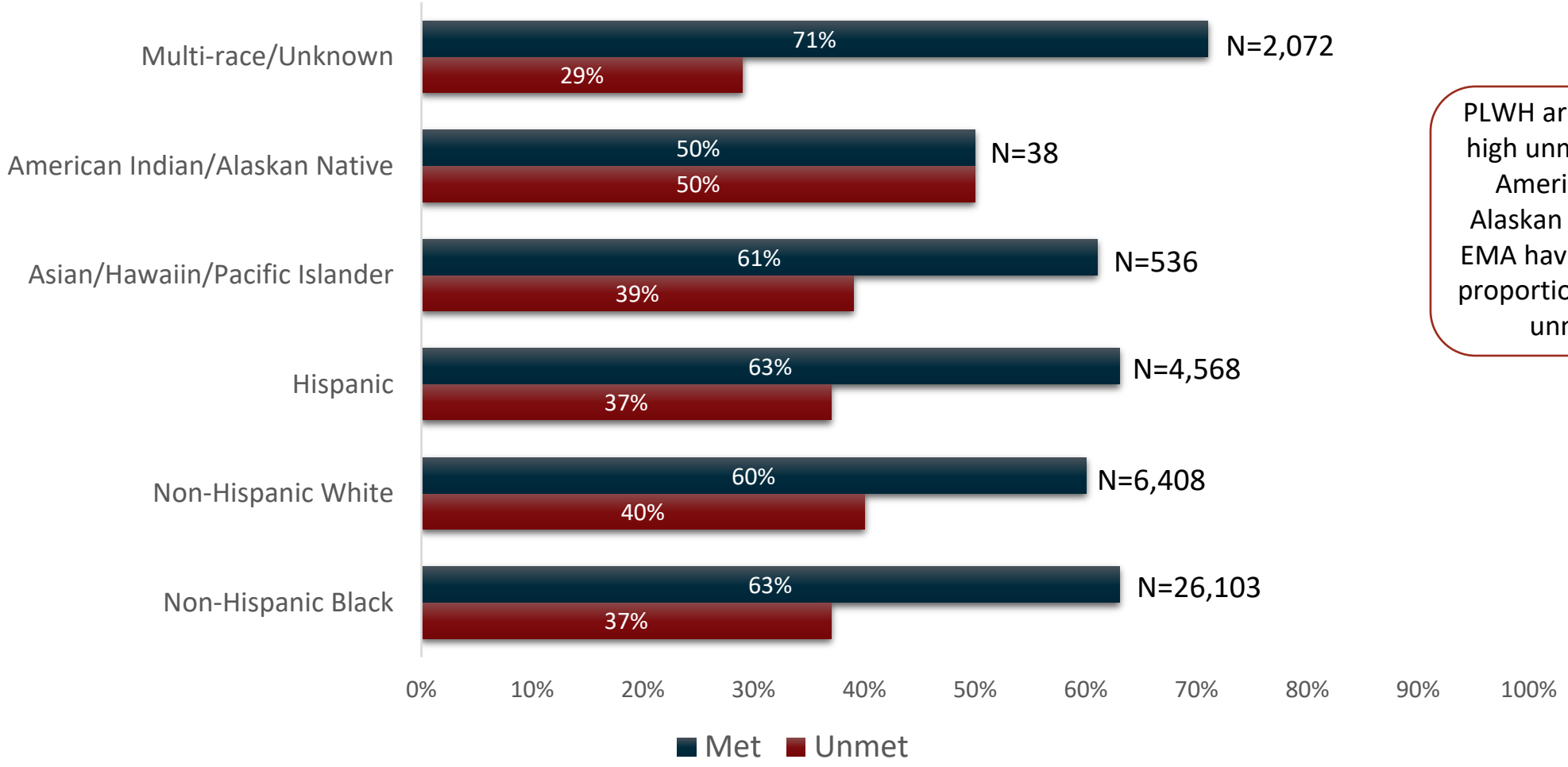
Unmet need estimates by race/ethnicity, DC EMA, 2022



PLWH are experiencing high unmet need, with American Indian / Alaskan Natives in the EMA having the highest proportion of estimated unmet need

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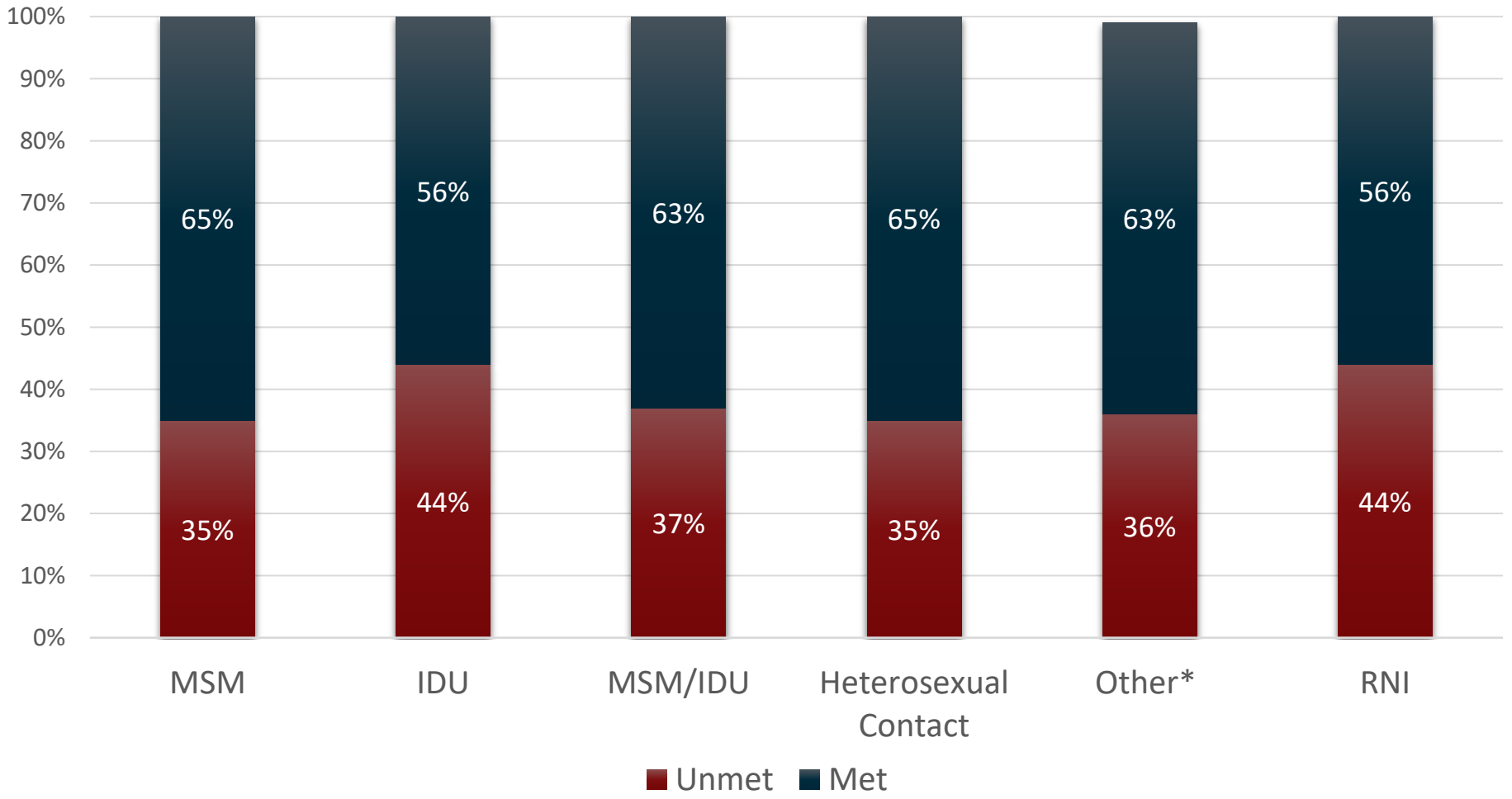
Unmet need estimates by mode of transmission, DC EMA, 2022



Estimated unmet need varies by mode of transmission, from 35% among MSM to 44% among IDU.

*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

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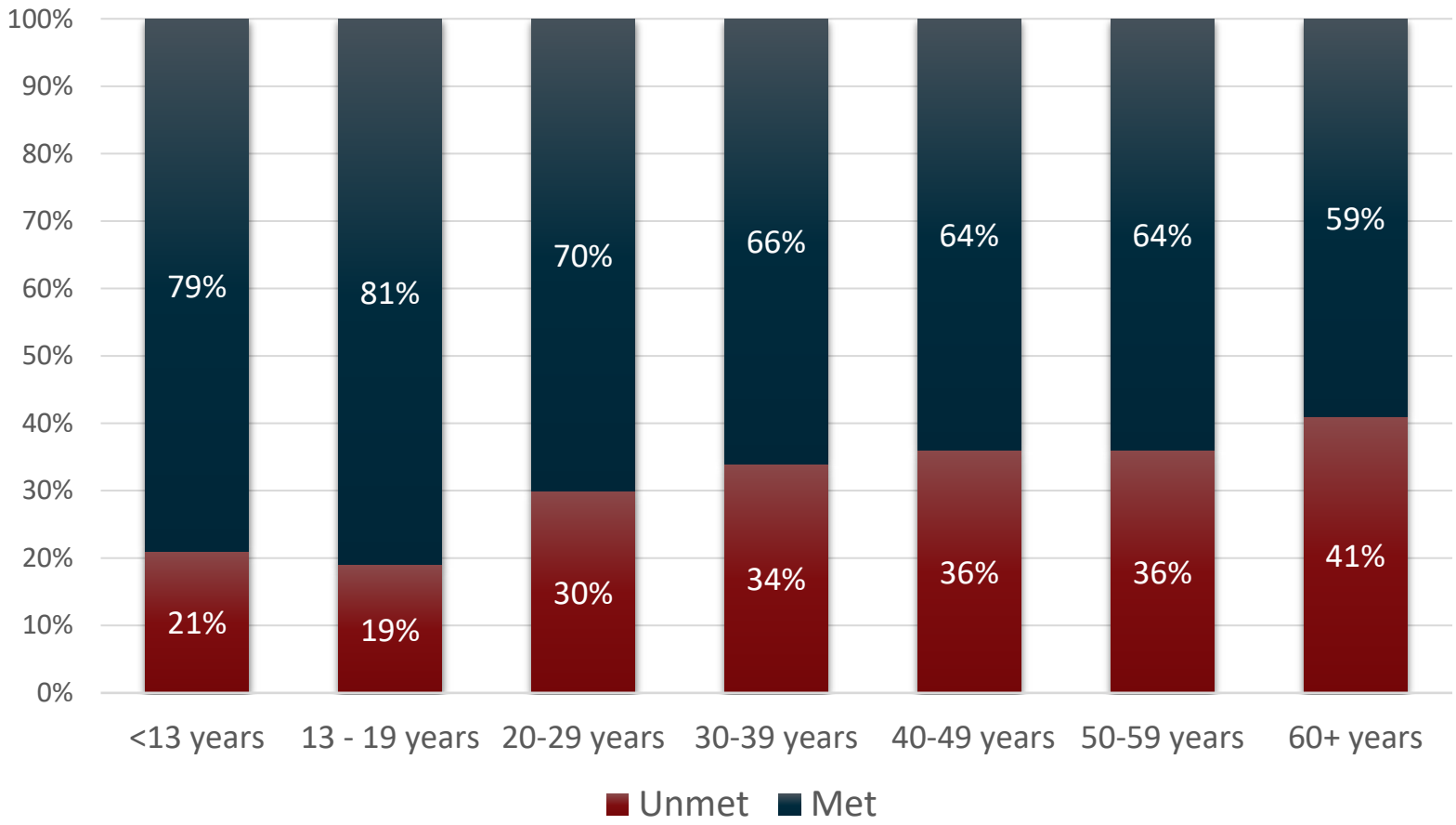
Unmet need estimates by current age, DC EMA 2022



Estimated unmet need varies by age at in 2022, from 19% among those aged younger than 13-19 to 41% among those aged 60+.

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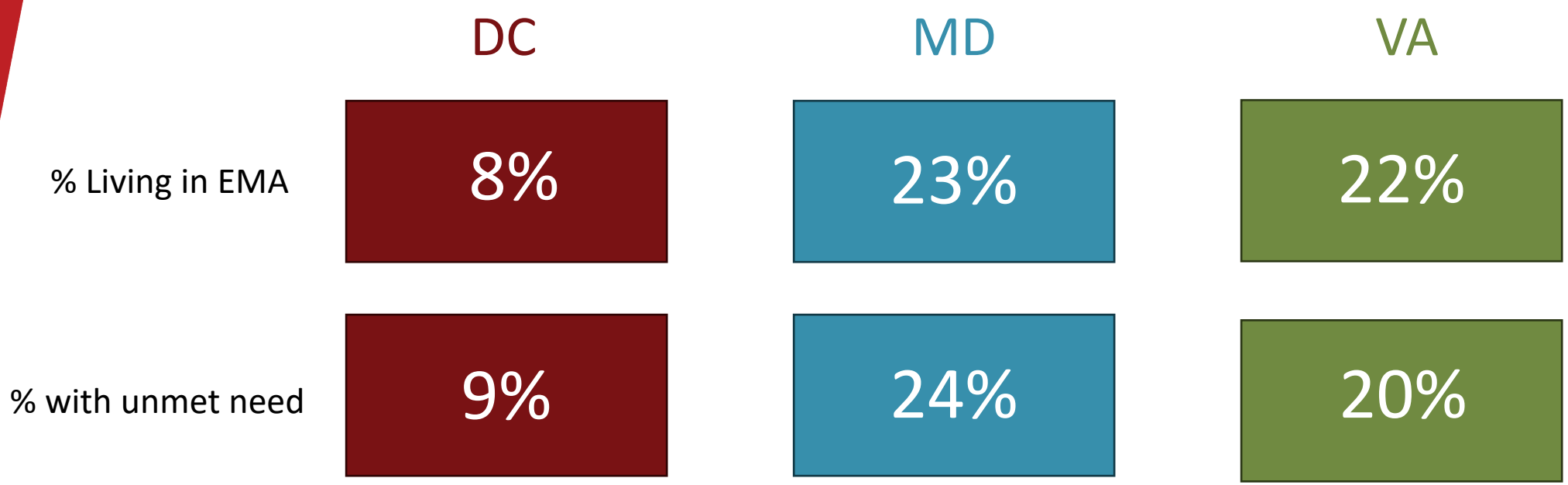
Unmet need estimates among foreign-born persons, DC EMA 2022



Estimated unmet need is proportional to overall prevalence.

Cause of Death and Co-Infections

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Cause of Death among People Living with HIV

Underlying Cause of Death	2017		2018		2019		2020		2021		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
HIV-Related	151	32%	142	31%	118	29%	166	26%	120	23%	697	28%
Non-HIV Related												
Non-AIDS Cancer (All Neoplasms except: C46, C85 & C53)	75	16%	65	14%	50	12%	88	14%	73	14%	351	14%
Cardiovascular Disease (I30-I52)	13	3%	15	3%	8	2%	8	1%	11	2%	55	2%
Liver Disease (K70-K77)	6	1%	7	2%	5	1%	11	2%	7	1%	36	1%
Chronic Obstructuve Lung Disease (J44)	9	2%	9	2%	11	3%	9	1%	6	1%	44	2%
Cerebrovascular Disease (I60 - I69)	8	2%	11	2%	7	2%	12	2%	14	3%	52	2%
Diabetes (E10-E14)	7	1%	7	2%	10	2%	11	2%	2	0%	37	1%
Viral Hepatitis (B15 - B19)	3	1%	5	1%	2	0%	0	0%	2	0%	12	0%
Substance Use (F10-F19)	2	0%	3	1%	1	0%	3	0%	3	1%	12	0%
Suicide (X60-X84)	7	1%	4	1%	2	0%	8	1%	4	1%	25	1%
Accidental Death (V01 - X59, Y40-Y89)	46	10%	41	9%	39	9%	63	10%	71	14%	260	10%
Other	126	26%	131	29%	101	24%	225	35%	176	34%	759	30%
Unknown	25	5%	13	3%	59	14%	38	6%	29	6%	164	7%
Total	478	100%	453	100%	413	100%	642	100%	518	100%	2504	100%

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HCV Co-infections among PLWH in the DC EMA, 2022

Race/Ethnicity	N	%
White, not Hispanic	70	10%
Black, not Hispanic	514	76%
Hispanic	51	8%
Asian/Pacific Islander	2	0%
American Indian/Alaska Native	1	0%
Other/Unknown	42	6%
Gender		
Male	518	76%
Female	152	22%
Transgender	10	1%
Current Age (Years)		
<13 years	0	0%
13 - 19 years	2	0%
20-29 years	54	8%
30-39 years	147	22%
40-49 years	200	29%
50-59 years	197	29%
60+ years	80	12%
Total	680	100%

Comorbidity among PLWHA

	General Population		PLWHA	
	Number in 2022	Rate	Number in 2022	Rate
Chlamydia	17,397	275.8	774	2,375.5
Gonorrhea	7,300	115.7	833	2,556.6
P&S Syphilis	466	7.4	381	1,169.4
TB	230	3.6	8	24.6
HBV	1,254	19.9	77	236.3
HCV	1,889	29.9	119	365.2

QUESTIONS?

Contact: Kate Drezner Kate.Drezner@dc.gov

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