LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, June 15, 2021
1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

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https://tinyurl.com/58sw5j7m

**Link is for non-Committee members only*

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Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, JUNE 15, 2021|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/58sw5j7m
**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001
Access code: 145 207 5184

Planning, Priorities and Allocations Committee Members:			
Frankie Darling Palacios, Co-Chair	Alexander Luckie Fuller	Everardo Alvizo, LCSW	Al Ballesteros, MBA
Kevin Donnelly	Felipe Gonzalez	Joseph Green	Karl T. Halfman, MS
Damontae Hack, Alternate	William King, MD, JD (LOA*)	Miguel Martinez, MPH, MSW	Anthony M. Mills, MD
Derek Murray	LaShonda Spencer, MD	Maribel Ulloa	Guadalupe Velasquez
DHSP Staff			
QUORUM:	9		

AGENDA POSTED June 10, 2021 * Leave of Absence

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact Commission on HIV at (213) 738-2816 or via email at hivcomm@lachiv.org.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Comisión en HIV al (213) 738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it

was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.
If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Committee leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

Call to Order | Introductions | Statement – Conflict of Interest 1:00 P.M. – 1:02 P.M.

I. ADMINISTRATIVE MATTERS 1:02 P.M. – 1:04 P.M.

1. Approval of Agenda **MOTION #1**
2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:04 P.M – 1:06 P.M.

3. Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.

III. COMMITTEE NEW BUSINESS 1:06 P.M. – 1:10 P.M.

4. Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda

IV. REPORTS 1:10 P.M. – 1:20 P.M.

5. **EXECUTIVE DIRECTOR'S/STAFF REPORT**
   a. Commission and Committee Updates

6. **CO-CHAIR REPORT** 1:20 P.M. – 1:30 P.M.
   a. "So, You Want to Talk about Race" by I. Oluo Reading Activity Excerpts only from Chapters 6 or 7
   b. Committee Co-Chair Nominations/Elections (Need 2nd Co-Chair)

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP)** 1:30 P.M. – 1:45 P.M.
   a. Fiscal Update

b. Contracts and Procurement Update
c. Programmatic Update
   i. HIV/STD Surveillance Report

8. PREVENTION PLANNING WORKGROUP 1:45 P.M. – 1:50 P.M.

a. Meeting Update

9. V. DISCUSSION 1:50 P.M. – 2:55 P.M.

a. Data Summit Agenda and Content Development
b. Housing Opportunities for Persons with AIDS (HOPWA) - Special Projects of National Significance (SPNS) Grant Follow-up
c. Paradigms and Operating Values Readability
d. DHSP Directives PY 30, 31, & 32

10. VI. NEXT STEPS 2:55 P.M. – 2:58 P.M.

a. Task/Assignments Recap
b. Agenda Development for the Next Meeting

11. VII. ANNOUNCEMENTS 2:58 P.M. – 3:00 P.M.

a. Opportunity for Members of the Public and the Committee to Make Announcements

12. VIII. ADJOURNMENT 3:00 P.M.

a . Adjournment for the Meeting of June 15, 2021.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG • *VIRTUAL WEBEX MEETING*

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PLANNING, PRIORITIES AND ALLOCATIONS (PPA) COMMITTEE MEETING MINUTES

May 18, 2021

COMMITTEE MEMBERS P = Present | A = Absent | EA = Excused Absence			
Raquel Cataldo, Co-Chair	P	Karl T. Halfman, MS	P
Frankie Darling Palacios, Co-Chair	P	Damontae Hack, Alternate	A
Alexander Luckie Fuller	P	William King, MD, JD (Leave of Absence)	A
Everardo Alvizo, LCSW	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	A	Anthony M. Mills, MD	A
Kevin Donnelly	P	Derek Murray	P
Felipe Gonzalez	P	LaShonda Spencer, MD	P
Joseph Green	P	Maribel Ulloa	P
Michael Green, PhD, MHSA	A	Guadalupe Velasquez	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit and Carolyn Echols-Watson			
DHSP STAFF			
Pamela Ogata and Jane Bowers			

*

Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website at
http://hiv.lacounty.gov/Portals/HIV/Commission%20Meetings/2021/Packet/PPAVrtMtg%20-051821-merged%20packet.pdf?ver=wKqEvQNWHaYjgC4zdWJPxg%3d%3d

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST
Frankie Darling Palacios called the meeting to order at approximately 1:06pm. Members introduced themselves and stated their conflicts.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approved the April 20, 2021 Planning, Priorities and Allocations Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

3. Opportunity for members of the public to address the Committee on items of interest that is within the
Jurisdiction of the Committee.

III. COMMITTEE NEW BUSINESS ITEMS

Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

- Derek Murray expressed a concern with the planning and allocation process approaching that a discussion should include an understanding of DHSP/County's response to the alarming increase in STD rates. He inquired about DHSP's response on HIV/STD issues as part of the priority setting and resource allocation process (PSRA).

➢ Insights from DHSP on considering STD surveillance data in the PSRA process will be in the PP&A June agenda.

Frankie Darling Palacios requested more information on the National Minority AIDS Council (NMAC) blog regarding MAI funding and who benefits from funding. They also requested discussing expenditure information provided by DHSP in more depth at the June meeting. Cheryl Barrit noted that NMAC Executive Director, Paula Kawata, made a correction to his initial blog. P. Kawata used MAI funding and data as an example of how to respond to a federal Request for Information on how the federal government can advance equity and support in underserved communities across the United States.

➢ DHSP expenditure discussion will be included on the June PP&A meeting agenda.
➢ C. Barrit will make sure to forward the correction letter from NMAC to Committee members.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Commission and Committee Updates

The national HealthHIV organization presented their findings on an effectiveness assessment of the Commission as the local planning council for Los Angeles County. The findings will be reviewed will move forward for additional deliberation and specific implementation of recommendations and opportunities for Commission improvement at the upcoming Executive Committee meeting on May 27, 2021.

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The Operations Committee will meet on May 27th and will debrief on the planning council effectiveness assessment and talk about ways to engage and pay attention to ideas around membership, recruitment, engagement, and retention.

The Consumer Caucus debriefed and discussed the planning council effectiveness assessment findings.
They offered suggestions on putting recommendations and findings into practice.

The Caucus is thinking of ways to address all Committees of the Commission not just in engagement and recruitment, but in terms of ending the epidemic and consumer leadership.

C. Barrit announced the departure of Raquel Cataldo as a Co-Chair of PP&A and as a Commissioner. R. Cataldo said a few words in farewell to the Committee. Raquel Cataldo resigned as Co-Chair of the PP&A Committee.

- Committee Co-Chair Nominations/Elections (need 2nd Co-chair) will be added to the June PP&A agenda.

b. Ending the HIV Epidemic (EHE) Activities

C. Barrit introduced Katja Nelson as one of the Commission's liaisons to the DHSP EHE Steering Committee. K. Nelson will provide an update on EHE activities as they relate to the activities of the Commission.

K. Nelson posed the following question to the PP&A Committee.

- What EHE activities/efforts does the Committee want to implement?
- How do activities align with planning council efforts?
- What do Commissioners want liaisons to achieve?
- What information should be conveyed?

Decisions should be made through a racial justice and health equity framework.

It was recommended prevention planning efforts be made to improve PrEP information and viral suppression rates for all Ryan White clients. It was further noted, PP&A plans to include strong directives around prevention.
The Prevention Planning Workgroup (PPW) provides a focused opportunity for Commissioners to participate in prevention planning efforts.

Everardo Alvizo stated the City of Long Beach is planning to invite DHSP EHE Steering Committee members to speak to their planning council. This is to reduce the duplication of efforts and determine how the City of Long Beach can work with DHSP and other County partners

It was further noted, the Department of Public Health (DPH) should play an active role in providing medical providers/physicians with information on where to refer those diagnosed with HIV.

It was noted the Commission has service standards for medical providers established by the Standards and Best Practices (SBP) Committee. Additionally, DHSP has a Medical Advisory Committee to share best practices with medical providers.

The Committee encouraged expanding activities to providers educating involvement of physicians.

6. CO-CHAIR REPORT

a. "So, You Want to Talk About Race" by I. Oluo Reading Activity **Excerpts Only** from Chapters 4 **or** 5

- Due to time constraints, there was no reading.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

a. Fiscal and Programmatic Update

Pamela Ogata presented a revised allocation table for PY 31. The revised allocations required approval by the Committee because the document is due June 30, 2021 per DHSP.

i. PY 31 (FY2021) Revised Allocation **Motion #3**

The Motion #3 was passed. (Ayes 8; Noes 0)
Vote is for current PY allocation March 1, 2021 – February 28, 2022
P. Ogata presented the following information on the PY 31 Revised Allocation percentages.

- PY 30 Part A expenditures exceed the allocation amount indicating a need to reallocate PY 31 funding.
- Linkage and Re-engagement Program (LRP) is better aligned with Health Resources and Services Administration (HRSA) EHE grant funds. Historically DHSP used Part A funding under the service category of Outreach for an annual cost of $1.3 to $1.8 million. DHSP feels this program is more in line with EHE goals which includes working with out of care and not virally suppressed individuals.

  The LRP identifies People Living with HIV (PLWH) that are out of care, using surveillance data, and has DHSP staff work to re-engage those individuals into care.

➢ W. Garland will present data in July 2021 regarding RW utilization from PY 30 and LRP will be included.

- HIV testing administered by DSHP had low numbers in 2020 due to COVID-19. Other contracted testing services are supported by CDC funding. Realigning testing services administered by DHSP will ease reporting responsibility by putting all testing services together and relieving the possibility of HRSA overspending in PY 31.

The Committee was concerned about the estimated over expending of Part A funds in PY 30. DHSP was asked how this would be addressed. DHSP identified the following factors.

- Allocation are developed in percentage so funding allocation do not exceed total funds received.

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- DHSP moves cost to maximize funding. It was noted EHE funding in 2020-21 was $5.1 million.
- Part of the over expenditures in Part A funding were due to PY 30 telehealth services increasing. These services were cost reimbursement contracts not performance-based or fee-for-service. COVID-19 increased operational cost for providers so contract funding increased to reimburse providers.
- It was noted funding amounts are not decreased, just the percentage allocation from the particular funding source. The additional funds needed are derived from other funding sources.

➢ DHSP will present Minority AIDS Initiative funding, demographic, and health outcomes data at the July PP&A meeting.

b. **Contracts and Procurement Update**
No updates were provided.

8. PREVENTION PLANNING WORKGROUP (PPW)

a. Update from April Meeting

Maribel Ulloa provided a brief review of the April 28, 2021 PPW meeting. DHSP provided a significant amount of prevention data which included funding, expenditures, programs, and demographics of client served. (PowerPoints with prevention data are included in the meeting packet.)

Committee members were invited to submit questions and attend the May 26, 2021 PPW meeting. The meeting will include DHSP addressing questions on the data presented at the April 28th meeting.

It was noted the evening time of the meeting has help with the participation of community members that do not regularly participate in Commission planning activities.

b. Challenges, Workgroup Feedback and Timeline, Committee Expectations
Due to time restraints this issue was not addressed.

V. DISCUSSION

a. Housing Opportunities for Person with AIDS (HOPWA) – Special Projects of National Significance (SPNS) Grant

M. Ulloa provided an overview of the SPNS grant. It is a 3-year grant. The grant funds can be used to provide data- centered approaches/strategies to homeless and CD4 count viral load suppression.

SPNS grant does not have to be specifically used for housing. It can be for maintaining or supporting housing. Grant applicants should be innovative in identifying and addressing disparities.

The minimum grant amount is $300,000 and the maximum is $2.5 million. No renewal projects are permitted unless they can be sustained through other funding sources after the grant ends.

Due to grant time restraints and procurement contracts procedures, contracts may be limited to established existing providers.

It was also noted, HRSA housing services has a two-year limit and thus cannot support permanent long-term housing because the funding is short term funding.

K. Nelson asked if clients participating in Residential Care Facilities for Chronically Ill/ Transitional Residential Care Facilities (RCFCI)/(TRCF) were displaced after the 2-year funding limit. P. Ogata stated clients work with Housing for Health program to place all clients in other forms of housing once they have timed out of the RCFCI/TRCF programs.

- M. Ulloa will provide details at the June meeting PP&A meeting. The Committee agreed to include the SPNS grant on the June agenda for follow-up.

b. Paradigms and Operating Values Readability

- The Committee agreed to postpone the agenda item until the June 15, 2021 PP&A meeting.

c. DHSP Directives PY 30, 31, & 32

- The Committee agreed to postpone the agenda item until the June 15, 2021 PP&A meeting.

VI. NEXT STEPS

a. Task/Assignments Recap

Committee is requesting clarification on efforts of DHSP/County of Los Angeles to address issues identified in the NMAC article regarding MAI funds and the percentage of minorities living with HIV, and the care received. Clarify funding DHSP has not read the email/formula based.

- C. Barrit will forward the correction e-mail to committee members.

b. Agenda Development for the Next Meeting

The next meeting is scheduled for June 15, 2021

VII. ANNOUNCEMENTS

a. Opportunity for Members of the Public and the Committee to Make Announcements

There were no announcements.

VIII. ADJOURNMENT

a. **ADJOURNMENT**:

The meeting was adjourned at approximately 3:02PM.

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LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We strive for consensus and compassion in all our interactions.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **We give and accept respectful and constructive feedback.**
7) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
8) **We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).**
9) **We give ourselves permission to learn from our mistakes.**

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19)**

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 6/07/21

The following list identifies "conflicts-of-interest" for Commission members who represent agencies with Part A/B –and/or CDC HIV Prevention-funded service contracts with the County of Los Angeles. According to Ryan White legislation, HRSA guidance and Commission policy, Commission members are required to state their "conflicts-of-interest" prior to priority- and allocation-setting and other fiscal matters concerning the local HIV continuum of care, and to recuse themselves from discussions involving specific service categories for which their organizations have service contracts.

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KAMURIGI	**Nestor**	No Affiliation	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROBINSON	**Mallery**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

COUNTY OF LOS ANGELES
Public Health

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Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

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Director, Division of HIV and STD Programs

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May 6, 2021

Dear Division of HIV and STD Programs Colleagues:

On April 13, 2021, the federal Centers for Disease Control and Prevention (CDC) released its 2019 Annual Sexually Transmitted Disease (STD) Surveillance Report which can be accessed at (https://www.cdc.gov/std/statistics/2019/default.htm). The national report showed that the number of reported STDs reached an all-time high with a combined 2.6 million cases of chlamydia, gonorrhea, and syphilis reported. The highest increase was observed in cases of syphilis among newborns which has quadrupled in the United States over the last 5 years. The inaugural Sexually Transmitted Infection (STI) National Strategic Plan, released in 2020, has set forth five high-level goals to develop, improve, and bring to scale STD prevention and control programs over the next five years. These goals include:

1. Preventing new STDs through increased awareness, expansion of high-quality programs, improving Human Papilloma Virus vaccination coverage, and increasing the public health and health care capacity to prevent STDs.
2. Improving health by expanding high-quality STI prevention in communities most impacted by STDs and increasing the capacity to identify, diagnose and provide care and treatment for persons with STDs.
3. Accelerating progress in STD research, technology and innovation in vaccines, preventive strategies, diagnostic technologies, and therapeutic agents.
4. Reducing health inequities by addressing stigma and discrimination, expanding culturally competent and linguistically appropriate STD programs, and addressing social determinants of health and co-occurring conditions among those most vulnerable to disease.
5. Achieving a coordinated STD response by addressing the syndemics of STDs, HIV, viral hepatitis, and substance abuse disorders in STD programs; improving the quality, timeliness, and use of STD data, and improving systems for measuring, monitoring, evaluating, reporting, and disseminating progress.

The Los Angeles County (LAC) Department of Public Health's Division of HIV and STD Programs (DHSP) has prepared a STD snapshot highlighting key findings from STD case surveillance data reported to DHSP through the end of 2019. Similar to the trends outlined in the CDC report, LAC showed increases in the number of syphilis and chlamydia cases in 2019. In LAC, syphilis cases among infants reached its highest level in 2019, reflecting a 1,300% increase since 2012 when congenital syphilis cases were at a nadir. Conversely, gonorrhea cases have plateaued after a peak in 2018, reflecting a difference from the national trend.

Disparities in STD disease persist across age, gender, and racial/ethnic groups in LAC, underscoring the need for STD programs to address the barriers that prevent the most at-risk communities from accessing the services needed to improve health. This includes improved access to sex-positive and culturally appropriate programs that provide integrated services for persons with low health literacy, persons who are unstably housed or experiencing homelessness, persons with substance use disorders, and persons experiencing poverty. To reverse the STD epidemic, LAC Public Health will continue to focus the STD response on four priorities that aim to strengthen policy efforts and intensify screening, treatment, and awareness, particularly for at-risk populations.

1. Improve early detection of cases through testing of at-risk populations.
2. Interrupt disease transmission through the appropriate treatment of cases and their partners.
3. Educate consumers and community to raise awareness of STDs.
4. Create effective policies to impact health care provider behavior.

For your reference, LAC's 2019 STD snapshot is attached and can be accessed on the DHSP website at: http://publichealth.lacounty.gov/dhsp/Reports.htm.

Sincerely,

Mario J. Pérez, MPH
Director

Sonali Kulkarni, MD, MPH
Medical Director

Andrea Kim

Andrea Kim, PhD, MPH
Chief of HIV and STD Surveillance

MJP:AK
R:\Executive Office\Executive Common\Correspondence\Announcement Memos

Sexually Transmitted Diseases in Los Angeles County, 2019[1]

(excludes Long Beach and Pasadena)

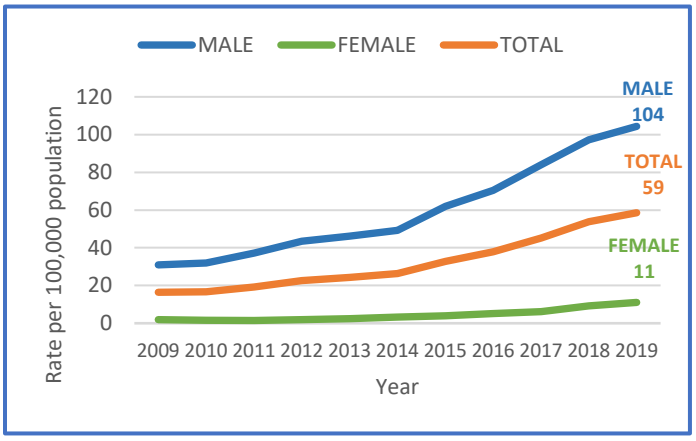
Sexually transmitted diseases (STDs) continue to rise in Los Angeles County (LAC). In 2019, there were a total of 98,427 cases of STDs reported to the LAC Department of Public Health. The majority of reported cases (66%) were chlamydia followed by gonorrhea (25%) and syphilis (9%). Sixty-five percent of the syphilis cases were early syphilis.[2] Data do not include Long Beach and Pasadena due to reporting delays.

Early Syphilis

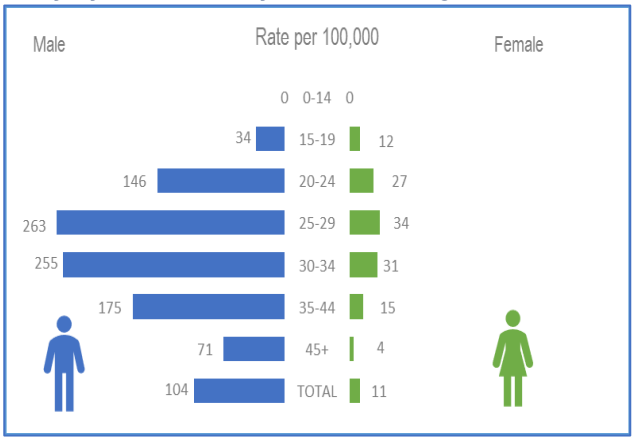
Syphilis is a sexually transmitted infection caused by the bacteria, Treponema pallidum and is a known risk factor for HIV. While it is the least prevalent of the reportable STDs, if untreated, it can cause significant health issues including damage to the brain, nerves, eyes, or heart. Early syphilis includes the infectious stages of syphilis infection.

In 2019, 5,643 early syphilis cases were reported to LAC with a rate of 59 per 100,000, reflecting a 9% rate increase compared with the 2018 rate. In 2019, early syphilis among males occurred at 9.5 times the rate as that of females; however, from 2018 to 2019, there was a lower relative increase in early syphilis rates among males (7%) compared to females (20%). Transgender individuals represented 2.5% of the early syphilis cases.[3] Among both males and females, rates were highest among persons aged 25-29 years. By race, rates were highest among Pacific Islanders (141 per 100,000) and African Americans (135 per 100,000).

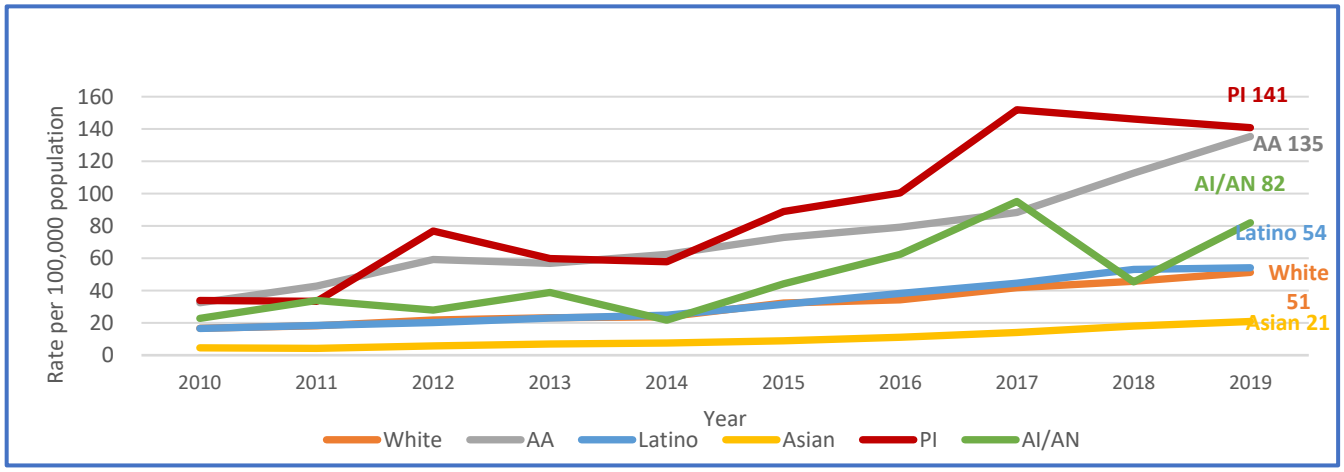
Early Syphilis Rates by Gender, 2010-2019



Early Syphilis Rates by Gender and Age Group, 2019



Early Syphilis Rates by Race/Ethnicity, 2010-2019



Congenital Syphilis

[1] Data are provisional and subject to change due to reporting delays. Data do not include Long Beach and Pasadena. This document will be updated to include these jurisdictions when data become available.

[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent). Note that syphilis rates are unstable for PI (2010-2011, 2013-2014) and AI/AN (2010-2016) due to small numbers.

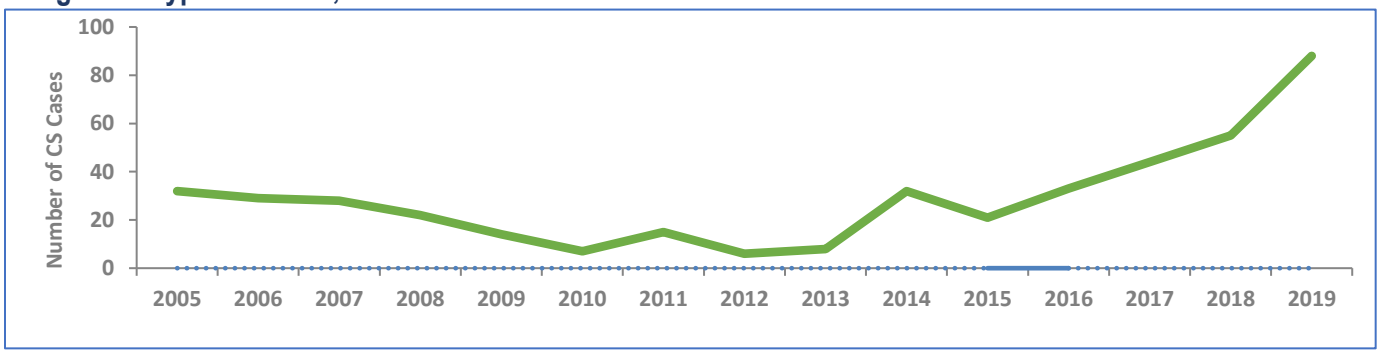
[3] Transgender women represented 2.4%, 0.6% and 0.2% of the early syphilis, gonorrhea, and chlamydia cases, respectively.

Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

Congenital syphilis is a multi-system infection caused by the bacteria, Treponema pallidum, in a fetus or infant, passed during pregnancy. It can cause preterm birth, miscarriage or stillbirth. It can also lead to serious birth defects.

In 2019, the number of congenital syphilis cases continued to rise (N=88) with an increase of 60% since 2018. Since 2012, the number of reported congenital syphilis cases has increased over 1,300%. Latinx (57%) females represented the majority of mothers of infants with congenital syphilis.

Congenital Syphilis Cases, 2005-2019

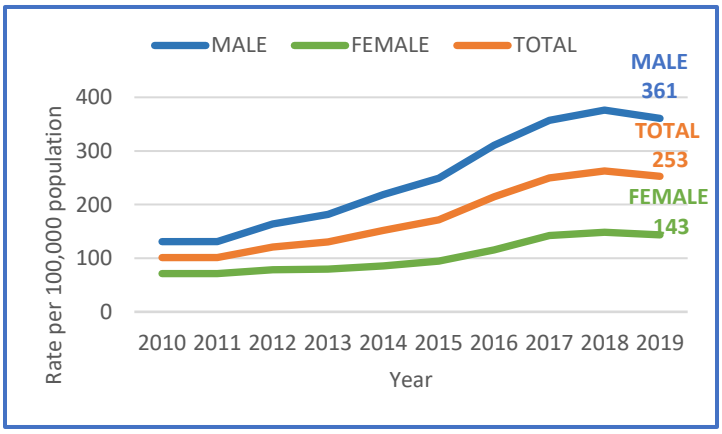


Gonorrhea

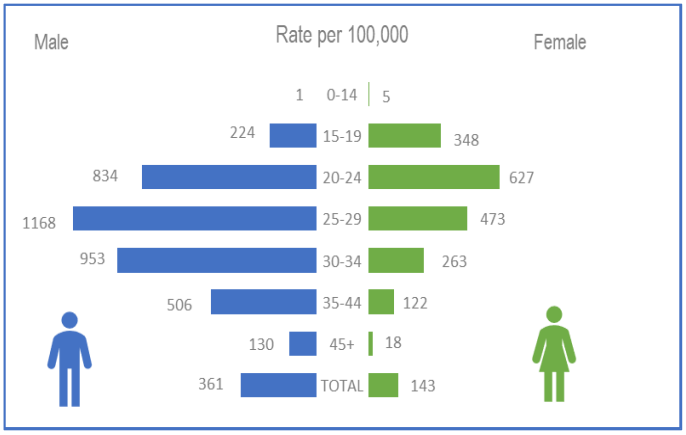
Gonorrhea is one of the most commonly reported sexually transmitted infections. It can cause infection in the genitals, rectum, and throat. If untreated, gonorrhea can cause serious health problems including infertility for men and women. It may also increase the chances of getting HIV. Though gonorrhea is treatable, it has progressively developed resistance to the antibiotic drugs prescribed for treatment.

In 2019, 24,342 gonorrhea cases were reported to LAC with a rate of 253 per 100,000, reflecting a 4% rate decrease compared with the 2018 rate. Among males, gonorrhea rates were 2.5 times higher than among females in 2018. Male gonorrhea rates decreased 4% and female rates decreased 3% since 2018 with rates highest among males 25-29 years and females 20-24 years. Transgender individuals represented 0.7% of the gonorrhea cases.[3] By race, African Americans had rates (666 per 100,000) 3.9 times higher than Whites (171 per 100,000).

Gonorrhea Rates by Gender, 2010-2019

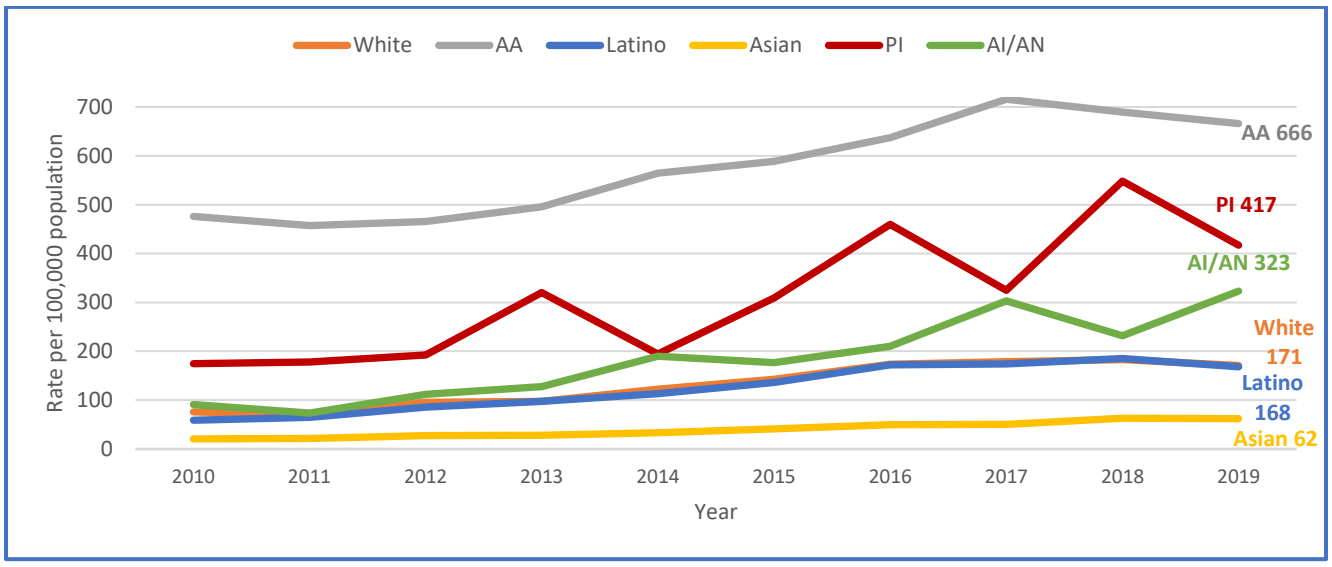


Gonorrhea Rates by Gender and Age Group, 2019



[1] Data are provisional and subject to change due to reporting delays. Data do not include Long Beach and Pasadena. This document will be updated to include these jurisdictions when data become available.
[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent).
[3] Transgender women represented 2.4%, 0.6% and 0.2% of the early syphilis, gonorrhea and chlamydia cases, respectively.
Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

Gonorrhea Rates by Race/Ethnicity, 2010-2019

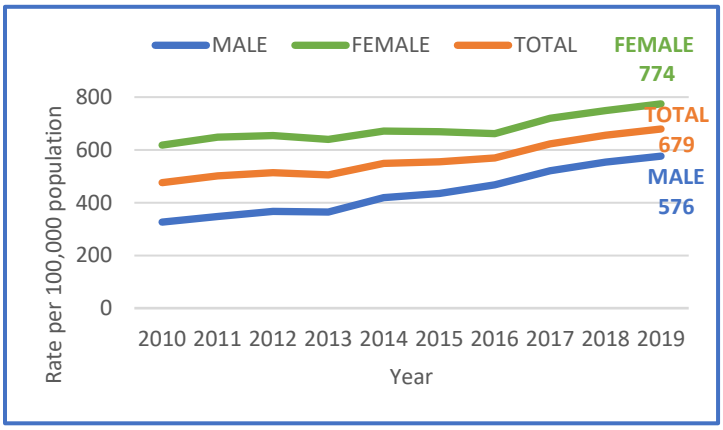


Chlamydia

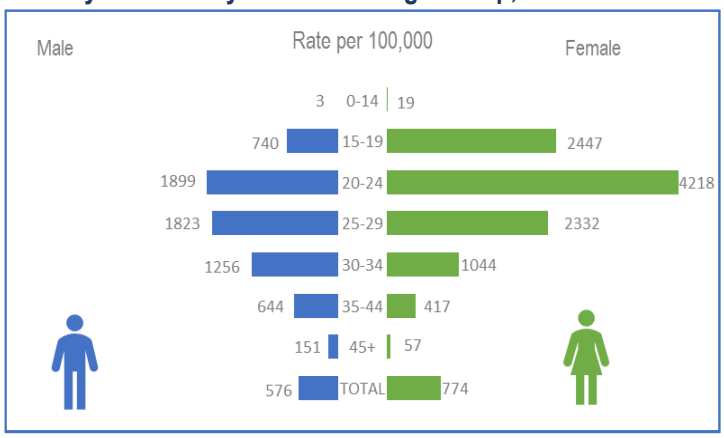
Chlamydia is the most commonly reported sexually transmitted infection and can be transmitted via vaginal, rectal or oral sex. If untreated, it can cause infertility in women.

In 2019, 65,431 chlamydia cases were reported to LAC with a rate of 679 per 100,000, reflecting a rate increase of 4% compared with the 2018 rate. Rates among males increased 4% while females increased 3% since 2018. Transgender individuals represented 0.2% of the chlamydia cases.[3] Chlamydia was most prevalent among youth 15-29 years old. Due to changes in chlamydia reporting in the State of California in which providers are no longer required to report cases, race/ethnicity information are not complete for chlamydia cases and therefore case rates are not reported for race/ethnicity categories.

Chlamydia Rates by Gender, 2009-2019



Chlamydia Rates by Gender and Age Group, 2019



[1] Data are provisional and subject to change due to reporting delays. Data do not include Long Beach and Pasadena. This document will be updated to include these jurisdictions when data become available.
[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent).
[3] Transgender women represented 2.4%, 0.6% and 0.2% of the early syphilis, gonorrhea and chlamydia cases, respectively.
Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

CONTRACTED HIV PREVENTION SERVICES 2019

Unlike other contracted services, there is no centralized data collection system for HIV Prevention Services. Data are reported to DHSP through monthly reports using Excel spreadsheets to provide counts of clients served, types of services provided. Because these are submitted on a monthly basis in aggregate and not the client-level, it is difficult to deduplicate the data.

The data presented below is based on these monthly reports for 2019.

HEALTH EDUCATION/RISK REDUCTION (HERR) 2019

The HERR portfolio consists of a total of 21 programs targeting men who have sex with men who use crystal meth (MSM), people who use injection drugs (PWID), women, and people living with HIV (PLWH) across 13 contracted agencies.

Across all programs, these contractors were funded to conduct outreach encounters (which includes providing linkages to HIV testing, STD screening, PrEP/PEP, substance abuse, and mental health services)

- A total of 10,529 individuals received outreach encounters, of which 40% (N=4,227) were linked to HIV/STD testing, prevention and/or other support services (as identified above).

In addition, programs implemented navigation services to assist clients with accessing more individualized prevention services. These were provided during a 1:1 counseling session with a navigator who conducted a risk assessment and developed personalized plan of action with the client.

- A total of 1,742 individuals participated in navigation services, of which 71% (N=1,234) completed a 30-day follow up session.

Finally, some providers implemented group-level interventions that included implementation of CDC-Effective Interventions (SISTA, Healthy Relationships, MPowerment).

A total of 515 people participated and completed the three required sessions in these multi-session groups.

HERR CLIENT DEMOGRAPHICS:
Demographic data was collected for 2,862 clients.

- 58% were Male; 28% were cis-gender Women; and 6% were Transgender individuals
- The majority were older than 45 (36%) and 30-45 (34%)
- 67% reported substance use

Contracted agencies reported that a total of 62,565 condoms were distributed to HERR clients during the reporting period.

VULNERABLE POPULATION (VP) 2019
The Vulnerable Populations contracts consist of eight programs: six targeting YMSM (African-American and Latino); and two targeting transgender Individuals

In order to better engage agencies in the development of prevention programming, the SOW vary across providers, but the following categories are included across all programs:

- Community Advisory Boards (CAB): A total of 366 individuals participated in the various CABs (duplicated)
- Outreach Encounters: A total of 2,704 individuals were reached through outreach

VP CLIENT DEMOGRAPHICS

Demographic information was available for 3,800 VP clients:

- 67% were Male
- 33% identified as transgender individuals

- 42% 15-23 years old
- 41% 24-29 years old
- 12% 30-45 years old
- 6% over age 45

- 45% African-American
- 37% Latino

- 22% reported substance use

Contracted agencies reported that a total of 47,983 condoms were distributed to HERR clients during the reporting period.

RESPONSE TO PREVENTION PLANNING WORKGROUP MEETING, APRIL 28, 2021

Data Sources for "Overview of Contracted HIV Prevention and Testing Services in Los Angeles County" presentation

1. Los Angeles County Apps Based Survey
    a. The main purpose of this annual survey is to track trends in PrEP knowledge, awareness and use as well as U=U knowledge. It also collects feedback on social marketing messages related to PrEP and U=U among Black and Latino MSM and transgender person in LAC.
    b. Key data collected: sociodemographic characteristics, PrEP knowledge, awareness and use, U=U knowledge, medical mistrust, sexual and drug using risk behaviors, HIV status, and social marketing message exposure.
    c. Key indicators: PrEP knowledge, awareness and use, U=U knowledge, and social marketing exposure and message acceptability.
    d. Recruitment: Potential candidates are recruited through advertisements on selected dating apps and through social network referrals on social media. Candidates must report they live in an LAC zip code. To ensure representation among the priority populations for this survey, recruitment of Black or Latino MSM and transgender persons is emphasized.
    e. Eligible candidates complete an online survey that is self-administered.
    f. Limitations include:
        i. Respondents surveyed represent a convenience sample of Black and Latino MSM and transgender persons who could be reached through the online recruitment strategies and may not represent the experience of all Black and Latino MSM or transgender persons.
        ii. Data represent only a single point in time (cross sectional) and are only descriptive – causation cannot be inferred.
        iii. Data are self-reported and may be subject to social desirability and other types of bias however as it was an anonymous survey completed online, this may have resulted in more realistic responses from respondents.

2. Contracted Biomedical Services
    a. This dataset includes PrEP and PEP service data reported by the 12 PrEP Centers of Excellence (COE).
    b. Key data collected: sociodemographic characteristics, PrEP and PEP prescriptions, PrEP and PEP retention, sexual and drug using risk behaviors
    c. Key indicators: PrEP and PEP referrals, PrEP and PEP uptake (prescriptions, use) and PrEP persistence (adherence and retention)
    d. Limitations
        i. Data completeness: Missing data may be a result of agency not collecting, agency collecting but not reporting or client not reporting. Additionally, all data from clients are self-reported to the provider and may be subject to social desirability or other biases.

ii. Data timeliness: Frequency and timeliness of data vary by the agency, so data reports are based on the data available at the time of analysis.
iii. Representativeness: While data may be representative of clients accessing biomedical services at the COEs, they may not represent all clients accessing biomedical services in LAC.

3. HIV/STD Testing Services
    a. This dataset includes reported HIV testing and STD screening services conducted at contracted agencies, public health clinics, jails, court-ordered testing, and DHSP events.
    b. Key data collected: sociodemographic characteristics, sexual and drug using risk behaviors, HIV testing history, referrals to prevention, risk reduction and support services, PrEP, HIV care, provision of behavioral prevention services
    c. Key indicators: testing volume, test positivity (all tests), new test positivity (newly identified positive results), linkage to care within 30 days, linkage to partner services (through 2019), and PrEP knowledge and use (since 2017).
    d. Match with HIV surveillance data to verify client and provider reports of new positivity and linkage to care.
    e. Testing Modalities

CONTRACTED TESTING MODALITES	
2012-2019	2020-2022 (+2 optional years)
Routine Screening (HIV) • Routine Screening • Community Clinic • Community STD Clinic • Events • Public Health STD Clinic • Urgent Care	Category 1: STD SDT (chlamydia, gonorrhea, syphilis)
Targeted Screening and Treatment of STDs (chlamydia, gonorrhea, syphilis, HIV) • Community Clinic	Category 2: Sexual Health Express Clinics (SHEx-C) (chlamydia, gonorrhea, syphilis, HIV)
Targeted Screening (HIV) • Storefront • Sexual and Social Networks	Category 3a and 3b: HIV Screening and Referrals (HIV) • Storefront • Sexual and Social Networks
Targeted HIV and STD	Category 4: Commercial Sex Venues (HIV and syphilis)
Integrated HIV/STD Screening (chlamydia, gonorrhea, syphilis, HIV) • Community Clinics • Storefront • Mobile testing units	Category 4: Commercial Sex Venues (chlamydia, gonorrhea, syphilis, HIV)

City of Long Beach (April 2019) (chlamydia, gonorrhea, syphilis, HIV)	City of Long Beach (through December 2021) (chlamydia, gonorrhea, syphilis, HIV)
Vulnerable Populations (start in 2017) (chlamydia, gonorrhea, syphilis, HIV)	Vulnerable Populations (chlamydia, gonorrhea, syphilis, HIV)
HEALTH DEPARTMENT TESTING MODALITIES	
Department of Public Health Sexually Transmitted Disease Clinics (chlamydia, gonorrhea, syphilis, HIV)	
Jails (DHSP) • Men's Jail (chlamydia, gonorrhea, syphilis, HIV • Women's Jail (chlamydia, gonorrhea) • Juvenile Hall (chlamydia, gonorrhea, syphilis)	
Court Ordered (DHSP)	

f. Limitations
    i. Data completeness: Missing data may be a result of agency not collecting, agency collecting but not reporting or client not reporting. Additionally, all data from clients are self-reported and may be subject to social desirability or other biases.
    ii. Data timeliness: Frequency and timeliness of data vary by the agency, so data reports are based on the data available at the time of analysis
    iii. Representativeness: Data for clients seeking testing services is at the test level and not the client level so it may not be reflective of clients accessing testing services at DHSP HIV/STD testing sites or in Los Angeles County. Client level data is collected for those clients with a positive test result. These clients who test positive may be representative of clients with a positive test result at DHSP HIV/STD testing sites but may not represent all clients receiving positive test results in LAC.
    iv. From 2012-2019, forms and variables collected varied by modality so PrEP use and sexual and drug using risk behavior data are not available for Routine, Jails, Court Ordered settings.
        1. Within the Targeted and Integrated Screening settings, test counselors only asked the risk behavior and PrEP questions if the client reported any generally so those who did not report any generally to the counselor were excluded from further risk behavior or PrEP questions.
    v. As a result of COVID-19, transition to new HIV testing forms were delayed, requiring providers to continue using the forms for the 2012-2019 contracts. The new forms, which collect the same data across all testing modalities, were implemented January 1, 2021. These data will be subject to the same limitations as indicated above (i-iv).

LOS ANGELES COUNTY
COMMISSION ON HIV

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Data Presentations and Key Information Received from the Division of HIV and STD Programs and Other Agencies
(To help design the agenda and focus of the July Planning, Priorities and Allocations Committee Data Summit)

Document/Presentation Title	Presented by:	Date Received/Notes
Ending the HIV Epidemic (EHE) Progress to Date	J. Tolentino	Commission on HIV (COH) Meeting February 11, 2021
Overview of Contracted HIV Prevention and Testing Services in Los Angeles County	Dr. M. Green; W. Garland	Prevention Planning Workgroup April 28, 2021
Prevention Services Funding Table	P. Ogata	Prevention Planning Workgroup April 28, 2021
Update on HIV and STD Surveillance in Los Angeles County | *Intersections and Opportunities*	Dr. A. Kim	COH Meeting May 13, 2021
Provider Childcare and Language Services Survey Results	P. Zamudio	COH Meeting May 13, 2021
Ending the HIV Epidemic (EHE) Initiative in Los Angeles County	J. Tolentino	Prevention Planning Workgroup Meeting March 22, 2021
Contracted HIV Prevention Services 2019 Data Summary	P. Ogata; Dr. M. Green	Prevention Planning Workgroup Meeting May 26, 2021
RESPONSE TO PREVENTION PLANNING WORKGROUP MEETING, APRIL 28, 2021 Data Sources for "Overview of Contracted HIV Prevention and Testing Services in Los Angeles County" presentation	P. Ogata; Dr. M. Green	Prevention Planning Workgroup Meeting May 26, 2021
Sexually Transmitted Diseases in Los Angeles County, 2019 Snapshot	P. Ogata; Dr. M. Green	Prevention Planning Workgroup Meeting May 26, 2021

Summary Consolidated YR 30 Expense Report	M. Perez	COH Meeting November 12, 2020
Launch of the "Take Me Home" Self-Testing Program in Los Angeles County	W. Garland	COH Meeting November 12, 2020
Project Roomkey	LAHSA	COH Meeting 09/10/2020
COVID-19 and HOPWA-CV Funding	City of Los Angeles	COH Meeting September 10, 2020
Data in Action: Using the Right Data to End the HIV Epidemic in Los Angeles County | *2019 Annual HIV Surveillance Report*	Dr. A. Kim	COH Meeting August 20, 2020
Summary : Impact of COVID-19 on HIV/STD Prevention, Testing , Treatment and Care Services Delivery among DHSP Contracted Service Providers in Los Angeles County, May 2020		COH Meeting August 20, 2020
Ryan White Year 29 Utilization Report Summary 7/21/2020		COH Meeting August 20, 2020

Useful tables provided in past: Overlapping RW Populations Table

Data-based Decision Making: Understanding, Assessing, and Using Data

Module 10.1 Slides

Topic: Understanding Data Types and Sources

Understanding Data Types and Sources

- Importance of Data in RWHAP Planning
- Terms and Definitions
- Data Types and Sources

Training Objectives

Following the training, participants will be able to:

1. Define “data-based decision making”
2. Describe at least 3 reasons why it is so important that PC/PBs understand and effectively use data in RWHAP planning and decision making
3. Describe the role of data in implementing 5 important PC/PB roles

Training Objectives (cont.)

4. Define and differentiate the epidemiologic terms of *incidence* and *prevalence*
5. Explain the concept and importance of *unmet need* and of *individuals with HIV who are unaware of their HIV status*
6. Describe 4 data-related concepts used in assessing service needs and gaps within the EMA or TGA
7. Identify and describe 8 types of data PC/PBs should obtain and use in decision making

Importance of Data in RWHAP Planning

"Without data, all anyone has are opinions. Data elevates the probability that you'll make the right decision."

—W. Edwards Deming

What Is Data-based Decision Making?

- **Definition:** Decision making that is guided and supported by documented information – data – rather than based primarily or solely on personal experience, observation, anecdotes, or intuition/insight
- Some experts prefer the term “data-informed” decision making, since decisions are based on multiple factors
- Data used for decision making by PC/PBs should include:
  - Quantitative and qualitative information obtained and reviewed systematically, using sound methods
  - Information from multiple sources, gathered using several different approaches

Importance of Data

- **Data-based decision making is essential** to establishing, supporting, and improving a system of quality care
- **Data guide the entire planning process**:
  - Understanding service needs, barriers, and gaps in your service area – overall and for PLWH subpopulations
  - Making sound decisions about use of available funds
  - Targeting funds to particular service models, geographic areas, and PLWH subpopulations
  - Improving care for disproportionately affected groups

PC/PB Task	Role of Data in Implementing PC/PB Tasks
Needs Assessment	Collection and analysis of information about PLWH service needs, barriers, and gaps – a major source of data for decision making
Integrated/ Comprehensive Planning	Development of plan goals, objectives & strategies all based on data of many types and sources
PSRA including Directives	Decisions about priorities, resource allocation, directives, and reallocations all expected to be data-based
System of Care	Many types of data needed to identify and address system of care weaknesses/gaps and improve services
Assessment of the Administrative Mechanism	Data from recipient & subrecipients used to assess whether funds are getting to the community on a timely basis to support services

Importance of Data (cont.)

- **Data from multiple sources are needed to:**
  - Provide an understanding of diverse service needs of PLWH with varied characteristics and/or from different parts of the service area
  - Highlight service barriers and gaps
  - Help identify service models with positive clinical outcomes for all PLWH or particular subgroups
  - Help ensure best use of limited resources
  - Contribute to fair and objective decisions
- **Without access to adequate data from multiple sources,** decisions are often based on personal experience or "impassioned pleas"

Challenges of Using Data

- Everyone uses data in daily life, but people new to community planning may have limited experience in use of data for planning decisions
- Most PC/PB members need training on HIV-related data terminology, data sources, and how to assess and use data
- Data are not always presented in user-friendly formats
- Meaningful discussion and review of data requires time and effort

Quick Discussion A: Challenges in Using Data

1. How do you use data and research in your job or everyday activities?
2. What do you find most challenging about understanding and using data in HIV planning – or what was most challenging when you first became involved with the PC/PB?
3. If you are a “veteran” PC/PB member, what helped you become comfortable using data? What made it harder?

Terms and Definitions

- Epidemiologic Terms
- HIV Care Continuum
- Unmet Need
- Assessing Service Needs and Gaps
- Quantitative vs. Qualitative Data

Epidemiologic Terms: Incidence (New Cases)

- **Incidence:** The number of new cases of a disease in a population during a defined period of time – such as the number of new HIV cases in your EMA or TGA reported during 2018
- **Incidence rate:** The frequency of new cases of a disease that occur per unit of population during a defined period of time – such as the rate of new HIV cases per 100,000 population in your EMA or TGA in 2018

Epidemiologic Terms: Prevalence (Total Cases)

- **Prevalence:** The *total number* of people in a defined population diagnosed with a specific disease or condition at a given time—such as the total number of people diagnosed with HIV in your EMA or TGA as of December 31, 2018
  - Can refer to all cases diagnosed from the beginning of the epidemic
  - More often "total living cases": the number of people diagnosed and living with the disease
- **Prevalence rate:** The total or cumulative number of cases of a disease per unit of population as of a defined date—such as the rate of HIV cases per 100,000 population diagnosed in your EMA or TGA as of December 31, 2018

Other Common Epi Terms

- **Sample:** A group of people selected from a total population with the expectation that studying this group will provide important information about the total population
- **Percentage:** A proportion of the whole in which the whole is 100

  Example: 15 of 60 new cases of HIV were among women

  15 divided by 60 = .25 and .25 x 100 = 25%
- **Trends:** Long-term movement of change in frequency, such as 5-year trends in HIV incidence among youth

Other HIV-related Epi Terms

- **Risk factor:** A behavior, condition, or other factor that increases the likelihood of HIV infection
- **Transmission category:** The risk factor most likely to have resulted in HIV transmission
- **Stage 3 HIV infection:** AIDS – CD4 count falls below 200; immune system badly damaged and can no longer fight off serious illnesses ("opportunistic infections")
- **Late testers:** Individuals who have stage 3 HIV infection (AIDS) when first diagnosed or within 12 months after

HIV Care Continuum

- **Definition:** A model of HIV medical care that shows "the series of steps from the time a person receives a diagnosis of HIV through the successful treatment of their infection with HIV medications"*
- **Data:** Percent of individuals with HIV who are engaged at each step
- **Terminology:** Sometimes referred to as the "HIV treatment cascade" or Gardner cascade (developed by Dr. Edward Gardner and colleagues in 2011)

* CDC, "Understanding the HIV Care Continuum," July 2017


Diagnosed with HIV
Linked to Care
Engaged or Retained in Care
Achieved Viral Suppression

Steps in the HIV Care Continuum

1. **Diagnosed with HIV:** received a positive HIV test that was reported to the CDC
2. **Linked to care:** visited an HIV-related health care provider
3. **Received or retained in care:** received medical care for HIV infection
4. **Virally suppressed:** have a very low level of HIV in their blood

Sometimes included in the continuum of a RWHAP program prior to Virally Suppressed: **Prescribed antiretroviral therapy (ART)**

“Unmet Need” or “Not in Care” Definition

- **Unmet need** refers to individuals with HIV in a jurisdiction who are *aware* of their HIV status and are *not in care* – people who have been diagnosed with HIV but are not receiving HIV-related medical care
- **Estimate of unmet need:** Number and percent of all diagnosed PLWH who are not in care

Other Terms Related to Unmet Need

- **Assessment of unmet need:** Analysis of the characteristics of PLWH who are not in care – demographics, geographic location, risk factor – their care history, and barriers to care
- **Plan for addressing unmet need:** Strategies for linking PLWH to care immediately after diagnosis and for finding, relinking, and retaining in care those who dropped out
- **Service gaps:** The identified unfulfilled need for HIV-related services other than primary medical care among individuals who know their HIV status in a specified geographic area

Quick Discussion B: Unmet Need

1. Why is it important for your PC/PB to understand the concept of unmet need and to estimate, assess, and address it?
2. What might your PC/PB do to ensure careful consideration of the needs of PLWH who are out of care?

HIV-Positive Unaware Individuals

- **HIV-positive/unaware:** Individuals with HIV who are unaware of their status—they have not received an HIV diagnosis—because they have never been tested, or did not receive their test results
- **The Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative** helps to:
  - Identify individuals with HIV who do not know their status
  - Make them aware who are unaware of their status and enable them to use health and support services
  - Reduce barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities [§2603(b)(2)(A)]

Data-Related Concepts in Assessing Service Needs and Gaps

- **Geographic disparities:** Differences in access to needed services based on where an individual lives
- **Availability of services:** Level or number of available "slots" within a service category in a specified geographic area, and whether there are waiting lists
- **Accessibility of services:** Extent to which services in a particular geographic area can be obtained conveniently by PLWH who need them, based on factors like access to public transportation, parking, service hours, and disability access
- **Appropriateness of services:** Extent to which services meet the needs of various PLWH subpopulations, in terms of languages spoken, service models, and cultural competence with regard to race/ethnicity, sexual orientation and identity

Quantitative and Qualitative Data

- **Quantitative data:** Information that can be expressed in numbers, counted, or compared on a scale—such as epi data or PLWH survey data
- **Qualitative data:** Information that cannot easily be measured or expressed in numbers—such as narrative data from a focus group, consumer town hall meeting, open-ended interview, or direct observations
  - Usually described in terms of common themes and patterns of response
  - Often complement and help explain quantitative data

Measures of "Central Tendency" (Averages)

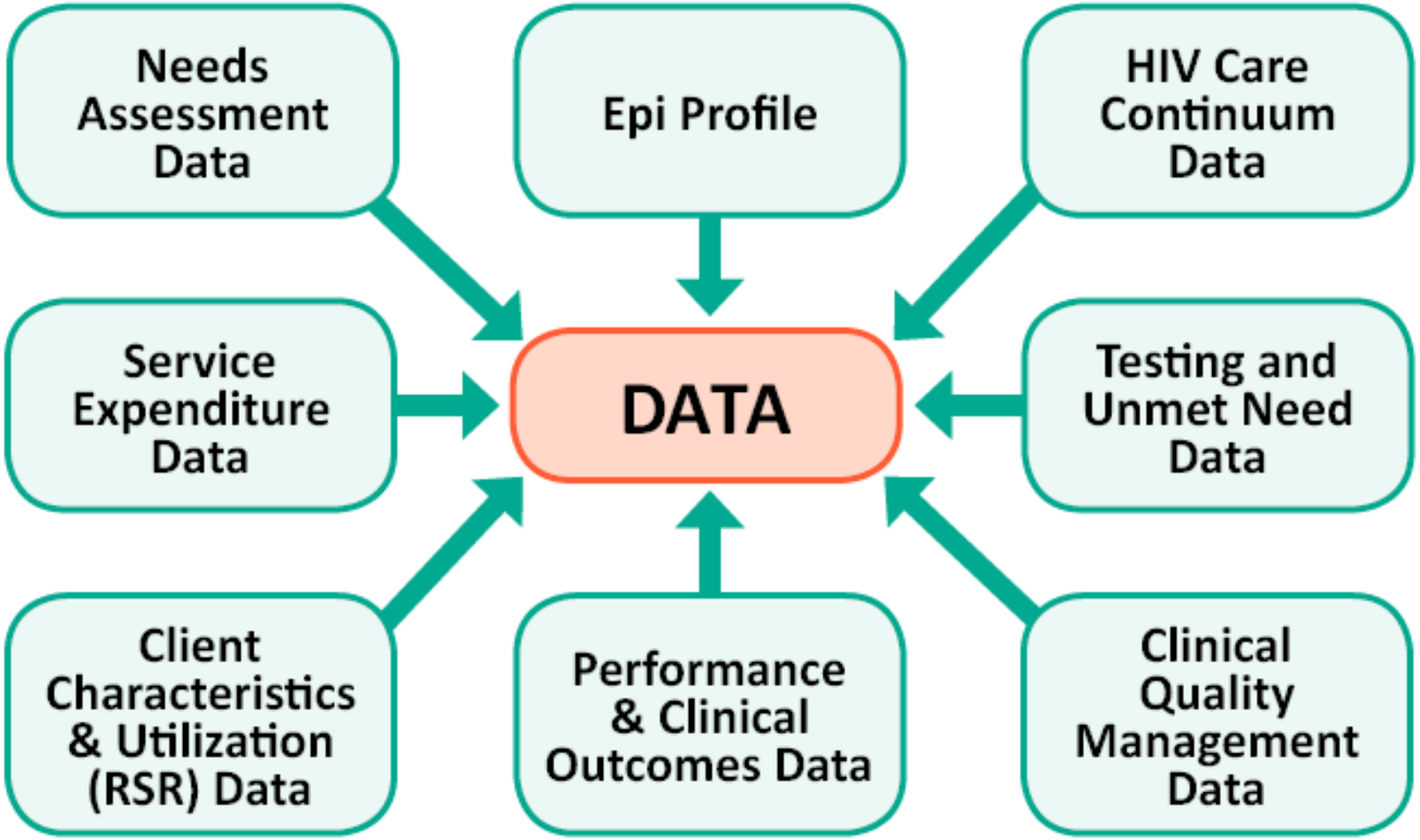
- **Mean:** the numerical average – the sum of values divided by the total number of values
- **Median:** the middle value in a data set, with about half the values higher and half lower
- **Mode:** the most commonly occurring value

  Example: **For values 10, 7, 5, 8, and 5:**
  - **Sum** is 10+7+5+8+5=35 and **total number of values** is 5
  - **Mean** is 35÷5=7
  - **Median** is 7 [10, 8, **7**, 5, 5]
  - **Mode** is 5 [it occurs twice]

Data Types and Sources

1. Epidemiologic profile
2. HIV care continuum data
3. Needs assessment data
4. Service expenditure and cost data
5. Client characteristics and service utilization data
6. HIV tests and diagnoses
7. Unmet need data (estimate and assessment)
8. Clinical Quality Management (CQM) data
9. Recipient monitoring data
10. Performance measures and clinical outcomes data
11. Data from other programs

Types of Data Needed for RWHAP Planning

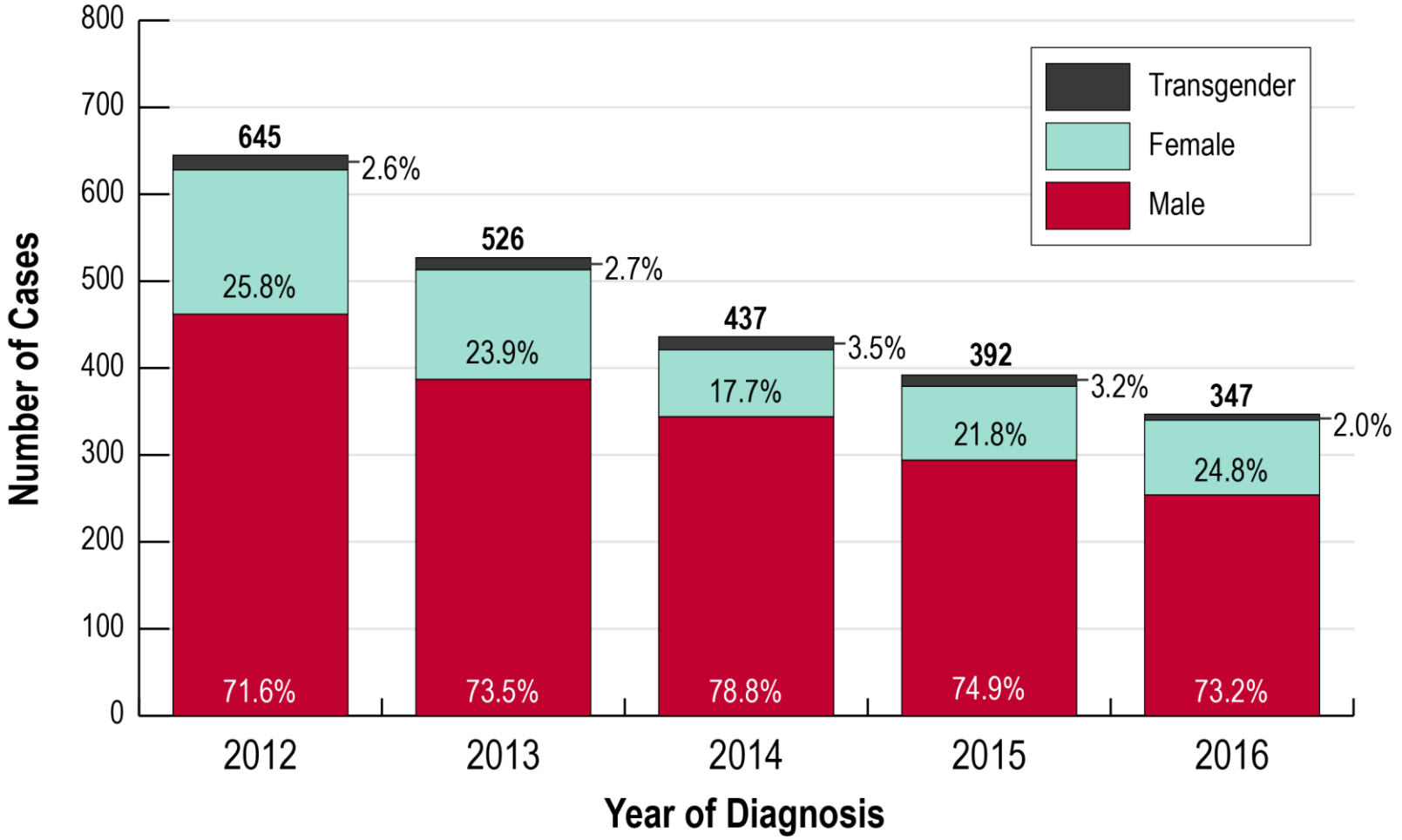


Note: Some data types overlap

Epidemiologic Profile

- **Source:** State or local HIV surveillance staff, from eHARS (enhanced HIV/AIDS Reporting System) data
- **Frequency:** Annual, usually based on a calendar year
- **Content:** The distribution of HIV in various populations in an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics; includes:
  - Characteristics of the general population, persons newly diagnosed with HIV infection, persons living with HIV disease, persons at risk for HIV
  - Trends in the epidemic
- **Use:** Helps PC/PBs understand the epidemic and implications for service needs and priorities

Sample Epi Profile Chart: 5-Year Trends in Newly Diagnosed HIV Cases by Year and Gender Identity, Washington DC

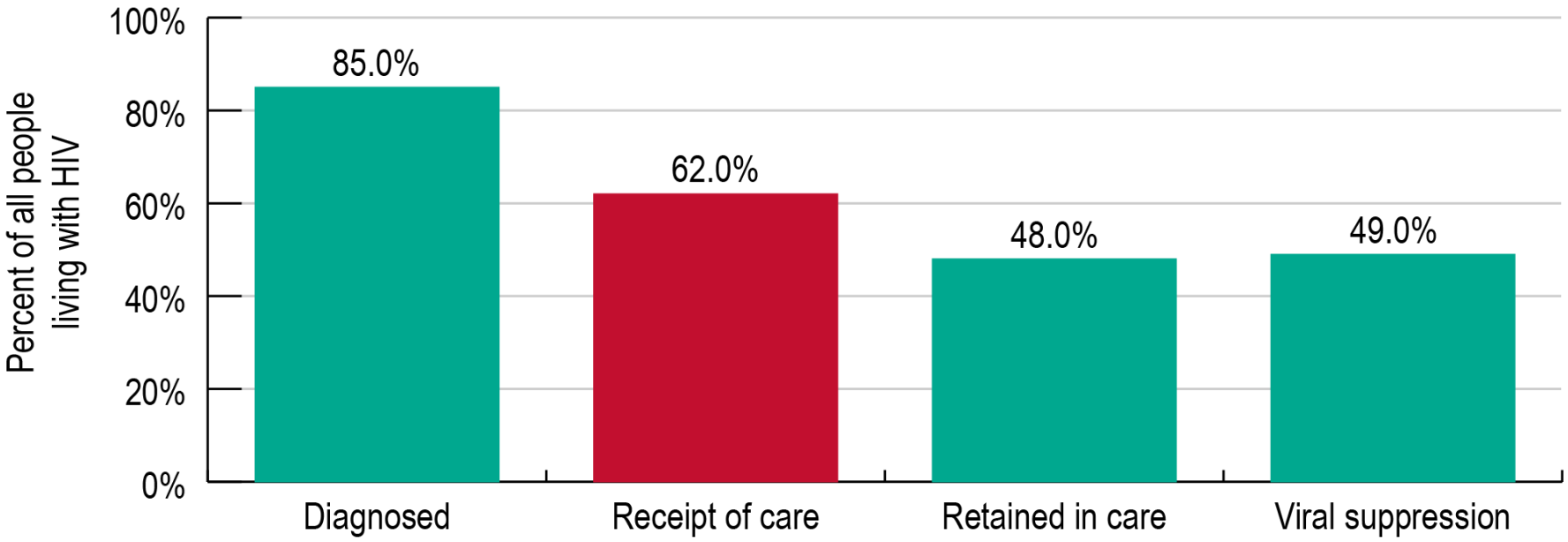


Source: Annual Epidemiology and Surveillance Report: Data through 2016, Washington, DC

HIV Care Continuum

- **Source:** State or local HIV surveillance staff
- **Frequency:** Varies; at least annually
- **Content:** Often 2 different continuums
  - All PLWH in the service area
  - RWHAP clients, often with multiple breakdowns to show both all RWHAP clients and various subpopulations
- **Use:** Helps PC/PB understand strengths and weaknesses in system of care and identify need for additional attention to particular steps (such as retention in care) and PLWH subpopulations

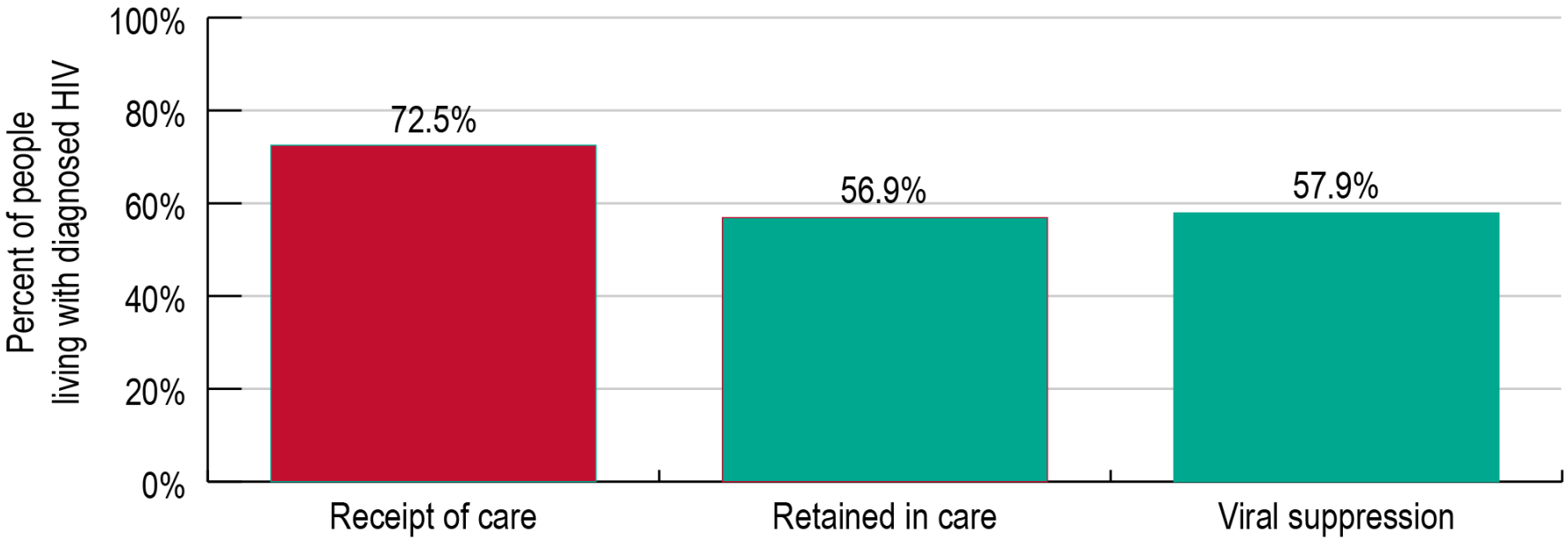
Prevalence-based HIV Care Continuum, U.S., 2014



This is called the ***prevalence-based*** HIV care continuum because it shows each step as a percentage of the total number of people living with HIV, including people whose infection has been diagnosed and those who are infected but don't know it

Source: CDC

Diagnosis-Based HIV Care Continuum, U.S., 2014



This is called the ***diagnosis-based*** HIV care continuum because it shows each step as a percentage of people living with diagnosed HIV

Source: CDC

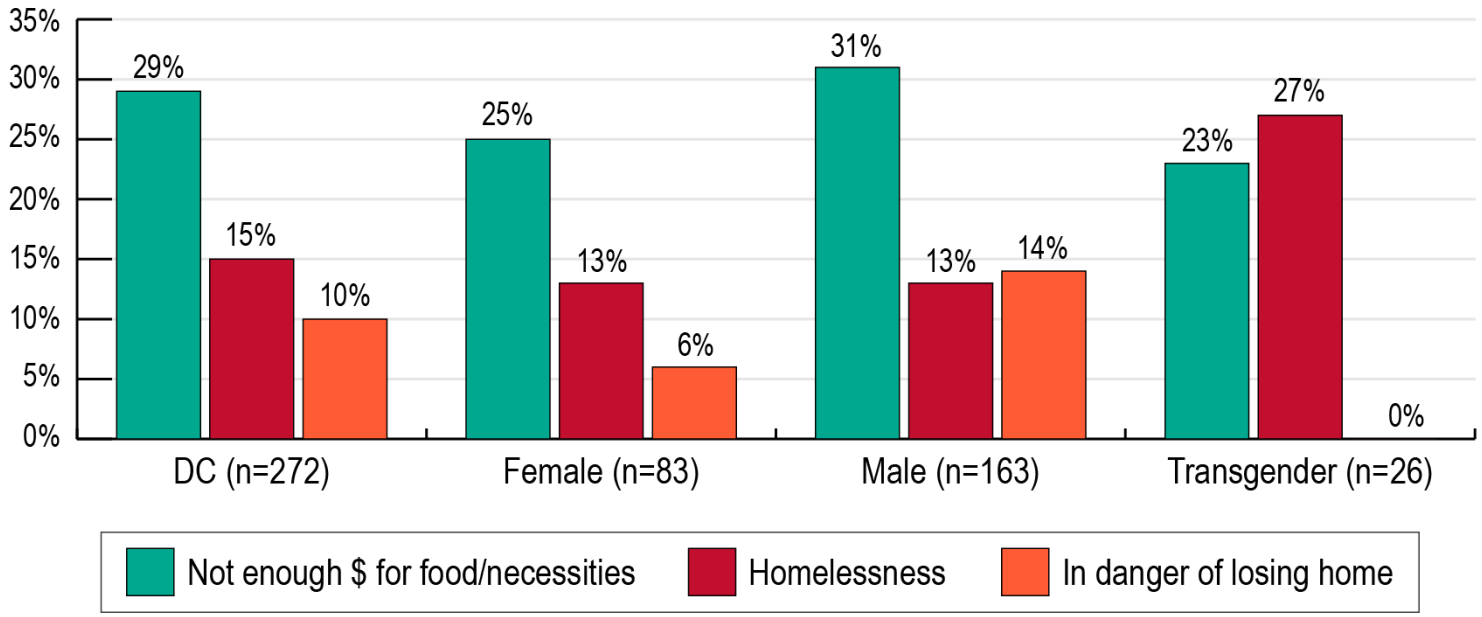
Quick Discussion C: Using HIV Care Continuum Data

1. Which of type of HIV care continuum do you think is most useful for your PC/PB – prevalence-based or diagnosis-based? Why?
2. Many jurisdictions now receive both an HIV care continuum for all PLWH and a continuum including only RWHAP clients. In addition, separate continuum data are often provided for major PLWH subpopulations. What are the benefits of these multiple continuums – how might the PC/PB use them?

Needs Assessment Data

- **Source:** Collected by PC/PB, including staff and/or consultants
- **Frequency:** Usually a multi-year cycle, with some new data each year
- **Content:**
  - Characteristics, service needs and barriers of PLWH, both in and out of care
  - Provider resources available to meet those needs
  - Service gaps, overall and for various PLWH subpopulations
- **Use:** Helps PC/PB to set priorities, allocate resources, develop directives, and improve service access and quality, overall and for specific populations

Most Frequently Reported Life Situations Faced by PLWH, by Gender (Percent) – Washington, DC

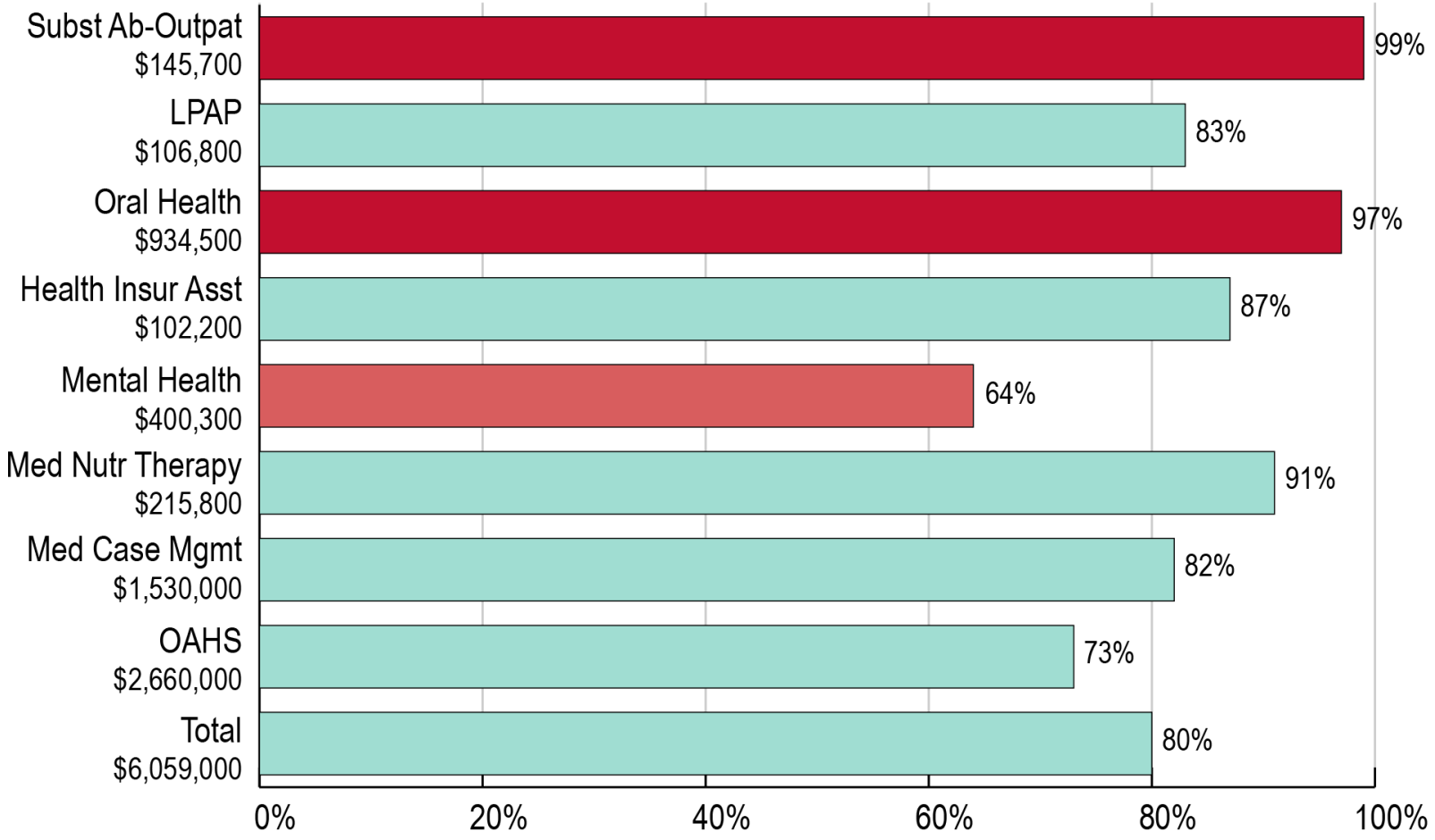


- The most frequently reported life situation PLWH said they dealt with over the past 12 months was not having money for food and other necessities
- Male PLWH were the most likely to report not having enough money for food and other necessities and being in danger of losing their home
- Transgender PLWH were the most likely to report homelessness

Service Expenditure and Cost Data

- **Source:** Recipient or administrative agency
- **Frequency:** Expenditures usually provided monthly, with an annual summary
- **Content:** Projected and actual expenditures by service category, plus:
  - Costs for one unit of service, such as 1 case management visit lasting 30 minutes
  - Cost to serve one client for a year
- **Use:** Helps PC/PB make funding decisions, adjust allocations based on actual use of funds and determine costs to serve additional clients

Core Medical Services: Total Allocations and Percent Expended after 10 Months



Service categories more than 10% over- or under-spent compared to the expected level of expenditure at 10 months are highlighted.

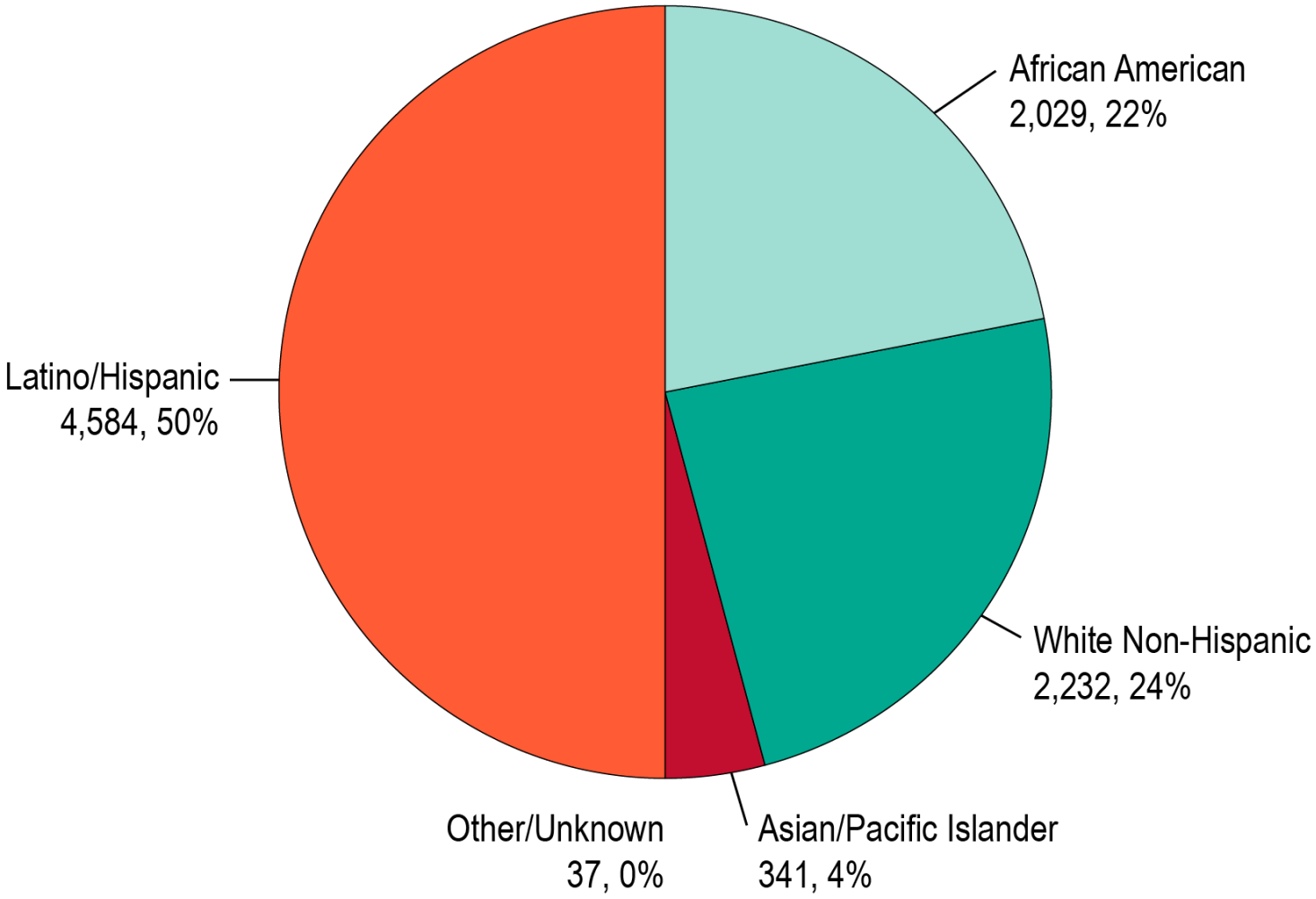
Quick Discussion D:
Using Expenditures Data

1. What percent of funding would you expect to see expended as of the end of the 10th month of the program year?
2. What concerns does this report raise for the PC/PB?
3. How might the PC/PB use this information?

Client Characteristics and Service Utilization Data

- **Source:** Recipient, usually gathered through its client-level data system and included in the RWHAP Services Report (RSR)
- **Frequency:** Annual
- **Content:** Information about the use of RWHAP Part A services, including the number and characteristics of clients, overall and by service category, and the amount or units of service provided
- **Use:** Help PC/PBs understand demand for specific services and identify differences in use of services by various PLWH groups

Race/Ethnicity of RWHAP Part A Clients, 2018 [N=9,224



HIV Tests and Diagnoses Data

- **Source:** State/local surveillance and HIV prevention unit staff, as reported by testing sites
- **Frequency:** Ongoing; reported at least annually
- **Content:**
  - Number of people who receive HIV tests
  - Number and percent testing positive and their characteristics
  - Number referred to needed services (care or prevention)
- **Use:** Helps PC/PB predict future demand for care and the need to fund services like Outreach and Early Intervention Services (EIS), which help get people identified, tested, and linked to care if HIV-positive

Newly Diagnosed Positive HIV Test Events Funded with Public HIV Prevention Funds for Key Target Populations, 2017

	Young MSM	African Immigrants	Hispanic/ Latino Men
a. Number of test events	1,112	203	556
b. Number of newly diagnosed positive test events	17	8	12
c. Number of positive test events with client linked to HIV medical are within 90 days	17	7	8
d. Number of confirmed positive test events	17	8	11
e. Number of confirmed positive test events with client interviewed for partner services	14	7	9
f. Number of confirmed positive test events with client referred to prevention services	N/A	N/A	N/A
g. Total number of newly diagnosed confirmed positive test events who received CD4 and viral load testing	17	7	8

Source: Sample TGA

Unmet Need Data (Estimate and Assessment)

- **Source:** State or surveillance staff provide estimate; PC/PB may assess unmet need as part of its needs assessment
- **Frequency:** Usually updated/reported annually
- **Content:**
  - Estimate of the number of PLWH in the service area who know they are HIV-positive but are not receiving HIV-related medical care
  - Assessment of the characteristics, service barriers and gaps of PLWH with unmet need
- **Use:** Helps PC/PBs to understand how many PLWH are out of care and consider ways to find such PLWH, link or relink them to care, and improve retention

Unmet Need Estimate, 2017

Population Sizes	Value	Percent
A. Number of persons living with HIV disease (PLWH)/aware from 1/1/17-12/31/17	3,457	100%
Care Patterns – Met Need	**Value**	**Percent**
B. Number of PLWH who received specified HIV primary care services in 2017	2,848	82.4%
Calculated Results – Unmet Need	**Value**	**Percent**
C. Number of PLWH who did not receive specified HIV primary medical care services in 2017	609	17.6%

Source: Sample TGA

Clinical Quality Management (CQM) Data

- **Source:** Recipient, based on a CQM program of coordinated activities carried out by recipient and subrecipients
- **Frequency:** Ongoing; data shared with PC/PB at least annually
- **Content:** Data on client care, health outcomes, and client satisfaction, including results of quality improvement activities
- **Use:** Helps PC/PBs identify need for changes in program models or funding to help improve service quality and outcomes

Recipient Monitoring Data

- **Source:** Recipient, based on monitoring of subrecipients, including an annual monitoring visit
- **Frequency:** Ongoing; data shared with PC/PB at least annually
- **Content:** Information on extent to which subrecipients are meeting requirements, including service standards, for their service categories
- **Use:** Helps PC/PBs identify need for changes in program models or funding to improve service quality and outcomes, and possible need to refine service standards

Percent of New Clients Receiving a Mental Health Screening

	2015	2016	2017
Total number of clients receiving HIV-related medical care through RWHAP Part A	635	643	652
Percent of clients who received a mental health screening (as required by service standards)	92.3%	85.4%	82.5%
Change from prior year		**7.5%**	**3.4%**
Percent of clients found to have mental health issues	28.2%	31.2%	30.7%
Percent of clients found to need mental health services	18.7%	21.2%	23.2%
Percent of clients needing mental health services who were successfully referred, with at least one mental health visit	**89.9%**	**91.3%**	**83.4%**

Analysis: The percent of clients with HIV who had a mental health screening decreased by 10.6% from 2015 to 2017, and the percent needing mental health services who received them decreased by 7.2%.

Source: Sample TGA

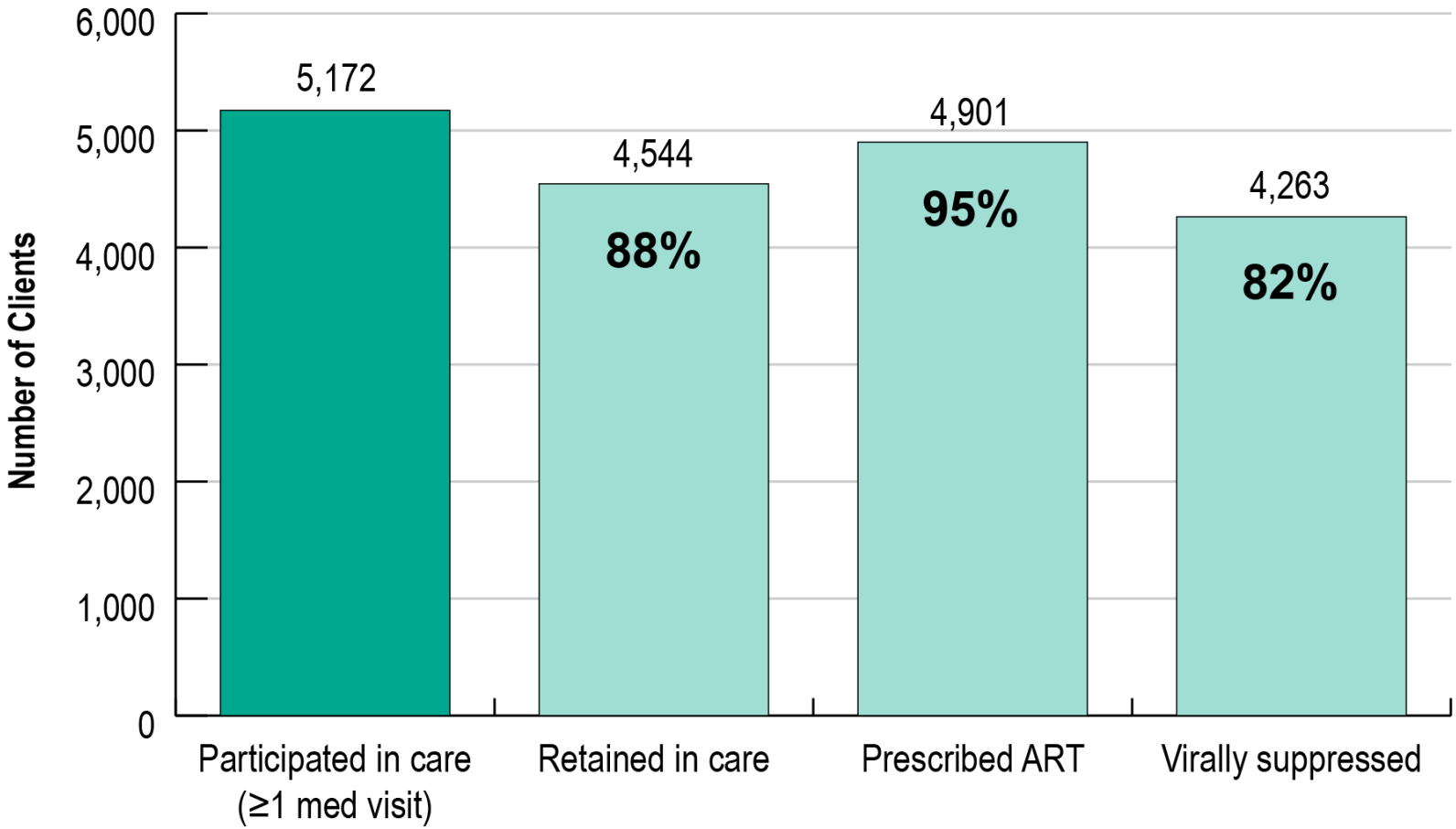
Quick Discussion E:
Using CQM and Monitoring Findings

1. If your PC/PB received information like that shown in the previous slide, what committee(s) would review it?
2. How might such information be used by the PC/PB?
3. What other information might you want to obtain to better understand the situation?

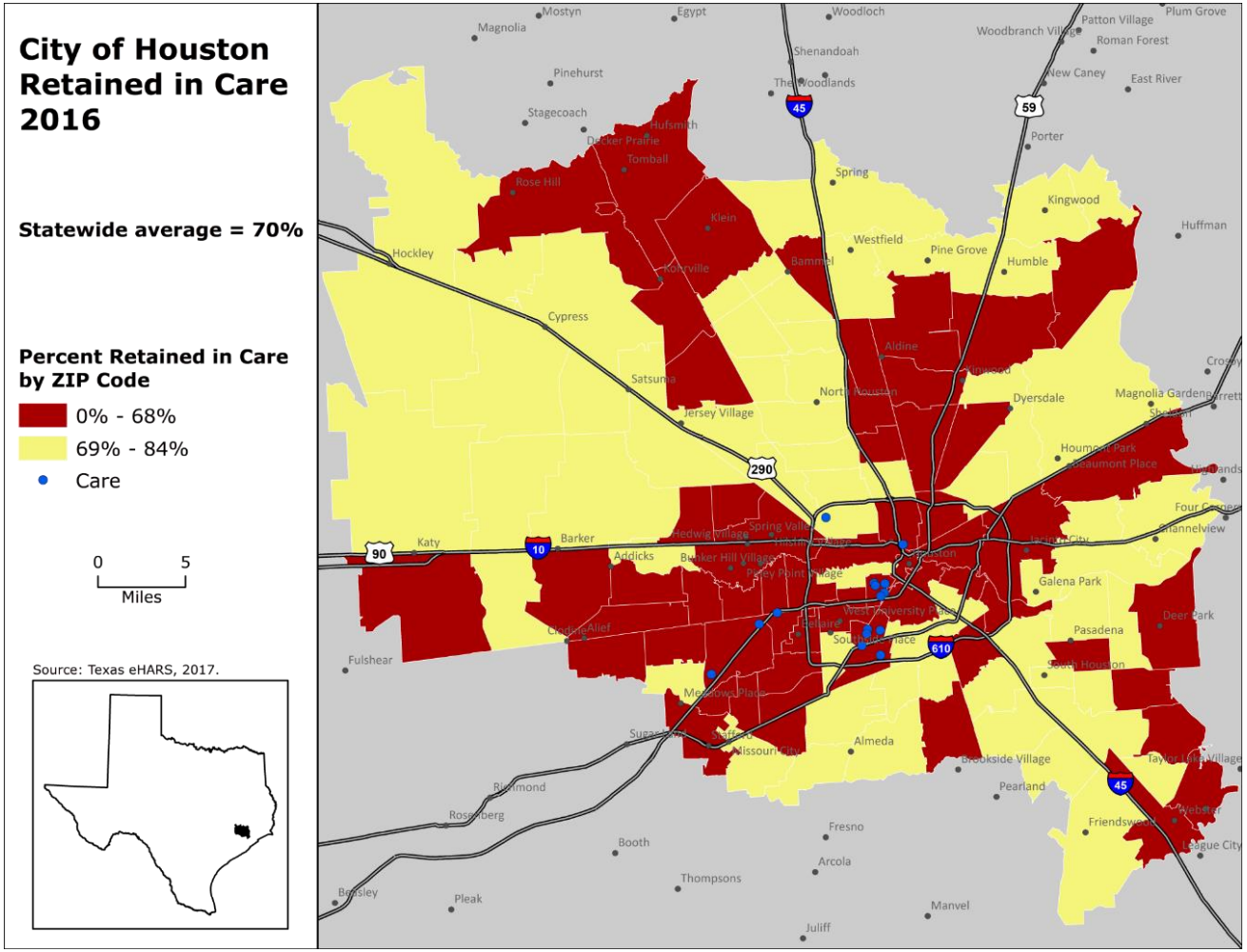
Performance Measures and Clinical Outcomes Data

- **Source:** Usually provided by the recipient, based on various data sources (e.g., HIV care continuum, client-level database, CQM data, monitoring data)
- **Frequency:** At least annually
- **Content:** Percent of all PLWH or RWHAP clients that meet a particular measure or standard, usually chosen from the HRSA Performance Measure Portfolio. May relate to:
  - A process, such as development of a case management care plan or a mental health assessment
  - A clinical outcome, such as viral suppression
- **Use:** Helps PC/PB identify service strengths and weaknesses and develop directives, improve models of care, and/or revise service standards to improve care

Performance Measures for RWHAP Clients in a Mid-Atlantic EMA, 2016 (Based on an HIV Care Continuum including ART)



Sample Performance Data: "Heat Map" Showing Percent of Clients Retained in Care by Zip Code, 2016



Source: HIV/STD/TB/Viral Hepatitis Unit, Texas Department of State Health Service, 2018

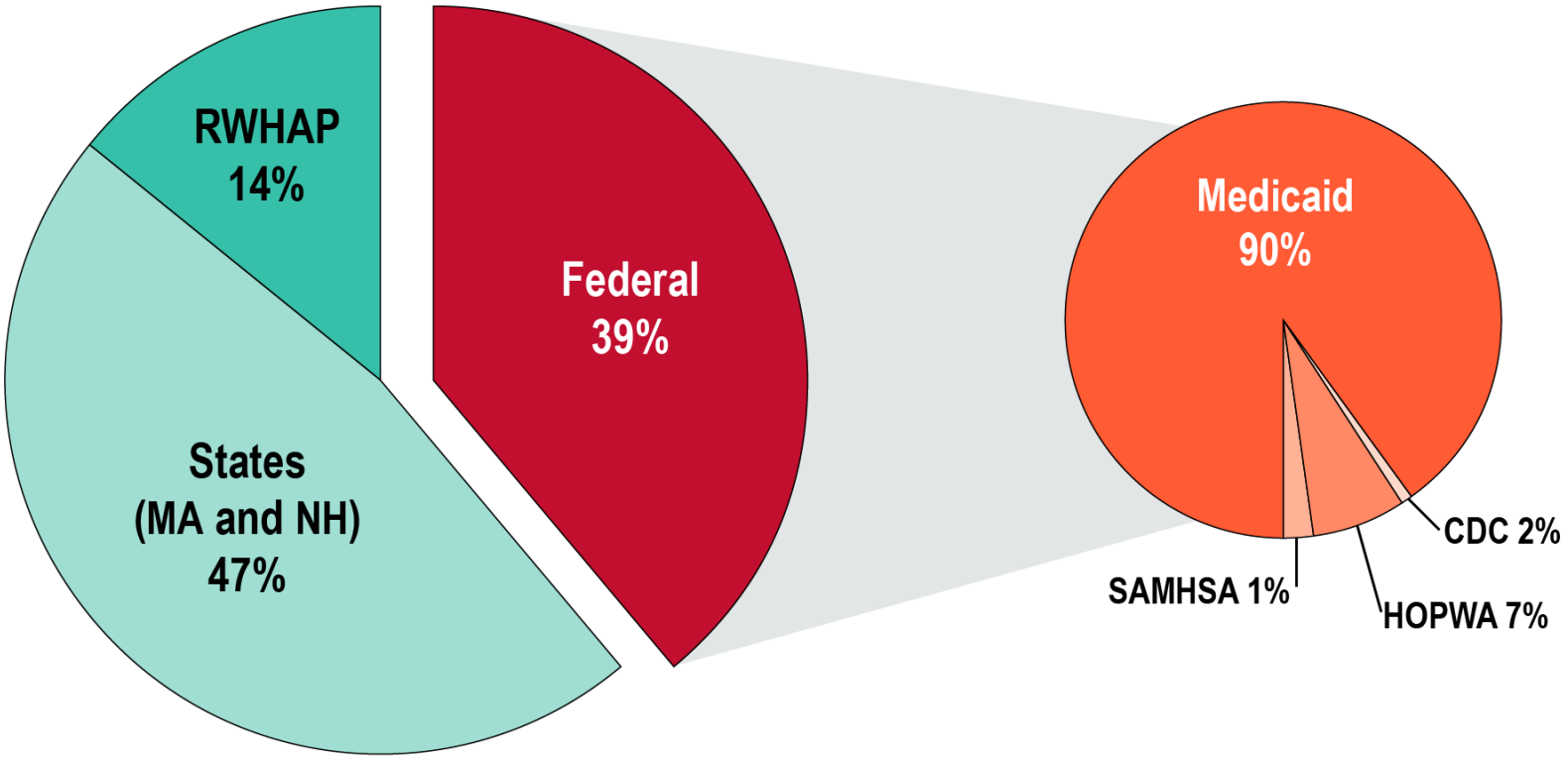
Quick Discussion F: “Heat Map” Showing Retention in Care by Zip Code

1. The map on the prior slide shows zip codes with retention rates below and above 68%.
2. If this kind of map were available to your PC/PB, how might you use the information in decision making?
3. What other data would you most like to review along with this map?

Data from Other Programs

- **Sources:** Many, including other federal agencies and programs such as CDC HIV prevention funding, Housing Opportunities for Persons With AIDS (HOPWA), Medicaid and Medicare, Substance Abuse and Mental Health Services Administration programs, state and local agencies
- **Frequency:** Usually annual, prior to PSRA
- **Content:** Most often number of clients in the program who are PLWH and their characteristics, services provided to them, and costs overall and/or by type of service
- **Use:** Helps PC/PBs determine the level and sources of other funding for HIV services and avoid duplication of effort

Public Funding Sources for HIV Services, Boston EMA, 2016



Total HIV-related Public Funding: $235 million

Source: 2016 Funding Streams Overview for HIV/AIDS Services in the Boston EMA, Boston Planning Council, May 2016

Obtaining Needed Data: Sound Practices

- Be sure responsible committees – including your consumer committee/caucus – and full PC/PB schedule time to receive and discuss data before decision making
- Decide how to be sure data are in user-friendly formats
  - Negotiate whether recipient will provide its data in appropriate formats or share data sets for PC/PB support staff or consultants to analyze and format

Obtaining Needed Data: Sound Practices (cont.)

- Develop and follow an annual work plan that specifies data needs and timing for meeting them
- Define data to be provided by the recipient in the Memorandum of Understanding (MOU)
- Allocate time and effort to train all – including consumers

Sum Up

- RWHAP Part A planning is data-based
- PC/PBs need to become familiar with:
  - Data-related terms
  - Various types of data reports and summaries used in decision making about priorities, allocations, directives, and service models
- Each type of data provides important information about some aspect of service needs, barriers, gaps, system of care, and service quality and outcomes
- Data now more detailed and useful for directing funds and tailoring services to meet diverse PLWH needs
- PC/PBs need to arrange timely access to needed data

Optional Slides for Activities

Instructions for Activity 10.1: Data Terms and Concepts

1. You will receive at least 1 definition or 1 term related to data used by RWHAP PCs/PBs for decision making.
2. Your job is to find the other participant with the definition of your term, or the term that fits your definition.
3. *Warning:* A few terms have no matching definition.
4. If you need a hint, ask one of the assigned resource people, or discuss your term or definition with other participants.
5. Once you have found your match, take your seat. We will ask you to present your match or to identify any terms for which you couldn't find a match.
6. At the end of the session, we will ask you to take the quiz individually.

Instructions for Activity 10.3: Finding Needed Data

1. Please work with a small group, choosing a **facilitator, recorder,** and **reporter.**
2. Review the scenario assigned to your group, and identify existing data sources/types that can provide needed information, as well as possible data gaps and how they might be filled.
3. Have your reporter prepared to summarize your scenario and the types of data and possible data gaps you identified, and share them with the full group.

U.S. Department of Housing and Urban Development

Community Planning and Development

Fiscal Year (FY) 2020 Housing Opportunities for Persons With AIDS (HOPWA) Competitive Grant: Housing as an Intervention to Fight AIDS

FR-6400-N-11

07/06/2021

Table of Contents

Program Office:
Community Planning and Development

Funding Opportunity Title:
Fiscal Year (FY) 2020 Housing Opportunities for Persons With AIDS (HOPWA) Competitive Grant: Housing as an Intervention to Fight AIDS

Funding Opportunity Number:
FR-6400-N-11

Primary CFDA Number:
14.241

Due Date for Applications:
07/06/2021

Overview

The U.S. Department of Housing and Urban Development (HUD) issues this Notice of Funding Opportunity (NOFO) to invite applications from eligible applicants for the program and purpose described within this NOFO. Prospective applicants should carefully read all instructions in all sections to avoid sending an incomplete or ineligible application. HUD funding is highly competitive. Failure to respond accurately to any submission requirement could result in an incomplete or noncompetitive proposal.

During the selection process HUD is prohibited from disclosing 1) information regarding any applicant's relative standing, 2) the amount of assistance requested by an applicant, and 3) any information contained in the application. Prior to the application deadline, HUD may not disclose the identity of any applicant or the number of applicants that have applied for assistance.

For Further Information Regarding this NOFO: Please direct questions regarding the specific requirements of this Notice of Funding Opportunity (NOFO) to the office contact identified in Section VII.

Paperwork Reduction Act Statement. *The information collection requirements in this notice have been approved by OMB under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). In accordance with the Paperwork Reduction Act, HUD may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid OMB control number. Each NOFO will identify its applicable OMB control number unless its collection of information is excluded from these requirements under 5 CFR part 1320.*

OMB Approval Number(s):
2506-0133

I. FUNDING OPPORTUNITY DESCRIPTION.

A. Program Description.

1. Purpose

The Housing Opportunities for Persons With AIDS (HOPWA) program was enacted to provide states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of low-income persons with Human Immunodeficiency

Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and their families. Stable housing has been a major issue facing many persons living with HIV since the beginning of the epidemic. Achieving and maintaining stable housing can be a powerful structural intervention in ending the HIV/AIDS epidemic.

As discussed in *HIV Care Continuum*: *The Connection Between Housing and Improved Outcomes Along the HIV Care Continuum (2014)*, a resource created by HUD's Office of HIV/AIDS Housing and available on the HUD Exchange, approximately half of all persons living with HIV in the U.S. will experience homelessness or housing instability at some point following their diagnosis. Economic disadvantages, episodes of poor health, and co-occurring health diagnoses make it difficult for many persons living with HIV to secure or maintain housing.

HIV/AIDS-related stigma and discrimination add additional barriers to accessing and maintaining housing. To end the HIV/AIDS epidemic, persons living with HIV must have access to high-quality and culturally competent services including housing and supportive services that are non-stigmatizing, non-discriminatory, inclusive, and responsive to their needs. Issues such as discrimination and systemic racism that contribute to differences in access in housing and lead to ongoing disparities among racial, ethnic, and LGBTQ+ communities must be addressed. Reducing these disparities requires a focus on the needs of disproportionately affected populations, supporting racial justice, LGBTQ+ rights, combating HIV-related stigma and discrimination, providing leadership and employment opportunities for people with or at risk for HIV, and addressing social determinants of health and co-occurring conditions to reduce health inequities and disparities.

HUD's 2014 *HIV Care Continuum* report also found that housing has a direct, independent, and powerful impact on HIV incidence, health outcomes, and health disparities. According to the report, "Housing status is a more significant predictor of health care access and HIV outcomes than individual characteristics, behavioral health issues, or access to other services. People who are stably housed are more likely to be virally suppressed, more likely to have a reduced risk of HIV transmission, more likely to use fewer public resources, and more likely to return to care if not currently engaged, among other positive outcomes."

Collectively, our local, domestic, and global communities have committed to ending the HIV/AIDS Epidemic through strategies and initiatives including Ending the HIV Epidemic: A Plan for America, the HIV National Strategic Plan, and Getting to Zero. With aggressive goals set to end the HIV/AIDS epidemic under each of these initiatives and strategies, all available resources must be used to achieve these goals. HOPWA has the opportunity to take part in these efforts by using housing as an effective structural intervention to end HIV/AIDS epidemic. Grants funded under this NOFO will enhance local and federal efforts to end the U.S. HIV/AIDS epidemic.

Ending the HIV Epidemic: A Plan for America (EHE) is a federal initiative led by the Department of Health and Human Services (HHS) with a goal to end the HIV epidemic in the United States within 10 years by reducing new HIV infections in the United States by 75 percent by 2025 and by 90 percent by 2030. EHE leverages critical scientific advances in HIV

prevention, diagnosis, treatment, and outbreak response by coordinating the highly successful programs, resources, and infrastructure of many HHS agencies and offices and providing a targeted infusion of new resources and support to the jurisdictions most heavily impacted. Phase I of EHE has a geographic focus on 48 counties plus Washington, DC and San Juan, PR and seven states where new HIV infections are highly concentrated.

The National HIV/AIDS Strategy was first released on July 13, 2010 and identified a set of priorities and strategic action steps tied to measurable outcomes for moving the Nation forward in addressing the domestic HIV epidemic. In July 2015, the National HIV/AIDS Strategy for the United States: Updated to 2020 was released, and it expired in 2020. In January 2021, the HIV National Strategic Plan was released as the nation's third consecutive five-year national HIV strategy and covers 2021-2025. The HIV Plan focuses on four goals: (1) Reduce New Infections, (2) Increase Access to Care and Improve Health Outcomes for People Living with HIV, (3) Reduce HIV-Related Health Disparities and Health Inequities, and (4) Achieve a More Coordinated National Response to the HIV Epidemic. The HIV National Strategic Plan and the Ending the HIV Epidemic: A Plan for America initiative are closely aligned and complementary, with the EHE initiative serving as a leading component of the work by HHS, in collaboration with local, state, and federal partners, to achieve both the Plan's and the initiative's goal of reducing new HIV infections by 90 percent by 2030.

This NOFO announces the availability of funding under the authority for HOPWA Special Projects of National Significance at Section 854(c)(5) of the AIDS Housing Opportunity Act (42 U.S.C. 12903(c)(5)). This funding will provide communities an opportunity to create and implement new projects that align with initiatives aimed at ending the HIV/AIDS epidemic, and elevate housing as an effective structural intervention in ending the epidemic. HUD is seeking projects with exemplary and innovative qualities, including community-level coordination, data collection with emphasis on stable housing and positive health outcomes, culturally competent approaches to providing housing and services, and a systemic approach to advance equity in underserved communities that can serve as a national place-based model.

Each project must be designed for the Grantee to achieve the following six required project objectives:

1. Implement and document housing and services models for low-income persons living with HIV and their families that are innovative and replicable in other similar localities or nationally;
2. Increase alignment with new or existing local initiatives or strategies to end the HIV/AIDS epidemic by elevating housing as an effective structural intervention;
3. Improve coordination among local housing and service providers and use of available community resources;
4. Increase the amount of quality data collected and used for data-driven decision making with an emphasis on stable housing, positive health outcomes, and racial equity;
5. Assess and document replicable practices that ensure equitable access and culturally competent approaches to providing housing and services for populations of persons living with HIV experiencing service gaps; and

6. Prioritize sustainable, effective, and equitable approaches to providing housing and services to persons living with HIV and their families that can be continued past the funded project's period of performance.

Each successful applicant under this NOFO will received a one-time, non-renewable grant to fund housing assistance and supportive services for eligible beneficiaries, coordination and planning activities, and grants management and administration. Reporting requirements under this NOFO are more comprehensive than traditional HOPWA program reporting. Grantees will be required to collect client-level data to produce a programmatic HIV Housing Care Continuum Model at the end of each operating year. At the end of the grant period of performance, each grantee must also develop a Housing as an Intervention to Fight AIDS (HIFA) Model, consisting of promising practices for and lessons learned in using housing as a structural intervention to end the AIDS epidemic. Each HIFA Model will be shared with the public, and lessons learned through these grantee efforts will help inform national and community policy and actions.

Pre-Application Webcast: HUD will conduct a Pre-Application Webcast for anyone interested in submitting an application for a Fiscal Year (FY) 2020 HOPWA Competitive Grant. The webcast will cover the information contained in this NOFO. Viewing the webcast is optional. Interested applicants who do not view the webcast are still eligible to apply and will receive equal consideration for their grant applications. More information on the webcast will be provided through the HOPWA mailing list and posted online here: https://www.hud.gov/program_offices/comm_planning/hopwa/listserv. To sign up for the mailing list, please visit: https://www.hud.gov/subscribe/signup?listname=Housing%20Opportunities%20for%20Persons%20with%20AIDS%20Program&list=HOPWA-L

2. Changes from Previous NOFO.

The last NOFO published with HOPWA funding was FR-5900-N-11B, Violence Against Women Act (VAWA) and Housing Opportunities for Persons With AIDS (HOPWA) Project Demonstration. This NOFO is completely new and different. The only similarity from the previous NOFO is HOPWA funding being awarded.

3. Definitions.

a. Standard Definitions

Affirmatively Furthering Fair Housing (AFFH). Affirmatively Furthering Fair Housing (AFFH) means taking meaningful actions, in addition to combating discrimination, that overcome patterns of segregation and foster inclusive communities free from barriers that restrict access to opportunity based on protected characteristics. Specifically, affirmatively furthering fair housing means taking meaningful actions that, taken together, address significant disparities in housing needs and in access to opportunity, replacing segregated living patterns with truly integrated and balanced living patterns, transforming racially and ethnically concentrated areas of poverty into areas of opportunity, and fostering and maintaining compliance with civil rights and fair housing laws. The duty to affirmatively further fair housing extends to all of a program participant's activities and programs relating to housing and urban development.

Assistance Listings means a unique number assigned to identify a Federal Assistance Listing, formerly known as the CFDA Number.

Federal Financial Assistance means assistance that entities received or administer in the form of:

1) Grant;

2. Cooperative agreements (which does not include a cooperative research and development agreement pursuant to the Federal Technology Transfer Act of 1986, as amended (15 U.S.C. 3710a));
3. Loans;
4. Loan guarantees;
5. Subsidies;
6. Insurance;
7. Food commodities;
8. Direct appropriations;
9. Assessed or voluntary contributions; or
10. Any other financial assistance transaction that authorizes the non-Federal entity's expenditure of Federal funds.

b. Federal Financial Assistancedoes not include:
    1. Technical assistance, which provides services in lieu of money; and
    2. A transfer of title to federally owned property provided in lieu of money, even if the award is called a grant.

Authorized Organization Representative (AOR) is the person authorized to submit applications on behalf of the organization via Grants.gov. The AOR is authorized by the E-Biz point of contact in the System for Award Management. The AOR is listed in item 21 on the SF-424.

Consolidated Plan is a document developed by states and local jurisdictions. This plan is completed by engaging in a participatory process to assess their affordable housing and community development needs and market conditions, and to make data-driven, place-based investment decisions with funding from formula grant programs. (See 24 CFR part 91 HUD's requirements regarding the Consolidated Plan and related Action Plan).

Contract means, for the purpose of Federal financial assistance, a legal instrument by which a recipient or subrecipient purchases property or services needed to carry out the project or program under a Federal award. For additional information on contractor and subrecipient determinations see 2 CFR 200.331.

Contractor means an entity that receives a contract as defined in 2 CFR 200.1.

Deficiency is information missing or omitted within a submitted application. Examples of deficiencies include missing documents, information on a form, or some other type of unsatisfied information requirement (e.g., an unsigned form, unchecked box.). Depending on specific criteria, deficiencies may be either curable or non-curable.

- *Curable Deficiencies* may be corrected by the applicant with timely action. To be curable the deficiency must:

- Not be a threshold requirement, except for documentation of applicant eligibility;
- Not influence how an applicant is ranked or scored versus other applicants; and
- Be remedied within the time frame specified in the notice of deficiency.
- *Non-Curable Deficiencies* cannot be corrected by an applicant after the submission deadline.

Non-curable deficiencies are deficiencies that, if corrected, would change an applicant's score or rank versus other applicants. Non-curable deficiencies may result in an application being marked ineligible, or otherwise adversely affect an application's score and final determination.

DUNS Number is the nine-digit Dun and Bradstreet Data Universal Number

System identification number assigned to a business or organization by Dun & Bradstreet and provides a means of identifying business entities on a location-specific basis. OMB removed duplicate recipients based on recipient Data Universal Number System (DUNS) numbers, from Dun & Bradstreet (D&B). At this time all Federal financial assistance recipients are required to register for DUNS numbers.

E-Business Point of Contact (E-Biz POC) A user registered as an organization applicant who is responsible for the administration and management of grant activities for his or her organization. The E-Biz POC is likely to be an organization's chief financial officer or authorizing official. The E-Biz POC authorizes representatives of their organization to apply on behalf of the organization (see Standard AOR and Expanded AOR). There can only be one E-Biz POC per DUNS Number.)

Eligibility requirements are mandatory requirements for an application to be eligible for funding.

Federal award, has the meaning, depending on the context, in either paragraph (1) or (2) of this definition:

(1)(i) The Federal financial assistance that a recipient receives directly from a Federal awarding agency or a subrecipient receives indirectly from a pass-through entity, as described in 2 CFR §200.101; or

ii. The cost-reimbursement contract under the Federal Acquisition Regulations that a non-Federal entity receives directly from a Federal awarding agency or indirectly from a pass-through entity, as described in 2 CFR §200.101.

2. The instrument setting forth the terms and conditions. The instrument is the grant agreement, cooperative agreement, other agreement for assistance covered in paragraph (2) of the definitions of Federal financial assistance in 2 CFR §200.1, or the cost-reimbursement contract awarded under the Federal Acquisition Regulations.
3. Federal award does not include other contracts that a Federal agency uses to buy goods or services from a contractor or a contract to operate Federal Government owned, contractor operated facilities (GOCOs).
4. See also definitions of Federal financial assistance, grant agreement, and cooperative agreement.

Grants.gov is the website serving as the Federal government's central portal for searching and applying for Federal financial assistance throughout the Federal government. Registration on Grants.gov is required for submission of applications to prospective agencies unless otherwise specified in this NOFO.

Non-Federal Entity (NFE) means a state, local government, Indian tribe, Institution of Higher Education (IHE), or non-profit organization that carries out a Federal award as a recipient or subrecipient.

Point of Contact (POC) is the person who may be contacted with questions about the application submitted by the AOR. The POC is listed in item 8F on the SF-424.

Recipient means an entity, usually but not limited to non-Federal entities, that receives a Federal award directly from HUD. The term recipient does not include subrecipients or individuals that are beneficiaries of the award.

Small business is defined as a privately-owned corporation, partnership, or sole proprietorship that has fewer employees and less annual revenue than a corporation or regular-sized business. The definition of "small"—in terms of being able to apply for government support and qualify for preferential tax policy—varies by country and industry. The U.S. Small Business Administration defines a small business according to a set of standards based on specific industries.{e-CFR Title 13-Chapter I – Part 121}

Subaward means an award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program. A subaward may be provided through any form of legal agreement, including an agreement that pass-through entity considers a contract.

Subrecipient means an entity, usually but not limited to non-Federal entities, that receives a subaward from a pass-through entity to carry out part of a Federal award but does not include an individual that is a beneficiary of such award. A subrecipient may also be a recipient of other Federal awards directly for a Federal awarding agency.

System for Award Management (SAM) means the Federal Repository into which an entity must provide information required for the conduct of business as a recipient. Registration with SAM is required for submission of applications via Grants.gov. You can access the website

athttps://www.sam.gov/SAM/. There is no cost to use SAM.

Threshold Requirements are an eligibility requirement that must be met for an application to be reviewed. Threshold requirements are not curable, except for documentation of applicant eligibility and are listed in Section III.D Threshold Eligibility Requirements. Similarly, there are eligibility requirements under Section III.E, Statutory and Regulatory Requirements Affecting Eligibility.

Unique Entity Identifier means the identifier required for SAM registration to uniquely identify business entities.

4. Program Definitions

The following apply in addition to program definitions stated in 24 CFR 574.3.

Client is an eligible person as defined at 24 CFR 574.3 who is receiving HOPWA-funded assistance.

Continuous Quality Improvement (CQI) is the systematic process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions. More simply, CQI can be described as an ongoing cycle of collecting data and using it to make decisions to gradually improve program processes. For more information, see the following publication from the Office of Adolescent Health of the U.S. Department of Health and Human Services: https://www.hhs.gov/ash/oah/sites/default/files/cqi-intro.pdf

Equity is the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. For more information on equity, see Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government published January 20, 2021: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

HIV Housing Care Continuum Model is an annual reporting document available as form HUD-4154. This reporting document uses a diagnosis-based HIV Care Continuum that outlines where eligible beneficiaries are on the sequential stages of HIV medical care including receipt of care, retained in care, and viral suppression. The HIV Housing Care Continuum Model requires grantees to collect client-level data to aggregately report where clients are on the HIV Care Continuum by type of HOPWA assistance received through this NOFO. For more information on the HIV Housing Care Continuum, see published CDC resources at: https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf; and HOPWA resources at: https://www.hudexchange.info/programs/hopwa/hiv-housing-care-continuum-initiative/

Housing as an Intervention to Fight AIDS (HIFA) Model is a reporting document available as form HUD-4153. This reporting document is due to HUD 90 days after the end of the grant period and will be made available to the public via the Office of HIV/AIDS Housing. The HIFA Model includes the following components: a vision or goal for the project; description of the need being met by the project; description of the program design; description of the alignment with initiatives or strategies to end the HIV/AIDS epidemic; description of data collection and analysis used to make data-driven decisions on stable housing, positive health outcomes, and racial equity; description of culturally competent approaches used for clients experiencing service gaps; partnerships formed or continued with community organizations and other housing and service providers; resources and partnerships used to transition clients to self-sufficiency or other forms of housing assistance by the end of the grant period; successes and challenges in using housing as a structural intervention to end the HIV/AIDS epidemic; client outcomes

related to health and housing stability including a summary of HIV Housing Care Continuum results and, if applicable, employment and income growth.

Project Sponsor is any nonprofit organization or governmental housing agency that receives funds under a contract with the grantee to carry out eligible activities under this NOFO. The selection of project sponsors is not subject to the procurement requirements of 2 CFR part 200, subpart D.

Receipt of Care is a data element collected for the HIV Housing Care Continuum. Receipt of Care is measured as a person with diagnosed HIV receiving HOPWA assistance under this NOFO who had at least one CD4 or viral load test during a single operating year.

Retained in Care is a data element collected for the HIV Housing Care Continuum. Retained in Care is measured as a person with diagnosed HIV receiving HOPWA assistance under this NOFO who had two or more CD4 or viral load tests, performed at least three months apart, during a single operating year.

Trauma-informed is a term referring to how one thinks about and responds to those who have experienced or may be at risk for experiencing trauma. An approach that is trauma-informed reflects an understanding of the widespread impact of trauma and potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with a program, organization, or system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, while actively resisting re-traumatization. For more information, see the following publication from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services: http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Underserved Communities refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the definition of "equity." For more information on underserved communities, see Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government published January 20, 2021: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

Viral Suppression is a data element collected for the HIV Housing Care Continuum. Viral Suppression is measured as a person with diagnosed HIV receiving HOPWA assistance under this NOFO who has a viral load test result of <200 copies/mL at the most recent viral load test during a single operating year.

B. Authority.

HUD's authority to award funding under this NOFO is provided by the AIDS Housing Opportunity Act (codified as amended at 42 U.S.C. 12901-12912), and the Further Consolidated Appropriations Act, 2020 (Pub. L. No. 116-94, enacted December 20, 2019). Awards are also

subject to the HOPWA program requirements under 24 CFR part 574 (as now in effect and as may be amended from time to time), except as expressly stated in Section III of this NOFO.

II. Award Information.

A. Available Funds

Funding of approximately **$ 41,000,000** is available through this NOFO.
Additional funds may become available for award under this NOFO, because of HUD's efforts to recapture funds, use carryover funds, or because of the availability of additional appropriated funds. Use of these funds is subject to statutory constraints. All awards are subject to the funding restrictions contained in this NOFO.

B. Number of Awards.

HUD expects to make approximately 18 awards from the funds available under this NOFO.

C. Minimum/Maximum Award Information

HUD reserves the right to add time to the competitive submission period if the initial round of applicant submissions does not provide enough eligible applicants to award the funds available. Alternatively, if there are not enough eligible applicants, HUD reserves the right to adjust the funding range to accommodate a smaller number of applicants with the funds available.

Estimated Total Funding:
$ 41,000,000

Minimum Award Amount:
$ 300,000
Per Project Period

Maximum Award Amount:
$ 2,250,000
Per Project Period

D. Period of Performance

Estimated Project Start Date:
03/01/2022

Estimated Project End Date:
03/01/2025

Length of Project Periods:
Other

Length of Periods Explanation of Other:
The Period of Performance and Budget Period for each grant will be a 36-month project period with a 36-month budget period.

E. Type of Funding Instrument.

Funding Instrument Type:
G (Grant)

III. Eligibility Information.

A. Eligible Applicants.

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

Additional Information on Eligibility

Eligible applicants for funding under this NOFO are States, units of general local government, and nonprofit organizations. To be eligible, nonprofit organizations must meet the definition of an eligible "nonprofit organization" under the HOPWA program found regulations at 24 CFR 574.3.

B. Ineligible Applicants.

HUD will only score applications from eligible applicants as defined in Section III.A.

C. Cost Sharing or Matching.

This Program does not require cost sharing or matching, but provides points based on leverage as describe below.

More information on leveraging is available at Rating Factor 4 in Section V.A.

D. Threshold Eligibility Requirements.

Applicants who fail to meet any of the following threshold eligibility requirements will be deemed ineligible. Applications from ineligible applicants will not be evaluated.

1. Resolution of Civil Rights Matters. Outstanding civil rights matters must be resolved before the application deadline. Applicants, who after review are confirmed to have civil rights matters unresolved at the application deadline, will be deemed ineligible. Their applications will receive no further review, will not be rated and ranked, and they will not receive funding.

a. Applicants having any of the charges, cause determinations, lawsuits, or letters of findings referenced in subparagraphs (1) – (5) that have not been resolved to HUD's satisfaction before or on the application deadline date are ineligible for funding. Such matters include:
    1. Charges from HUD concerning a systemic violation of the Fair Housing Act or receipt of a cause determination from a substantially equivalent state or local fair housing agency concerning a systemic violation of a substantially equivalent state or local fair housing law proscribing discrimination because of race, color, religion, sex, national origin, disability or familial status;
    2. Status as a defendant in a Fair Housing Act lawsuit filed by the Department of Justice alleging a pattern or practice of discrimination or denial of rights to a group of persons raising an issue of general public importance under 42 U.S.C. 3614(a);
    3. Status as a defendant in any other lawsuit filed or joined by the Department of Justice, or in which the Department of Justice has intervened, or filed an amicus brief or statement of interest, alleging a pattern or practice or systemic violation of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Section 109 of the Housing and Community Development Act of 1974, the Americans with Disabilities Act or a claim under the False Claims Act related to fair

housing, non-discrimination, or civil rights generally including an alleged failure to affirmatively further fair housing;

4. Receipt of a letter of findings identifying systemic non-compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Section 109 of the Housing and Community Development Act of 1974; or the Americans with Disabilities Act; or
5. Receipt of a cause determination from a substantially equivalent state or local fair housing agency concerning a systemic violation of provisions of a state or local law prohibiting discrimination in housing based on sexual orientation, gender identity, or lawful source of income.

b. HUD will determine if actions to resolve the charge, cause determination, lawsuit, or letter of findings taken before the application deadline date will resolve the matter. Examples of actions that may be sufficient to resolve the matter include, but are not limited to:

1. Current compliance with a voluntary compliance agreement signed by all the parties;
2. Current compliance with a HUD-approved conciliation agreement signed by all the parties;
3. Current compliance with a conciliation agreement signed by all the parties and approved by the state governmental or local administrative agency with jurisdiction over the matter;
4. Current compliance with a consent order or consent decree;
5. Current compliance with a final judicial ruling or administrative ruling or decision; or
6. Dismissal of charges.

2. Timely Submission of Applications. Applications submitted after the deadline stated within this NOFO that do not meet the requirements of the grace period policy will be marked late. Late applications are ineligible and will not be considered for funding. See Section IV. D. Application Submission Dates and Times.

3. Complete Application. HUD reserves the right to determine whether an application is substantially deficient and non-responsive to the NOFO application requirements. Refer to Section IV.B., Content and Form of Application Submission, for information on the required documentation for submission.

E. Statutory and Regulatory Requirements Affecting Eligibility.

Eligibility Requirements for Applicants of HUD's Grants Programs

The following requirements affect applicant eligibility. Detailed information on each requirement is posted on HUD's Funding Opportunities Page.

- Active Prime and Sub Recipient registration with SAM.gov
- Outstanding Delinquent Federal Debts
- Debarments and/or Suspensions
- Pre-selection Review of Performance
- Sufficiency of Financial Management System
- False Statements
- Mandatory Disclosure Requirement

- Prohibition Against Lobbying Activities
- Equal Participation of Faith-Based Organizations in HUD Programs and Activities

F. Program-Specific Requirements.

1. Required Project Objectives. Each Project must be designed for the Grantee to achieve the following six required project objectives. Applicants must clearly show how the proposed project will achieve the required project objectives in the submitted application narratives.

- Implement and document housing and services models for low-income persons living with HIV and their families that are innovative and replicable in other similar localities or nationally;
- Increase alignment with new or existing local initiatives or strategies to end the HIV/AIDS epidemic by elevating housing as an effective structural intervention;
- Improve coordination among local housing and service providers and use of available community resources;
- Increase the amount of quality data collected and used for data-driven decision making with an emphasis on stable housing, positive health outcomes, and racial equity;
- Assess and document replicable practices that ensure equitable access and culturally competent approaches to providing housing and services for populations of persons living with HIV experiencing service gaps; and
- Prioritize sustainable, effective, and equitable approaches to providing housing and services to persons living with HIV and their families that can be continued past the funded project's period of performance.

2. Required Participation in Technical Assistance (TA) Initiative. Awarded grantees and their project sponsors must participate in a TA initiative that will support grantee efforts to identify and document promising practices and replicable innovative qualities from the projects to share with the broader HIV/AIDS housing and service provider networks. The TA initiative will provide a structured environment where grantees and project sponsors will have the opportunity to collaboratively problem solve, share successes and challenges, and engage in peer-learning. Grantees will be expected to engage in continuous quality improvement (CQI) efforts with the support of the TA initiative. The TA initiative will consist of regular facilitated conference calls and may also require travel for a group meeting in Washington, DC, and/or participation in conferences.

3. Eligible Activities. Funded projects must comply with the HOPWA program requirements at 24 CFR 574, as modified below. Applicants may choose to use a combination of eligible activities under this NOFO to achieve the funding opportunity's required project objectives and address the housing and service needs of eligible persons in the service area.

a. Housing Assistance. Applicants must commit to providing housing assistance as a main focus of program activities and at least 60 percent of the proposed budget must consist of housing assistance costs. All housing assistance eligible under 24 CFR 574 can be funded under this NOFO, except for the following activities, which are ineligible for this funding: acquisition, new construction, or rehabilitation of housing facilities; and

assistance through emergency shelters. **HUD is providing funding via this NOFO on a one-time-only basis.** It is expected that all program beneficiaries will have secured permanent housing by the end of the grant period of performance. This includes outplacement to self-sufficiency or to permanent rental housing subsidized by HUD or other Federal, state, and local resources. Housing assistance must not be conditioned on the eligible person's acceptance of and/or participation in supportive services.

i. Operating Costs. Funding may be used for the Grantee's or Project Sponsor's cost of operating a housing facility owned or leased by the Grantee or Project Sponsor, to the extent the costs are necessary to house eligible persons. Eligible Operating Costs include utilities, property insurance, minor repairs and upkeep of the facility, maintenance both inside and outside the facility, procurement and contracting of services for facility operation or maintenance, furniture and appliances that will remain with the facility, food purchases and kitchen operation for HOPWA clients at the facility, and staff time for directing the operation of all activities at the facility for HOPWA clients.

ii. Leasing. Funding may be used to lease all or a portion of a building as needed to provide housing to eligible persons. For eligible persons unable to hold leases in their names, funding may be used to master lease units, where the eligible persons choose the units, the grantee or project sponsor leases the units and pays the full rent to the landlord, and the eligible persons pay the grantee or project sponsor the amount required by 24 CFR 574.310(d). This type of master leasing can be administered as “turn-key” housing assistance, to be replaced with TBRA if the landlord agrees to transfer the lease to the eligible person. Funding may also be used to master lease units to be operated as transitional housing for eligible persons. For example, post-incarceration programs often lease a unit to temporarily house an eligible person returning to the community until other more permanent housing arrangements can be made. The lease is always in the organization's name. The furniture, housing equipment, and supplies belong to the organization and remain in the unit for the next household’s use. Eligible leasing costs include the cost to lease a housing facility or scattered site units, staff time to negotiate lease terms with lessor or landlord, and annual housing inspections to ensure HOPWA habitability standards are met for scattered-site units assisted with Leasing.

iii. Tenant-Based Rental Assistance (TBRA). TBRA may be used to provide eligible persons with a rental subsidy through the duration of the grant period and give them the opportunity to transition in place to self-sufficiency or another subsidy. Eligible TBRA costs include client income verification for TBRA assistance, calculation of resident rent payment, monthly rental payments, processing a TBRA rental payment on behalf of the program beneficiary, annual housing inspections to ensure HOPWA habitability standards are met for units being assisted with TBRA, reasonable travel costs to units for housing inspections, review of a program beneficiary’s selected unit for rent reasonableness and rent standard,

annual recertifications for program beneficiaries receiving on-going TBRA, and staff time for resolving landlord issues directly related to providing the TBRA assistance.

iv. Short-Term Rent, Mortgage, and Utility (STRMU). STRMU may be used to prevent homelessness of the tenant or mortgagor of a dwelling. The goal of STRMU assistance under the HOPWA program is to provide short-term, stabilizing interventions to HOPWA eligible households experiencing a financial crisis as a result of their HIV/AIDS health condition or a change in their economic circumstances. The amount of STRMU assistance provided to a program beneficiary should be based on need, and not applied uniformly to all clients. Eligible STRMU costs include up to 21 weeks of the eligible person's rent, mortgage, and/or utility costs, and the costs of staff time to review and determine client's need for STRMU assistance, and make the STRMU payments. For the purposes of STRMU assistance, to the extent that taxes, insurance, condominium fees, or other building operation costs are included in the monthly mortgage payment either by federal regulation or the terms of the mortgage, these expenses are eligible to be included in STRMU mortgage assistance payments. STRMU mortgage assistance for taxes, insurance, or condo fees that are not included on the monthly mortgage statement are not eligible.

v. Housing Information Services. Housing Information Services may be used to provide counseling, information, or referral services to assist an eligible person to locate, acquire, finance, and maintain housing. Some eligible costs under Housing Information Services include staff time to assist clients in searching for or locating appropriate housing whether HOPWA-subsidized or not; staff time to provide fair housing guidance for eligible persons who may encounter discrimination on the basis of race, color, religion, sex, age, national origin, familial status, or disability; staff time to provide housing counseling to acquire and finance housing; and development and use of Homeless Management Information System (HMIS) elements to coordinate housing and services. HMIS costs billed to housing information services must be pro-rated and not include HMIS reporting. Use of HMIS for reporting purposes is considered an administration activity and must be billed to administrative costs.

vi. Permanent Housing Placement Assistance (PHP). Permanent housing placement authorized at 24 CFR 574.300(b)(7) may be used in connection with the provision of housing support provided under these awards and is not considered a supportive service. Some eligible costs under PHP include security deposits not to exceed two months rent, rental application fees, credit checks, one-time utility hook-up fees paid directly to the utility company, utility arrears only if the cost is creating a barrier to establishing permanent housing in a new unit, rent arrears only if past due rent debt at a prior unit is a barrier to accessing a new unit, initial housing inspections, reasonable travel costs to units for initial housing inspections, staff time

to review and identify causes for eviction and responsibilities of the tenant within the lease, staff time for assisting clients with executing the lease, and staff time for resolving landlord issues directly related to the PHP assistance being provided. PHP can be used in conjunction with TBRA where PHP pays the security deposit and TBRA covers ongoing monthly rent payments starting with the first month. PHP should only be used to assist the client in entering permanent housing. PHP should never be used for monthly rent or on-going utility costs where a client is already in permanent housing.

vii. Other HUD-Approved Activities. Other housing activities not already authorized at 24 CFR 574.300(b) may be proposed, but are subject to HUD's approval. Your proposal must address the expected beneficial impact of this alternative activity in addressing housing needs of eligible persons by describing the project impact and the identified performance output and client outcome measures for this activity. Examples of past approved Other HUD-approved Activities include rental assistance allowing clients to pay more or less than the required resident rent payment at 24 CFR 675.310(d), moving costs, and non-amortizing second mortgages to assist with homeownership. Funding restrictions for acquisition, new construction, or rehabilitation of housing facilities, and assistance through emergency shelters still apply. HUD will not approve Other Activities outside of the application submission process.

b. Supportive Services. Supportive Services funding may be used to provide access to mainstream resources and public benefits, improve access to healthcare, and provide other needed support to maintain stable housing and support positive health outcomes, subject to the supportive services requirements in 24 CFR 574. Eligible supportive services costs include staff time to develop and process individual housing and service plans for clients; staff time to connect clients to appropriate services and treatment in accordance with their housing and service plans; staff time to review progress on the client's housing and service plan, management-level consultation on client case issues; health and mental health assessment services; direct outpatient treatment by licensed professionals of mental health conditions; substance abuse treatment services designed to prevent, reduce, eliminate, or deter relapse of substance abuse or addictive behaviors provided by licensed or certified professionals; individual, family, or group therapy to address co-occurring disorders; nutritional services including food banks, nutritional supplements, and counseling on proper nutrition by certified nutrition specialists; life skills trainings such as budgeting resources, managing money, managing a household, resolving conflict, shopping for food and needed items, improving nutrition, using public transportation, parenting, and cleaning and unit maintenance; credit counseling; education services including instruction or training in consumer education, health education, substance abuse prevention, literacy, English as a Second Language, and General Educational Development (GED); job training or job coaching including resume development; client transportation to and from medical care, employment, child care, or other eligible essential services facilities; and HOPWA provider transportation to meet with clients for supportive service needs.

c. Resource Identification. Resource Identification funds may be used to comprehensively plan, coordinate, and integrate housing and services for program beneficiaries with strategies and resources in the service area. There are four activities for which Resource Identification funds should be used: (1) Increasing coordination with local initiatives or strategies to end the HIV/AIDS epidemic; (2) Conducting preliminary research and making expenditures necessary to determine the feasibility of specific housing-related initiatives; (3) Planning and Coordination for Client Transitions; and (4) Participation in a Peer Learning Cohort. Applicants may propose through the application narratives other use of Resource Identification funds for purposes not listed here if the activities are in compliance with HOPWA regulations at 24 CFR 574.300.

i. Increasing coordination with local initiatives or strategies to end the HIV/AIDS epidemic. Two of the required project objectives for this funding opportunity are (1) Increase alignment with new or existing local initiatives or strategies to end the HIV/AIDS epidemic by elevating housing as a structural intervention; and (2) Improve coordination among local housing and service providers and use of available community resources. Grantee planning and coordination efforts should strive to meaningful integrate HIV housing into local efforts to end the HIV/AIDS epidemic by creating new or strengthening existing community partnerships. Resource identification can be used for staff time to participate in local planning bodies where staff are establishing, coordinating, or developing housing assistance resources for HOPWA eligible persons. Applicants must provide signed commitment letters with community organizations regarding intentions to partner. These commitment letters should be submitted with the leveraged resources narrative information under Rating Factor 4. Applicants must address their planning and coordination activities under Rating Factor 3, Soundness of Approach.

ii. Conducting research and making expenditures necessary to determine the feasibility of specific housing-related initiatives. Four of the required project objectives for this funding opportunity are (1) Implement and document housing and services models for low-income persons living with HIV and their families that are innovative and replicable in other similar localities or nationally; (2) Increase the amount of quality data collected and used for data-driven decision making with an emphasis on stable housing, positive health outcomes, and racial equity; (3) Assess and document replicable practices that ensure equitable access and culturally competent approaches to providing housing and services for populations of persons living with HIV experiencing service gaps; and (4) Prioritize sustainable, effective, and equitable approaches to providing housing and services to persons living with HIV and their families that can be continued past the funded project's period of performance. The client-level data collected for the HIV Housing Care Continuum Model should be used to identify service gaps preventing stable housing and viral

suppression. Identified service gaps should be analyzed to determine whether discrimination and systemic racism contributed to differences in access in housing and services for people of color and others who have been historically underserved. The Resource Identification budget line item can be used to analyze the client-level data collected and research causes preventing clients from achieving stable housing and viral suppression. Collected data should also be analyzed to determine whether, and to what extent programmatic policies and procedures are perpetuating systemic barriers to opportunities and benefits for people of color and other underserved groups being served under this grant. It can be used to make necessary expenditures to determine the feasibility of approaches to providing housing and services to persons living with HIV and their families being culturally competent, equitable, effective, and sustainable. It can also be used to write and publish the HIFA Model at the end of the grant period of performance to document housing and services models for low-income persons living with HIV and their families that are innovative and replicable in other similar localities or nationally. Please note that Resource Identification cannot be used for data collection or reporting on form HUD-40110-C (APR) and form HUD-4154, HIV Housing Care Continuum Model which are administrative costs.

iii. Planning and Coordination for Client Transitions. As funding under this NOFO will be provided on a one-time only basis and **will not** be eligible for renewal, grant recipients must ensure the full integration of their clients into local systems of care including any continuing housing assistance and services, if needed. The Resource Identification budget line item can be used to identify and coordinate local resources to ensure the successful transition of assisted clients to permanent housing by the end of the grant operating period.

iv. Participation in HUD-funded TA. Awarded grantees and their project sponsors will participate in a Peer Learning Cohort supported by a HUD-funded Technical Assistance (TA) initiative as part of this funding opportunity. The TA initiative will consist of regular facilitated conference calls and may also require travel for a group meeting in Washington, DC, and/or participation in conferences. Resource Identification can be used for staff time and reasonable travel costs related to participating in the TA initiative. Applicants should, at minimum, include staff costs to participate in the Peer Learning Cohort and travel costs for two staff persons to attend a two-day meeting in Washington, DC.

d. Administrative costs. HOPWA regulations (24 CFR 574.300(b)(10)) limit administrative costs to 3 percent of the award for grantees and, for project sponsors, 7 percent of the amounts received. HOPWA funds may be used for administrative costs as provided under 24 CFR 574, including costs of compiling data for and preparing form HUD-40110-C, Annual Performance Report (APR) and form HUD-4154, HIV Housing Care Continuum Model report at the end of each operating year.

3. Required Performance Goals and Reporting. Grant recipients must conduct eligible HOPWA activities consistent with their planned annual performance output goals, objectively measure actual achievements against anticipated achievements, report on their actual performance in form HUD-40110-C Annual Progress Report (APR), and report aggregated client-level health outcomes through an annual HIV Housing Care Continuum Model Report. The HIV Housing Care Continuum Model report requires grantees to collect client-level data elements including receipt of care, retained in care, and viral suppression to aggregately report on client outcomes through this NOFO. Applicants are also required to use the HOPWA Budget Form (form HUD-40110-B) found in the attachments to this NOFO for recording the funds being requested with the associated performance outputs for each activity, and any commitments of leveraged funding to support the program. Applicants will be required to establish project goals in Rating Factor 5 to be reported on in the narrative section of the APR and the Housing as an Intervention to Fight AIDS (HIFA) Model. Project goals must incorporate the six required project objectives.

HUD expects that each grantee will show that eligible program beneficiaries have achieved stable housing, have reduced risks of homelessness, and improved access to care in their program during the operating year, as shown by an assessment of the housing status and health outcomes for the household at the end of each operating year. Required Outputs refer to the number of units of housing or households assisted during the year, as measured by the annual use of HOPWA funding. The application must specify yearly goals for the number of households to be provided housing and services through the use of eligible activities. See Section III.F.3 of this NOFO for more information on eligible activities. Required Outcomes refer to the number of eligible households that have been provided housing assistance (as noted above for outputs) and thereby maintain a stable living environment in housing that is safe, decent, and sanitary. The program will measure these results in annual assessments on the housing status of beneficiaries along with other outcome measures on the reduced risks of homelessness, improved access to HIV/AIDS treatment and other health care and supportive services, and achieved viral suppression. On a nationwide basis, the HOPWA program is expected to demonstrate stable housing results, reduced risks of homelessness, and improved access to care results for beneficiaries.

Reporting requirements under this NOFO are more comprehensive than traditional HOPWA program reporting. Grantees will be required to submit an APR and HIV Housing Care Continuum Model report within 90 days of the end of each operating year. Grantees will also develop a Housing as an Intervention to Fight AIDS (HIFA) Model to be submitted within 90 days of grant expiration date. More information on reporting requirements under this NOFO can be found in Section VI.C.5.

4. Disbursement of Funds. Grant recipients must fully expend their grant funding no later than three years following the effective date or the operation start date in the grant agreement, unless HUD approves a one-time extension for an additional 12 months or less. HOPWA grantees are required to use HUD's Integrated Disbursement and Information System (IDIS) for financial transactions and reimbursement of approved project activities. It is important that grantees understand the required separation of duties to draw down funding and how to keep the accounts active. New IDIS users will need to work with HUD to submit a request for access to an IDIS account. More information on IDIS account creation and maintenance can be found

here: https://www.hudexchange.info/programs/idis/idis-technical-assistance/.

Grant funds under this award must be used in a consistent and regular manner over the three-year period of performance. Grantees will be required to drawdown funds and reconcile the account quarterly at minimum in IDIS. It is recommended as a sound financial management practice and oversight action, that drawdowns and reconciliations occur on a monthly basis. Grant recipients must also reimburse project sponsors for eligible incurred expenses in a reasonable and timely manner.

5. Consistency with the Consolidated Plan.

This program requires a certification of Consistency with the Consolidated Plan under 24 CFR 91.2. This certification means the proposed activities in the application are consistent with the jurisdiction's strategic plan, and the location of the proposed activities is consistent with the geographic areas specified in the Consolidated Plan.

G. Criteria for Beneficiaries.

To receive assistance funded under this NOFO, an individual or family must meet the eligibility criteria that applies to that assistance under 24 CFR 574.

IV. Application and Submission Information.

A. Obtaining an Application Package.

Instructions for Applicants.

You must download both the Application Instructions and the Application Package from Grants.gov. You must verify that the Assistance Listing Number and Assistance Listing Description on the first page of the Application Package, and the Funding Opportunity Title and the Funding Opportunity Number match the Program and NOFO to which you are applying.

The Application Package contains the portable document forms (PDFs) available on Grants.gov, such as the SF-424 Family. The Instruction Download contains official copies of the NOFO and forms necessary for a complete application. The Instruction Download may include Microsoft Word, Microsoft Excel and additional documents.

An applicant demonstrating good cause may request a waiver from the requirement for electronic submission, for example, a lack of available Internet access in the geographic area in which your business offices are located. Lack of SAM registration or valid DUNS Number is not good cause. If you cannot submit your application electronically, you must ask in writing for a waiver of the electronic grant submission requirements. HUD will not grant a waiver if HUD does not receive your written mailed, shipped, or emailed request at least 15 calendar days before the application deadline and if you do not demonstrate good cause. If HUD waives the requirement, HUD must receive your paper application before the deadline of this NOFO. To request a waiver, you must contact:

Name:

Email:

HOPWA@hud.gov

HUD Organization:

Street:

City:

State:

Zip:

B. Content and Form of Application Submission.

You must verify that boxes 11, 12, and 13 on the SF-424 match the NOFO for which you are applying. If they do not match, you have downloaded the wrong Application Instruction and Application Package.

Submission of an application that is otherwise sufficient, under the wrong Assistance Listing and Funding Opportunity Number is non curable unless otherwise stated in Threshold requirements.

1. Content.

Forms/Assurances/Certifications	Submission Requirement	Notes/Description
Application for Federal Assistance (SF424)	Submission is required for all applicants by the application due date.	
Disclosure of Lobbying Activities (SFLLL), if applicable	HUD will provide instructions to grantees on how the form is to be submitted.	If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the applicant shall complete and submit the SF-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Applicants must furnish an executed copy of the Certification Regarding Lobbying prior to award.
Assurances for Non-Construction Programs (SF-424B)	Submission is required for all applicants by the	This is a required form for all applicants. The Authorized Representative must sign and date this

Forms/Assurances/Certifications	Submission Requirement	Notes/Description
	application due date.	form and include the organization name.
Certification of Consistency with the Consolidated Plan (HUD-2991)	Submission is required for all applicants by the application due date.	Applicants must obtain a Consolidated Plan certification signed by the applicable state or local government official for submitting the appropriate plan for the areas in which activities are targeted. The authorizing official from the state or local government must sign this certification. If your project will be carried out on a national basis or will be located on an Indian reservation or in one of the U.S. Territories of Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands, you are not required to include a Consolidated Plan certification from these areas with your application.
HOPWA Budget (HUD-40110-B)	Submission is required for all applicants by the application due date.	Applicants must use this program-specific budget form (HUD-40110-B) that demonstrates how HOPWA funds will be used for eligible activities. The HUD-40110-B will provide a summary of the total budget for the project, the annual HOPWA amounts to be used in each of the three years of operation, and a detailed budget for each project sponsor and the grantee. On the detailed budget, applicants must provide a short narrative which summarizes each of the requested budget line items and how the funds will be used, including the amount of requested funding by budget line item for the grantee and project sponsors and, as appropriate, community team members.

Forms/Assurances/Certifications	Submission Requirement	Notes/Description
Commitment Letter(s)	Submission is required for all applicants by the application due date. This is required for all leveraged resources, and planning partnerships that increase coordination under Resource Identification.	Each organization providing leveraged resources for this project must submit a signed letter from an Authorized Representative to the grantee during the development of the application. The commitment letter must include: the name and address of the organization(s) providing the commitment(s) (state if the organization will serve as a project sponsor); the type of commitment (applicant or third party cash resources, non-cash resources, volunteer time, contribution of a building, contribution of a lease hold interest, etc.); the dollar value of the commitment; the date of the commitment letter or other document; the source of the funding (federal, state, local, private, or in-kind contribution); and the organization's Authorized Representative's name, title, and contact information who has made this commitment. A single commitment letter from the lead Ending the Epidemic: A Plan for America (EHE) planning agency or HOPWA formula grantee is acceptable to show partnership with all organizations involved with EHE or HOPWA modernization work in a community, but the letter should provide the names of all relevant organizations involved in the work and the amount of funding leveraged for the project.

Additionally, your complete application must include the following narratives and non-form attachments.

a. **Narratives.** Each narrative must be titled with a corresponding heading. The application must contain the following narratives:

i. Executive Summary. On no more than two pages, provide an Executive Summary of the proposed project. The summary must provide an overview of the main components of your planned project including any special service delivery method or project purposes, and the projected annual housing output. The summary should briefly identify your innovative approach to achieving the required project objectives for this NOFO. In the executive summary, provide the name of the applicant, and any project sponsors, along with contact names, phone numbers, and email addresses.

ii. Narratives to Address the Rating Factors for Award. Applicants must provide written responses to each of the five rating factors described in Section V.A. of this NOFO. The rating factor narratives are where applicants should provide a clear vision of their proposed project within the guidelines provided. Responses should follow the formatting in Section IV.B.2. and be within the page limit stated under each rating factor.

2. Format and Form.

Narratives and other attachments to your application must follow the following format guidelines.

50 Pages maximum length of narratives

Double spaced 12-point (minimum) Times Roman font on letter sized paper (8 1/2 x 11 inches) with at least 1-inch margins on all sides

Other

All narratives should be formatted as described here. Page limits for each narrative are provided with its Rating Factor description in Section V.A.

- Font size/style for headings: 14 point, Bold. (subheadings - 12 point, Bold.)
- Headers: Left-justified - indicate the rating factor or executive summary.
- Footers: Left-justified - name of applicant. Right-justified - page number out of total pages. (ex. Page 1 of 3)

C. System for Award Management (SAM) and Dun and Bradstreet Universal Numbering System (DUNS) Number.

1. SAM Registration Requirement.

Applicants must be registered with https://www.sam.gov/ before submitting their application. Applicants must maintain current information in SAM on immediate and highest-level owner and subsidiaries, as well as on all predecessors that have been awarded a Federal contract or grant within the last three years, if applicable. Information in SAM must be current for all times during which the applicant has an active Federal award or an application or plan under consideration by HUD.

2. DUNS Number Requirement.

Applicants must provide a valid DUNS number, registered and active at https://www.sam.gov/ in the application. DUNS numbers may be obtained for free from Dun & Bradstreet.

3. Requirement to Register with Grants.gov.
Anyone planning to submit applications on behalf of an organization must register at grants.gov and be approved by the E-Biz POC in SAM to submit applications for the organization. Registration for SAM and grants.gov is a multi-step process and can take four (4) weeks or longer to complete if data issues arise. Applicants without a valid registration cannot apply through grants.gov. Complete registration instructions and guidance are provided on grants.gov.

D. Application Submission Dates and Times.

Application Due Date Explanation
The application deadline is 11:59:59 PM Eastern Standard time on

07/06/2021
Applications must be received no later than the deadline, or, if HUD has issued you a waiver allowing you to submit your application in paper form, by HUD no later than the deadline.

Submit your application to Grants.gov unless a waiver has been issued allowing you to submit your application in paper form. Instructions for submitting your paper application will be contained in the waiver of electronic submission.

"Received by Grants.gov" means the applicant received a confirmation of receipt and an application tracking number from Grants.gov. Grants.gov then assigns an application tracking number and date-and timestamps each application upon successful receipt by the Grants.gov system. A submission attempt not resulting in confirmation of receipt and an application tracking number is not considered received by Grants.gov.

Applications received by Grants.gov must be validated by Grants.gov to be received by HUD.

"Validated by Grants.gov" means the application has been accepted and was not rejected with errors. You can track the status of your application by logging into Grants.gov, selecting "Applicants" from the top navigation, and selecting “Track my application” from the dropdown list. If the application status is "rejected with errors,” you must correct the error(s) and resubmit the application before the 24-hour grace period ends. Applications in “rejected with errors” status after the 24-hour grace period expires will not be received by HUD. Visit Grants.gov for a complete description of processing steps after applying.

HUD strongly recommends you submit your applications at least **48 hours before the deadline** and during regular business hours to allow enough time to correct errors or overcome other problems.

Grants.gov Customer Support. Grants.gov provides customer support information on its website at https://www.grants.gov/web/grants/support.html . Applicants having difficulty accessing the application and instructions or having technical problems can receive customer support from Grants.gov by calling (800) 518-GRANTS (this is a toll-free number) or by sending an email to support@grants.gov. The customer support center is open 24 hours a day, seven days per week, except Federal holidays. The phone number above may also be reached by individuals who are deaf or hard of hearing, or who have speech disabilities, through the Federal Relay Service’s teletype service at 800-877-8339.

You can verify the contents of your submitted application to confirm Grants.gov received everything you intended to submit. To verify the contents of your submitted application:

- Log in to Grants.gov.
- Click the Check Application Status link, which appears under the Grant Applications heading in the Applicant Center page. This will take you to the Check Application Status page.
- Enter search criteria and a date range to narrow your search results.
- Click the Search button. To review your search results in Microsoft Excel, click the Export Data button.
- Review the Status column, to view more detailed submission information, click the Details link in the Actions column.
- To download the submitted application, click the Download link in the Actions column.

Please make note of the Grants.gov tracking number as it will be needed by the Grants.gov Help Desk if you seek their assistance.

HUD may extend the application deadline for any program if Grants.gov is offline or not available to applicants for at least 24 hours immediately prior to the deadline date, or the system is down for 24 hours or longer and impacts the ability of applicants to cure a submission deficiency within the grace period.

HUD may also extend the application deadline upon request if there is a presidentially declared disaster in the applicant's area.

If these events occur, HUD will post a notice on its website establishing the new, extended deadline for the affected applicants. HUD will also include the fact of the extension in the program's Notice of Funding Awards required to be published in the Federal Register.

In determining whether to grant a request for an extension based on a presidentially-declared disaster, HUD will consider the totality of the circumstances including the date of an applicant's extension request (how closely it followed the basis for the extension), whether other applicants in the geographic area are similarly affected by the disaster, and how quickly power or services are restored to enable the applicant to submit its application.

PLEASE NOTE: Busy servers, slow processing, large file sizes, improper registration or password issues are not valid circumstances to extend the deadline dates or the grace period.

1. Amending or Resubmitting an Application.

Before the submission deadline, you may amend a validated application through Grants.gov by resubmitting a revised application containing the new or changed material. The resubmitted application must be received and validated by Grants.gov by the applicable deadline.

If HUD receives an original and a revised application for a single proposal, HUD will evaluate only the last submission received by Grants.gov before the deadline.

2. Grace Period for Grants.gov Submissions.

If your application is received by Grants.gov before the deadline, but is rejected with errors, you have a grace period of 24 hours after the application deadline to submit a corrected, received, and validated application through Grants.gov. The date and time stamp on the Grants.gov system determines the application receipt time. Any application submitted during the grace period not received and validated by Grants.gov will not be considered for funding. There is no grace period for paper applications.

3. Late Applications.
An application received after the NOFO deadline date that does not meet the Grace Period requirements will be marked late and will not be received by HUD for funding consideration. Improper or expired registration and password issues are not causes that allow HUD to accept applications after the deadline.

4. Corrections to Deficient Applications.
HUD will not consider information from applicants after the application deadline.

HUD will uniformly notify applicants of each curable deficiency. See curable deficiency in the definitions section (Section I.A.3). Examples of curable (correctable) deficiencies include inconsistencies in the funding request and failure to submit required certifications. These examples are non-exhaustive.

When HUD identifies a curable deficiency, HUD will notify the authorized organization representative identified on the SF 424 Application for Federal Assistance via email. This email is the official notification of a curable deficiency.

Applicants must email corrections of curable deficiencies to applicationsupport@hud.gov within the time limits specified in the notification. The time allowed to correct deficiencies will be no less than 48 hours and no more than 14 calendar days from the date of the email notification. The start of the cure period will be the date stamp on the email sent from HUD. If the deficiency cure deadline date falls on a Saturday, Sunday, Federal holiday, or on a day when HUD's Headquarters are closed, then the applicant's correction must be received on the next business day HUD Headquarters offices in Washington, DC are open.

The subject line of the email sent to applicationsupport@hud.gov must state: Technical Cure and include the Grants.gov application tracking number or the GrantSolutions application number (e.g., Subject: Technical Cure - GRANT123456 or Technical Cure - XXXXXXXXXXX). If this information is not included, HUD cannot match the response with the application under review and the application may be rejected due to the deficiency.

Corrections to a paper application must be sent in accordance with and to the address indicated in the notification of deficiency. HUD will treat a paper application submitted in accordance with a waiver of electronic application containing the wrong DUNS number as having a curable deficiency. Failure to correct the deficiency and meet the requirement to have a DUNS number and active registration in SAM will render the application ineligible for funding.

5. Authoritative Versions of HUD NOFOs. The version of these NOFOs as posted on

Grants.gov are the official documents HUD uses to solicit applications.

6. Exemptions. Parties that believe the requirements of the NOFO would impose a substantial burden on the exercise of their religion should seek an exemption under the Religious Freedom Restoration Act (RFRA).

E. Intergovernmental Review.

This program is not subject to Executive Order 12372, Intergovernmental Review of Federal Programs.

F. Funding Restrictions.

This NOFO will NOT fund acquisition, development, construction, rehabilitation, or emergency shelters.

Indirect Cost Rate.

Normal indirect cost rules under 2 CFR part 200, subpart E apply. If you intend to charge indirect costs to your award, your application must clearly state the rate and distribution base you intend to use. If you have a Federally negotiated indirect cost rate, your application must also include a letter or other documentation from the cognizant agency showing the approved rate. Successful applicants whose rate changes after the application deadline must submit new rate and documentation.

Applicants other than state and local governments. If you have a Federally negotiated indirect cost rate, your application must clearly state the approved rate and distribution base and must include a letter or other documentation from the cognizant agency showing the approved rate. If your agency does not have a current negotiated rate (including provisional) rate and elects to use the de minimis rate, your application must clearly state you intend to use the de minimis rate of 10% of Modified Total Direct Costs (MTDC). As described in 2 CFR 200.403, costs must be consistently charged as either indirect or direct costs but may not be double charged or inconsistently charged as both. Once elected, the de minimis rate must be applied consistently for all Federal awards until you choose to negotiate for a rate, which you may apply to do at any time. Documentation of the decision to use the de minimis rate must be retained on file for audit.

State and local governments. If your department or agency unit has a Federally negotiated indirect cost rate, your application must include that rate, the applicable distribution base, and a letter or other documentation from the cognizant agency showing the negotiated rate. If your department or agency unit receives more than $35 million in direct Federal funding per year, you may not claim indirect costs until you receive a negotiated rate from your cognizant agency for indirect costs as provided in Appendix VII to 2 CFR Part 200.

If your department or agency unit receives no more than $35 million in direct Federal funding per year and your department or agency unit has developed and maintains an indirect cost rate proposal and supporting documentation for audit in accordance with 2 CFR Part 200, Appendix VII, you may use the rate and distribution base specified in that indirect cost rate proposal. Alternatively, if your department or agency unit receives no more than $35 million in direct

Federal funding per year and does not have a current negotiated rate (including provisional) rate, you may elect to use the de minimis rate of 10% of MTDC. As described in 2 CFR 200.403, costs must be consistently charged as either indirect or direct costs but may not be double charged or inconsistently charged as both. Once elected, the de minimis rate must be applied consistently for all Federal awards until you choose to negotiate for a rate, which you may apply to do at any time. Documentation of the decision to use the de minimis rate must be retained on file for audit.

G. Other Submission Requirements.

1. Application, Assurances and Certifications.

Standard Form 424 (SF-424) Application for Federal Assistance Programs is the government-wide form required to apply for Application for Federal Assistance Programs, discretionary Federal grants and other forms of financial assistance programs. Applicants for this Federal assistance program must submit all required forms in the SF-424 Family of forms, including SF-424B (Assurances of Non construction Programs) or SF424D (Assurances for Construction Programs).Applications receiving funds for both non-construction programs and construction programs must submit both the SF-424B and SF-424D.

By signing the forms in the SF-424 either through electronic submission or in paper copy submission (for those granted a waiver), the applicant and the signing authorized organization representative affirm that they have reviewed the certifications and assurances associated with the application for Federal assistance and (1) are aware the submission of the SF-424 is an assertion that the relevant certifications and assurances are established and (2) acknowledge that the truthfulness of the certifications and assurances are material representations upon which HUD will rely when making an award to the applicant. If it is later determined the signing authorized organization representative to the application made a false certification or assurance, caused the submission of a false certification or assurance, or did not have the authority to make a legally binding commitment for the applicant, the applicant and the individual who signed the application may be subject to administrative, civil, or criminal action. Additionally, HUD may terminate the award to the applicant organization or pursue other available remedies. Each applicant is responsible for including the correct certifications and assurances with its application submission, including those applicable to all applicants, those applicable only to Federally recognized Indian tribes, or Alaska native villages and those applicable to applicants other than federally recognized Indian tribes or Alaska native villages.

Assurances. By submitting your application, you provide assurances that, if selected to receive an award, you will comply with U.S. statutory and public policy requirements, including, but not limited to civil rights requirements. Applicants and recipients are required to submit assurances of compliance with federal civil rights requirements. *See, e.g.,* Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments Act of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975; *see also* 24 C.F.R. §§ 1.5; 3.115; 8.50; and 146.25. HUD accepts these assurances in the form of the SF-424B and SF-424D, which also require compliance with all general federal nondiscrimination requirements in the administration of the grant.

V. Application Review Information.
A. Review Criteria.

1. Rating Factors.

The factors for rating and ranking applications and the points for each factor are provided below. Partial points may be awarded for a criterion if the applicant does not fully address the information needed for full points. A maximum of 100 points may be awarded under Rating Factors 1 through 5. Applicants must receive a minimum of 70 points to be eligible for funding.

Rating Factor 1: Capacity of the Applicant and Relevant Organizational Staff (20 points)
Rating Factor 2: Need/Extent of the Problem (14 points)
Rating Factor 3: Soundness of Approach (36 points)
Rating Factor 4: Leveraging Resources (10 points)
Rating Factor 5: Achieving Results and Program Evaluation (20 points)

Rating Factor 1: Capacity of the Applicant and Relevant Organizational Staff **Maximum Points:** 20

Applicants may receive a maximum of 20 points for this factor. A minimum of 12 points are required in Rating Factor 1 to qualify for funding. Responses are limited to six pages plus up to two extra pages for each project sponsor. An applicant that plans to use project sponsors but fails to provide information on their capacity will not receive the minimum score.

This factor addresses the extent to which the applicant has the organizational resources necessary to successfully implement the proposed activities. It is important that the applicant demonstrates its administrative and organizational capacity to implement, monitor, and evaluate effective housing and service programs for low-income persons living with HIV/AIDS. Applicants should strategically choose and involve team members with relevant experience. The team members include the proposed project manager and key staff relevant to carrying out the proposed activities. Team members will be evaluated in terms of recent, relevant, and successful experience in undertaking eligible program activities.

1. Describe team member experience and knowledge in serving persons living with HIV/AIDS and their families.

> *3 points* - Full points will be awarded if the application presents direct, extensive, and clear evidence of team member experience relevant to the proposed project activities in serving persons living with HIV/AIDS and their families.

2. Describe the involvement of HOPWA eligible persons in project-level processes for the planning, implementation, and evaluation stages of the proposed project. This can include paid or unpaid positions related to the proposed project.

> *2 points* - Full points will be awarded if the application presents direct, meaningful, and clear evidence of involvement of HOPWA eligible person(s) in the planning, implementation, and evaluation stages of the proposed project.

3. Describe team member experience in implementing trauma-informed approaches into programs and services for persons with special needs.

1 point - Full points will be awarded if the application presents direct, extensive, and clear evidence of team member experience in implementing trauma-informed approaches into programs and services for persons with special needs.

4. Describe team member experience in data collection and data analysis in adherence with confidentiality and/or privacy law and regulations.

2 points - Full points will be awarded if the application presents direct, extensive, and clear evidence of team member experience in data collection and data analysis in adherence with confidentiality and/or privacy law and regulations.

5. Describe team member experience with managing and implementing programs similar to those proposed in your application, including HOPWA, and other housing and service programs for special needs populations.

3 points - Full points will be awarded if the application presents direct, extensive, and clear evidence of team member experience and knowledge in providing activities similar to the range of housing and service activities proposed in the application.

6. Describe team member experience in coordinating with local planning bodies and building partnerships to leverage resources. Local planning bodies could include a Ryan White Planning Council, Continuum of Care, or Getting to Zero initiative.

3 points - Full points will be awarded if the application presents direct, extensive, and clear evidence of team member experience coordinating with local planning bodies and building partnerships to leverage resources.

7. Describe team member experience in achieving measurable results and meeting applicable performance benchmarks in the operation of existing or previous HOPWA grants, or other similar housing and supportive service grants. This includes meeting project goals and objectives, such as the number of persons assisted in comparison to the number that was planned at the time of the application; submitting timely performance reports; and expending funding as outlined in grant agreements/contracts, with no outstanding audit or monitoring issues.

3 points - Full points will be awarded if the application presents clear evidence of team member experience in achieving results and meeting benchmarks under existing or previous HOPWA grants or other similar grant programs.

8. Describe team member experience and knowledge in: (1) monitoring and evaluating the performance of housing and service programs; and (2) reporting on project outcomes similar to the HOPWA client outcomes of housing stability, reduced risks of homelessness, and access to care.

3 points - Full points will be awarded if the application fully describes team member experience in monitoring and evaluating program performance reporting on project outcome information similar to HOPWA outcomes.

9. Provide clarification and action taken for any past performance issues that may have occurred in the last 5 years. Past Performance of HOPWA grants will be evaluated by HUD and up to 8 points may be deducted due to untimely, inaccurate, and/or incomplete performance reports; financial issues with expending funding as outlined in grant agreements/contracts, and outstanding audit or monitoring issues.

Minus 2 points - Up to 2 points will be deducted for untimely, inaccurate, and/or incomplete performance reports.

Minus 2 points - Up to 2 points will be deducted for issues with expending funding as outlined in grant agreements/contracts including erratic spending where funds were drawn less than quarterly and unexpended funds of $10,000 or more were recaptured.

Minus 4 points - Up to 4 points will be deducted for unaddressed and unresolved audit or monitoring issues.

Maximum Points: 0

Rating Factor 2: Need/Extent of the Problem **Maximum Points:** 14

Applicants may receive a maximum of 14 points for this factor. Responses for Rating Factor 2 are limited to five pages. This factor must show a clear need for housing and coordinated services addressing the unique needs of low-income persons living with HIV and how the proposed project aligns with those needs.

1. Define your planned service area. The geographic location of your project will determine whether you receive a point. HUD will use HIV surveillance data pertinent to the service area from the Centers for Disease Control and Prevention (CDC) to the relative numbers of HIV/AIDS cases and per capita HIV/AIDS incidence within your service area. If there is a discrepancy in ranking applicants when looking at both relative HIV/AIDS cases and per capita HIV/AIDS incidence, HUD will use per capita HIV/AIDS incidence to determine which applicants receive the point.

1 point – Full points will be awarded if the defined service area has higher relative numbers of HIV/AIDS cases and per capita HIV/AIDS incidence than the majority of applicants under this NOFO.

2. Describe the need for housing and services for low-income persons living with HIV in the service area. Applicants should demonstrate a clear understanding of the clients to be served by providing eligible client demographics and shared characteristics of any identified target population. This may include but is not limited to race, gender, sexual orientation, age (e.g. youth or aged 50+), history of incarceration, intimate partner or domestic violence victimization, chronic homelessness, substance use, and co-occurring or multiply diagnosed medical

conditions. Data sources could include census data, health department statistics, CDC data sets, and other locally available data.

> *4 points* – Full points will be awarded if the need in the service area is clearly described and supported with relevant data sources for HIV and eligible client demographics and shared characteristics.

3. Identify the public and private resources/organizations available to coordinate housing and services for low-income persons living with HIV. Applicants should demonstrate viability through strong community partnerships linking together local organizations and resources to ensure that project efforts are sustained after the conclusion of the funding period. It is expected that applicants in EHE Phase I Jurisdictions and highly impacted HOPWA formula modernization communities will be working in partnership with organizations receiving EHE funding through the CDC and HOPWA formula funds. All organizations identified should also have a signed Commitment Letter submitted with the application. A single commitment letter from the lead EHE planning agency or HOPWA formula grantee is acceptable to show partnership with all organizations involved with EHE or HOPWA modernization work in a community, but the letter should provide the names of all relevant organizations involved in the work and the amount of funding leveraged for the project.

> *3 points* – Full points will be awarded if the community resources/organizations identified for coordination in this project clearly show experience with housing and services for low-income persons living with HIV, and exhibit formed partnerships through a Commitment Letter.

4. Identify local initiatives or strategies to end the HIV/AIDS epidemic and how the applicant and the proposed project will align with local efforts by elevating housing as an effective structural intervention.

> *4 points* - Full points will be awarded if the application clearly identified the local initiatives or strategies to end the HIV/AIDS epidemic and can clearly show how the applicant and the proposed project will align with local efforts through two or more specific actions that will elevate housing as an effective structural intervention.

5. Identify the need for systems level improvement in the community and how improved coordination among local housing and service providers and utilization of available community resources will benefit community members in the planned service area. Applicants are encouraged to consider new and non-traditional community partnerships and resources to address barriers such as discrimination and systemic racism that contribute to differences in access in housing and lead to ongoing disparities among underserved communities. Reducing these disparities requires a focus on the needs of disproportionately affected populations, supporting racial justice, LGBTQ+ rights, combatting HIV-related stigma and discrimination, providing leadership and employment opportunities for people with or at risk for HIV, and addressing social determinants of health and co-occurring conditions to reduce health inequities and disparities.

2 points – Full points will be awarded if the application clearly identifies current community barriers to coordination among local housing and service providers and discusses two or more high-quality benefits of planned project activities to overcome barriers and advance equity.

Rating Factor 3: Soundness of Approach **Maximum Points:** 36

Applicants may receive a maximum of 36 points for this factor. Responses for Rating Factor 3 are limited to a total of 10 pages.

This factor evaluates the proposed housing and supportive service activities to be carried out through this funding opportunity to help participants obtain and/or maintain safe, stable housing, the roles and responsibilities of coordinating organizations, and the innovative strategies in cross-agency coordination, resource utilization, and data-driven approaches to providing housing and services and reducing HIV-related disparities that can serve as models for other programs and/or support long-term change.

1. Show a clear strategy, with established project goals, to achieve the six required project objectives listed in Section III.F.1, Required Project Objectives, of this NOFO. The project should exhibit exemplary and/or innovative qualities, including community level coordination; data collection with emphasis on stable housing, positive health outcomes, and racial equity; and replicable practices that ensure equitable access and culturally competent approaches to providing housing and services that can serve as a national place-based model. Funds for Resource Identification are available to facilitate coordination during the program period, but applicants are expected to establish relevant partnerships and have an innovative strategy for cross-agency coordination, resource utilization, and data-driven approaches to providing housing and services and reducing HIV-related disparities that can serve as models for other program and/or support long-term change at the time of application.

6 points – Full points will be awarded if the strategy establishes clear goals to accomplish all the required project objectives for this NOFO.

2. Describe how success of the project's innovative strategic goals will align with and contribute to locally established goals to end the HIV/AIDS epidemic. For example, if the local community is collectively working towards a goal of increasing the percentage of individuals who are virally suppressed to 80 percent, applicants should clearly show how the project's goals will align with and contribute to accomplishing this locally established goal.

4 points - Full points will be awarded if there is a clear description showing how the project's goals align with and contribute to locally established goals to end the HIV/AIDS epidemic.

3. Describe the operations plan for the housing assistance being proposed with the projected number of persons to be served through each type of housing assistance for each year of the program. For rental assistance programs, this will include a plan for providing rental assistance and length of stay.

4 points – Full points will be awarded if the plan describes projected number of housing units, by type, to be provided through the program, by year, over a 3-year period. The projected yearly number of persons to be served is identified for each type of housing assistance and the number is appropriate and feasible.

4. Describe how eligible persons will access the housing assistance provided through the project and through any specific commitments with other community housing providers. Include a description of how a client moves through the housing program from outreach, intake, client assessment, the delivery of housing services, and when appropriate, the outplacement to more self-sufficient independent housing or permanent rental housing. The description should recognize and align with the needs of eligible HOPWA clients described in Rating Factor 2 and should exhibit equitable access and culturally competent approaches to provide housing for the identified population of persons living with HIV.

4 points – Full points will be awarded if there is a clear, feasible description of how a client moves through the housing program from outreach, intake, client assessment, the delivery of housing services, and when appropriate, the outplacement to more self-sufficient independent housing or permanent rental housing with support of organizations responsible for these actions. The description considers the needs of the identified population to be served under this grant and systemic barriers that may prevent people of color and other underserved groups from fully accessing housing and services.

5. Describe plans to facilitate the movement of eligible persons receiving housing support to permanent housing or independent living arrangements within the 36 months of the grant period of performance. This includes outplacement to self-sufficiency or to permanent rental housing subsidized by HUD or other Federal, state, and local resources. If funds will be used to help beneficiaries secure new housing units, applicants must describe plans to use the funds and the related housing outputs for these permanent housing placement services (under that budget line item), such as costs for first month's rent and security deposits.

4 points – Full points will be awarded if there is a clear, feasible plan to transition program beneficiaries off housing assistance provided through this program to alternative permanent housing or independent living arrangements, that presents flexibility and the necessity to address varying special needs of individuals receiving housing assistance, without any risk of homelessness or housing instability.

6. Describe how the supportive service needs of eligible persons will be met and the use of any additional leveraged resources by describing the type of supportive services that will be offered directly by the program and/or how agreements and project plans will ensure that services will be accessed and coordinated from other mainstream health and human welfare sources. Projects should provide access to a wide range of flexible and optional services that reflect the varying individual needs of persons living with HIV/AIDS. Individualized services may be offered, such as counseling, support groups, and advocacy services as well as other services such as case management, licensed childcare, employment services, nutritional support, transportation vouchers, and referrals to other agencies. Supportive services must never be required to receive housing assistance, but the plan should clearly show how the applicant plans to engage clients

uninterested in receiving supportive services. The description should recognize and align with the needs of eligible HOPWA clients described in Rating Factor 2.

4 points – Full points will be awarded if there is a precise, feasible plan ensuring program beneficiaries have viable access to a wide variety of supportive services that address needs associated with maintaining stable housing and achieving positive health outcomes. The proposed plan should clearly allow program beneficiaries to choose the course of action that is best for them and demonstrate cross-agency coordination, resource utilization and data-driven approaches to provide culturally competent services.

7. Describe the ways in which these services will help eligible persons obtain and/or maintain stable housing. Applicants must explain their comprehensive plan for ensuring equitable access to and delivering culturally competent supportive services in coordination with project partners and show how agreements with community organizations will ensure that eligible persons receive adequate access to medical care and other mainstream supportive services to address their needs.

4 points – Full points will be awarded if the roles and responsibilities of the organizations carrying out each eligible activity are reasonable and clearly identified, and clearly exhibit how the housing and service needs of beneficiaries will be addressed in an equitable, culturally competent, and holistic manner.

8. Explain how the coordination of HIV housing assistance and related services will continue past the funded period.

2 points – Full points will be awarded if the coordination of HIV housing assistance and related services exemplifies long-term partnerships that will continue past the conclusion of funding.

9. Complete the HOPWA budget form (HUD-40110-B) with amounts and descriptions that reflect the planned eligible activities along with leveraged resources discussed in the Rating Factor Narratives. The budget must follow the guidelines and requirements within this funding announcement. If the applicant is proposing an Other Activity to be approved by HUD, there must be an accompanying narrative description (maximum two pages which are not included in page limit for Rating Factor 3) specifically describing the Other Activity proposed in the budget. The Other Activity narrative must address the expected beneficial impact of this alternative activity in addressing housing needs of eligible persons by describing the project impact and the identified performance output and client outcome measures for this activity. Proposed Other Activities will be approved through the application review process if the description of the Other Activity shows a beneficial impact to the project and eligible persons

4 points – Full points will be awarded if all budget amounts and descriptions reflect the planned activities discussed in this narrative section, reflect funding amounts reasonable for the locality, and follow the guidelines and requirements within this funding announcement. If the applicant is proposing an Other Activity to be approved by HUD, there is a clear description of the proposed Other Activity including the project impact, the

performance output and client outcome measures, and how the funds included in the budget will be expended.

Rating Factor 4: Leveraging Resources **Maximum Points:** 10

Applicants may receive a maximum of 10 points for this factor. Applicants must receive a minimum of 2 points in Leveraging Resources to be eligible for funding.

This factor addresses the applicant's ability to secure community resources that can be combined with NOFO funds to achieve program purposes and to ensure sustainability of the housing efforts. Such commitments may involve provisions of funding or services by other agencies, or in-kind donation of dedicated personnel to lead or plan collaborative activities. Applicants can receive up to 10 points based on the extent to which resources from other state, local, federal, or private resources are listed with the required elements to demonstrate that these funds are committed at the time of application to support and sustain the project.

The leveraging information must be presented on a list or chart with the following information: the name and address of the organization(s) providing the commitment(s) (state if the organization will serve as a project sponsor); the type of commitment (applicant or third party cash resources, non-cash resources, volunteer time, contribution of a building, contribution of lease hold interest); the dollar value of the commitment; the date of the commitment letter or other document; the source of the funding or in-kind contribution, such as federal, state, local, private; and the organization's authorized representative's name, title, and contact information who has made this commitment. See Appendix A for an example leveraging chart.

Applicants will be awarded points based on the percentage of commitment dedicated to the project. The percentage of leveraging is determined by comparing the determined amount of leveraged resources to the total grant amount requested by the applicant under this NOFO.

10 points - 200.0% or greater
8 points - 150.0% to 199.9%
6 points - 100.0% to 149.9%
4 points - 50.0% to 99.9%
2 points - 1% to 49.9%

Rating Factor 5: Achieving Results and Program Evaluation **Maximum Points:** 20

Applicants may receive a maximum of 20 points for this factor. Responses for Factor 5 are limited to five pages.

Reporting requirements under this NOFO are more comprehensive than traditional HOPWA program reporting. Responses for this factor must describe the project's specific outcomes and goals and how data will be collected to ensure reporting is accurate and complete. This must also include a clear plan to monitor and evaluate project achievements based on the established goals.

1. Determine aggregated client-level outcomes for the project based off the strategic goals established in Rating Factor 3 including, but not limited to, improved housing stability, reduced

risk of homelessness, improved access to appropriate supportive services, increased access to healthcare, improved individual health (ex. CD4 count, viral load, perceived health, etc.), and, if applicable, employment and income growth.

> *4 points* – Full points will be awarded if outcomes are clearly stated, reasonable, and inclusive of housing and health.

2. Determine quantifiable systems-level outcomes for the project based off the strategic goals established in Rating Factor 3 including, but not limited to, increased alignment with initiatives or strategies to end the HIV/AIDS epidemic; reduced HIV-related disparities and health inequities for underserved communities; increased partnerships formed or continued with community organizations and other housing and service providers; increased utilization and leverage of available community resources.

> *4 points* – Full points will be awarded if quantifiable outcomes are clearly stated, reasonable, and inclusive of system-level improvements identified in the established strategic goals for the project.

3. Provide a clear plan for collecting client-level data and other necessary project data to produce accurate and complete reports for this NOFO inclusive of the APR, HIV Housing Care Continuum Model, and HIFA Model. The applicant should show they have systems or processes in place to accommodate the data collection for this funding opportunity.

> *4 points* – Full points will be awarded if there is a clear data collection plan to gather all the required data elements in the required reporting forms under this NOFO.

4. Provide a clear plan to monitor and evaluate the delivery of housing and services that objectively measures actual achievements against anticipated achievements. This should include a timeline with activities, benchmarks, and performance indicators.

> *4 points* – Full points will be awarded if there is a clear monitoring and evaluation plan to measure achievements with a timeline that includes activities, benchmarks, and performance indicators.

5. Indicate how monitoring will be used to make programmatic adjustments throughout the grant operating period to ensure goals are achieved. Applicants should consider when adjustments would be needed to advance equity for underserved communities at both a client level and a systems level.

> *4 points* – Full points will be awarded if there is clear indication that monitoring throughout the operating period will be used in set time intervals to ensure goals are being achieved with adjustments as needed.

2. Other Factors.

This program does not offer points for Section 3.

Preference Points

This program does not offer preference points.

Opportunity Zones.
This program does not offer Opportunity Zone preference points.

HBCU.
This program does not offer HBCU preference points.

Promise Zones
This program does not offer Promise Zone preference points.

B. Review and Selection Process.

1. Past Performance
In evaluating applications for funding, HUD will consider an applicant's past performance in managing funds. Items HUD will consider include, but are not limited to:

The ability to account for funds in compliance with applicable reporting and recordkeeping requirements;

Timely use of funds received from HUD;

Timely submission and quality of reports submitted to HUD;

Meeting program requirements;

Meeting performance targets as established in the grant agreement;

The applicant's organizational capacity, including staffing structures and capabilities;

Timely completion of activities and receipt and expenditure of promised matching or leveraged funds;

The number of persons served or targeted for assistance;

Producing positive outcomes and results.

The number of persons served or targeted for assistance.

HUD may reduce scores based on the past performance review, as specified under V.A. Review Criteria. Whenever possible, HUD will obtain past performance information. If this review results in an adverse finding related to integrity of performance, HUD reserves the right to take any of the remedies provided in Section III E., Statutory and Regulatory Requirements Affecting Eligibility, "Pre-selection Review of Performance" document link above.

2. Assessing Applicant Risk.
In evaluating risks posed by applicants, HUD may use a risk-based approach and may consider any items such as the following:

- Financial stability;
- Quality of management systems and ability to meet the management standards prescribed in this part;
- History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, failing to make significant progress in a timely manner, failing to meet planned activities in a timely manner, conformance to the terms and conditions of

previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
- Reports and findings from audits performed under Subpart F—Audit Requirements of this part or the reports and findings of any other available audits; and
- The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

VI. Award Administration Information.
A. Award Notices.

Following the evaluation process, HUD will notify successful applicants of their selection for funding. HUD will also notify other applicants, whose applications were received by the deadline, but have not been chosen for award. Notifications will be sent by email to the person listed as the AOR in item 21 of the SF424.

Negotiation. After HUD has made selections, HUD will negotiate specific terms of the funding agreement and budget with selected applicants. If HUD and a selected applicant do not successfully conclude negotiations in a timely manner, or a selected applicant fails to provide requested information, an award will not be made to that applicant. In this case, HUD may select another eligible applicant.

HUD may impose special conditions on an award as provided under 2 CFR 200.208:

• Based on HUD's review of the applicant's risk under 2 CFR 200.206;
• When the applicant or recipient has a history of failure to comply with the general or specific terms and conditions of a Federal award;
• When the applicant or recipient fails to meet expected performance goals contained in a Federal award; or
• When the applicant or recipient is not otherwise responsible.

Adjustments to Funding. To ensure the fair distribution of funds and enable the purposes or requirements of a specific program to be met, HUD reserves the right to fund less than the amount requested in an application.

a. HUD will fund no portion of an application that:
(1) Is not eligible for funding under applicable statutory or regulatory requirements;
(2) Does not meet the requirements of this notice; or
(3) Duplicates other funded programs or activities from prior year awards or other selected applicants.
b.If funds are available after funding the highest-ranking application, HUD may fund all or part of another eligible fundable application. If an applicant turns down an award offer, or if HUD and an applicant do not successfully complete grant negotiations, HUD may withdraw the award offer and make an offer of funding to another eligible application.
c. If funds remain after all selections have been made, remaining funds may be made available within the current FY for other competitions within the program area, or be held for future competitions, or be used as otherwise provided by authorizing statute or appropriation.

d. If, after announcement of awards made under the current NOFO, additional funds become available either through the current appropriations, a supplemental appropriation, other appropriations or recapture of funds, HUD may use the additional funds to provide additional funding to an applicant awarded less than the requested amount of funds to make the full award, and/or to fund additional applicants that were eligible to receive an award but for which there were no funds available.

Funding Errors. If HUD commits an error that when corrected would cause selection of an applicant during the funding round of a Program NOFO, HUD may select that applicant for funding, subject to the availability of funds. If funding is not available to award in the current fiscal year, HUD may make an award to this applicant during the next fiscal year, if funding is available then.

Program-specific Adjustments to Funding. HUD reserves the right to redistribute or remove incorrectly allocated activity costs on the HOPWA budget form (HUD-40110-B). Applicants should refer to Section III.F.3. for eligible costs under this NOFO's eligible budget line items.

Rating and Selection of Applications. HUD will select applications in order of the highest ranking score to the extent that funds are available. HUD will not select an application that is rated below 70 points, nor will an application be funded if it receives lower than 12 points for Rating Factor 1 or lower than 2 points for Rating Factor 4. If there is more than one applicant with planned activities in the same service area, the applicant with the highest score for that service area will receive the award and the lower scored application will only be considered if funding remains after all other eligible applications have been selected. In the event of a tie score between applications, HUD reserves the right to break the tie by selecting the application that was scored higher on a rating criterion in the following order: Rating Factor 3, Rating Factor 1, Rating Factor 2, Rating Factor 5, and Rating Factor 4.

B. Statutory and Administrative, National and Department Requirements for HUD Recipients

For this NOFO, the following Administrative, National and Department Policy Requirements and Terms for HUD Financial Assistance Awards apply. (Please select the linked text to read the detailed description of each applicable requirement).

1. Unless otherwise specified, these non-discrimination and equal opportunity authorities and other requirements apply to all NOFOs. Please read the following requirements carefully as the requirements are different among HUD's programs.
   • Compliance with Fair Housing and Civil Rights Laws, Which Encompass the Fair Housing Act and Related Authorities (cf. 24 CFR 5.105(a)).
   • Affirmatively Furthering Fair Housing.
   • Improving Access to Services for Persons with Limited English Proficiency (LEP) See https://www.hud.gov/program_offices/fair_housing_equal_opp/limited_english_proficiency.
   • Accessible Technology. See https://www.hud.gov/sites/dfiles/OCIO/documents/s508103017.pdf
2. Equal Access Requirements. See 24 CFR 5.105(a)(2)
3. Equal Participation of Faith-Based Organizations in HUD Programs and Activities.
4. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal

Awards.
5. Drug-Free Workplace.
6. Safeguarding Resident/Client Files.
7. Compliance with the Federal Funding Accountability and Transparency Act of 2006 (Pub. L.109-282) (Transparency Act), as amended.
8. Accessibility for Persons with Disabilities. See https://www.hud.gov/program_offices/fair_housing_equal_opp/disability_overview
9. Violence Against Women Act. See 24 CFR part 5, subpart L and applicable program regulations.
10. Conducting Business in Accordance with Ethical Standards/Code of Conduct.
11. Environmental Requirements, which include compliance with environmental justice requirements under Executive Order 12898.

Compliance with 24 CFR part 50 or 58 procedures is explained below:

All HOPWA assistance is subject to the National Environmental Policy Act of 1969 (NEPA), 42 U.S.C. 4321, and applicable related federal environmental authorities. Although many eligible HOPWA activities under this NOFO, such as tenant-based rental assistance, supportive services, and administrative costs, are excluded from environmental review because of the lack of environmental impact, other activities, including project-based assistance, require environmental review. In accordance with Section 856(h) of the AIDS Housing Opportunity Act and the HOPWA regulations at 24 CFR 574.510, environmental reviews for HOPWA activities are to be completed by responsible entities (as defined in 24 CFR 58.2) in accordance with 24 CFR part 58. Applicants or grantees that are not a responsible entity must request the unit of general local government to perform the environmental review, or HUD may make a finding in accordance with 24 CFR 574.510(c) and 24 CFR 58.11(d) and may itself perform the environmental review under the provisions of 24 CFR part 50 if a grant recipient that is not a responsible entity objects in writing to the responsible entity's performing the review under 24 CFR part 58. HOPWA grantees and project sponsors may not undertake any project or activity, or commit or expend any HUD or non-HUD funds on project activities (other than those listed in 24 CFR 58.22(f), 58.34 or 58.35(b) for which the responsible entity documents its findings of exemption or exclusion for the environmental review record (24 CFR 58.34(b) or 24 CFR 58.35(d)) that could limit the choice of reasonable alternatives or have an adverse environmental impact until HUD has approved a "Request for Release of Funds and Certification" (RROF), form HUD-7015.15, in compliance with NEPA and 24 CFR Part 58, or until HUD has completed the environmental review and the recipient has received HUD approval. The recipient, its project sponsors and their contractors may not lease property for a project, or commit or expend HUD or local funds for this eligible activity, until the responsible entity (as defined in 24 CFR 58.2) has completed the environmental review procedures required by 24 CFR part 58 and the environmental certification and the RROF have been approved, or until HUD has completed the environmental review and the recipient has received HUD approval. HUD will not release grant funds if the recipient or any other party commits HUD or non-HUD funds (i.e., incurs any costs or expenditures to be paid or reimbursed with such funds) before the recipient submits and HUD approves its RROF (where such submission is required). The recipient shall supply all available, relevant information necessary for the responsible entity or HUD to perform, for each property, any environmental review required.

2 CFR 200.216 *Prohibition on Certain Telecommunication and Video Surveillance Services or Equipment*

2 CFR 200.340 *Termination*

Lead Based Paint Requirements.

When providing housing assistance funding for purchase, lease, support services, operation, or work that may be disturb painted surfaces, of pre-1978 housing, you must comply with the lead-based paint evaluation and hazard reduction requirements of HUD's lead-based paint rules (Lead Disclosure; and Lead Safe Housing (24 CFR part 35)), and EPA's lead-based paint rules (e.g., Repair, Renovation and Painting; Pre-Renovation Education; and Lead Training and Certification (40 CFR part 745)).

When providing education or counseling on buying or renting housing that may include pre-1978 housing under your grant you must inform clients of their rights under the Lead Disclosure Rule (24 CFR part 35, subpart A), and, if the focus of the education or counseling is on rental or purchase of HUD-assisted pre-1978 housing, the Lead Safe Housing Rule (subparts B, R, and, as applicable, F - M).

C. Reporting.

HUD requires recipients to submit performance and financial reports under OMB guidance and program instructions.

1. Recipient Integrity and Performance Matters. Applicants should be aware that if the total Federal share of your Federal award includes more than $ 500,000 over the period of performance, you may be subject to post award reporting requirements reflected in Appendix XII to Part 200-Award Term and Condition for Recipient Integrity and Performance Matters.

2. Race, Ethnicity and Other Data Reporting. HUD requires recipients that provide HUD-funded program benefits to individuals or families to report data on the race, color, religion, sex, national origin, age, disability, and family characteristics of persons and households who are applicants for, participants in, or beneficiaries or potential beneficiaries of HUD programs in order to carry out the Department's responsibilities under the Fair Housing Act, Executive Order 11063, Title VI of the Civil Rights Act of 1964, and Section 562 of the Housing and Community Development Act of 1987.

Grantees will be required to submit this information through the reporting form HUD-40110-C, HOPWA Annual Performance Report (APR).

4. Compliance with the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109-282) as amended (FFATA). FFATA requires information on Federal awards be made available to the public via a single, searchable website, which is www.USASpending.gov. Accordingly, each award HUD makes under this NOFO will be subject to the requirements provided by the Award Term in Appendix A to 2 CFR Part 170, "REPORTING SUBAWARD AND EXECUTIVE COMPENSATION INFORMATION," unless the Federal funding for the award (including funding that may be added through amendments) is not expected to equal or exceed $30,000. Requirements under this Award Term include filing subaward information in the Federal Funding Accountability and Transparency Act (FFATA) Sub-award Reporting System (FSRS.gov) by the end of the month following the month in which the recipient awards any sub-grant equal to or greater than $30,000. Each

applicant under this NOFO must have the necessary processes and systems in place to comply with this Award Term, in the event that they receive an award, unless an exception applies under 2 CFR 170.110.

5. Program-Specific Reporting Requirements

Reporting requirements under this NOFO are more comprehensive than traditional HOPWA program reporting. Grantees will be required to submit three different reporting documents including the HOPWA APR (HUD-40110-C), an HIV Housing Care Continuum Model Report, and a Housing as an Intervention to Fight AIDS (HIFA) Model.

a. **HOPWA APR (form HUD-40110-C)**. Grantees will be required to submit an APR within 90 days of the end of each operating year. The APR can be accessed at https://www.hudexchange.info/resource/1012/hopwa-annual-progress-report-apr-form-hud-40110-c/

b. **HIV Housing Care Continuum Model (form HUD-4154)**. Grantees will be required to submit an HIV Housing Care Continuum Model report within 90 days of the end of each operating year. The HIV Housing Care Continuum Model being reported under this NOFO uses the diagnosis-based approached established by the Center for Disease Control (CDC) through their fact sheet, "Understanding the HIV Care Continuum", published in July 2019. This fact sheet can be accessed at https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf. The HIV Housing Care Continuum Model will require grantees to collect four client-level data elements for each person with diagnosed HIV receiving HOPWA assistance by type of assistance received through this NOFO. The data elements include:

- **Receipt of Care**. Receipt of care is measured as a person with diagnosed HIV receiving HOPWA assistance under this NOFO who had at least one CD4 or viral load test during the operating year.
- **Retained in Care.** Retained in care is measured as a person with diagnosed HIV receiving HOPWA assistance under this NOFO who had two or more CD4 or viral load tests, performed at least three months apart during the operating year.
- **Viral Suppression.** Viral suppression is measured as a person with diagnosed HIV receiving HOPWA assistance under this NOFO who had a viral load test result of <200 copies/mL at the most recent viral load test during the operating year.
- **Type of HOPWA assistance received.** The type of HOPWA assistance received by the person with diagnosed HIV includes any HOPWA assistance for housing or supportive services funded through this NOFO. This data element will provide the denominator for the variety of HIV Housing Care Continuums created through the HIV Housing Care Continuum Model report. Grantees will be required to separately report receipt of care, retained in care, and viral suppression for persons with diagnosed HIV receiving the following categories of type of HOPWA assistance under this NOFO:
    - Any eligible HOPWA assistance;
    - Housing assistance defined in Section III.F.3.a. only;
    - Supportive Services only;
    - Both Housing assistance and Supportive Services;

- TBRA and Master Leasing only;
- TBRA, Master Leasing, and Supportive Services;
- Facility-based Housing only;
- Facility-based Housing and Supportive Services;
- STRMU only;
- STRMU and Supportive Services;
- Other Housing Activities only;
- Other Housing Activities and Supportive Services.

Each annual submission of the HIV Housing Care Continuum Model will cover only the data from the program year covered. The client-level data elements should be collected at minimum annually and at the following times: Client Intake, HOPWA Assistance Ends, Type of HOPWA Assistance Changes, or Recertification for HOPWA Assistance. In addition to the data elements collected, the grantee will provide a brief narrative to interpret the data reported.

c. **Housing as an Intervention to Fight AIDS (HIFA) Model (form HUD-4153).** Grantees will also develop a Housing as an Intervention to Fight AIDS (HIFA) Model to be submitted within 90 days of the grant expiration date. The HIFA Model will document the project's design, implementation, and outcomes, and identify best practices and model qualities related to the use of housing as a structural intervention in the ending the HIV/AIDS epidemic. The HIFA Model will include the following components: a vision or goal for the project; description of the need being met by the project; description of the program design; description of the alignment with initiatives or strategies to end the HIV/AIDS epidemic; description of data collection and analysis used to make data-driven decisions on stable housing, positive health outcomes, and racial equity; description of culturally competent approaches used for clients experiencing service gaps; partnerships formed or continued with community organizations and other housing and service providers; resources and partnerships used to transition clients to self-sufficiency or other forms of housing assistance by the end of the grant period; successes and challenges in using housing as a structural intervention to end the HIV/AIDS epidemic; client outcomes related to health and housing stability including a summary of HIV Housing Care Continuum results and, if applicable, employment and income growth. Health outcome measures will include eligible program beneficiary CD4 count, viral load, and perceived health. This data will be provided in the aggregate. Each HIFA Model will be shared with the public, and lessons learned through these grantee efforts will help inform national and community policy and actions.

D. Debriefing.

For a period of at least 120 days, beginning 30 days after the public announcement of awards under this NOFO, HUD will provide a debriefing related to their application to requesting applicants. A request for debriefing must be made in writing or by email by the authorized organization representative whose signature appears on the SF-424 or by his or her successor in office and be submitted to the POC in Section VII Agency Contact(s), below. Information provided during a debriefing may include the final score the applicant received for each rating

factor, final evaluator comments for each rating factor, and the final assessment indicating the basis upon which funding was approved or denied.

VII. Agency Contact(s).

HUD staff will be available to provide clarification on the content of this NOFO.
Questions regarding specific program requirements for this NOFO should be directed to the POC listed below.

Name:
Office of HIV/AIDS Housing

Phone:

Email:
HOPWA@hud.gov

Persons with hearing or speech impairments may access this number via TTY by calling the toll-free Federal Relay Service at 800-877-8339. Please note that HUD staff cannot assist applicants in preparing their applications.

VIII. Other Information.

1. National Environmental Policy Act.

This NOFO provides funding under 24 CFR 574.510 and applicants are required to follow the environmental requirements that are outlined at 24 CFR 574.510. This NOFO does not alter any of those environmental requirements. Accordingly, under 24 CFR 50.19(c)(5), this NOFO is categorically excluded from environmental review under the National Environmental Policy Act of 1969 (42 U.S.C. 4321).

Activities under this NOFO are subject to the environmental review provisions set out at 24 CFR 574.510.

2. Web Resources.

- **Affirmatively Furthering Fair Housing**
- **Code of Conduct list**
- **CFDA**
- **Dun & Bradstreet**
- **Equal Participation of Faith-Based Organizations**
- **Federal Awardee Performance and Integrity Information System**
- **FFATA Subaward Reporting System**
- **Grants.gov**
- **HBCUs**
- **Healthy Homes Strategic Plan**
- **Healthy Housing Reference Manual**
- **HUD's Strategic Plan**
- **HUD Grants**
- **Limited English Proficiency**
- **NOFO Webcasts**
- **Opportunity Zone**

- **Procurement of Recovered Materials**
- **Promise Zones**
- **Section 3 Business Registry**
- **State Point of Contact List**
- **System for Award Management (SAM)**
- **Uniform Relocation Assistance and Real Property Acquisition Act of 1970 (URA)**
- **USA Spending**

3. Program Relevant Web Resources

- HUD.gov HOPWA website
- HUD.gov HOPWA Listserv Sign up
- HUD.gov HOPWA Published Listservs
- HUD Exchange HOPWA Technical Assistance website

APPENDIX

APPENDIX A: Sample Leveraged Resources Chart
Chart of Leveraged Resources (SAMPLE)

Applicant:

Name/Address of Organization	Type of Commitment	$ Amount	Date of Commitment Letter	Source of Funding or In-kind Contribution	Organization Contact (name, title, phone, email)
We Leverage! Inc. 25 Percent Avenue Here, PP 00000	Third Party Cash Resources (for IT Services)	$200,000 (3 yrs)	1/1/11	Private Funding	Guy Help, Director 1-555-XXX-XXXX, [email]
Volunteers on Earth 2 Earth Dr. Gaia, EA 00001	Volunteer Time (Support Groups)	$5,000 (1,000hrs*$5/hr)	1/2/11	Private In-Kind Contribution	Phil Anthropist, Executive Director 1-555-XXX-XXXX, [email]
Junkyard Revival 2b 2nd Life Blvd. Hope, WE 00002	Vehicle for client transportation	$40,000 (Vehicle and 3 yrs of maintenance)	1/3/11	State In-Kind Contribution	Manual Transmission, Owner 1-555-XXX-XXXX, [email]

City of Sunshine 25 Rainbow Road Sunshine, XO 00003 *Applicant	Housing Placement Services	$100,000 (2,000hrs * $50/hr)	1/4/11	Local Funding	Rosie Outlook, Mayor 1-555-XXX-XXXX, [email]

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG VALUES
(Amended Draft - PP&A 04/20/2021)

PARADIGMS (Decision-Making)

- Equity: Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically. (1)
- ***Compassion: response to suffering of others that motivates a desire to help.*** (2)

OPERATING VALUES

- Efficiency: accomplishing the desired operational outcomes with the least use of resources
- Quality: the highest level of competence in the decision-making process
- Advocacy: addressing the asymmetrical power relationships of stakeholders in the process
- Representation: ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process
- Humility: Acknowledging that we do not know everything and ***willingness to listen carefully to others***. (3)

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1 Based on the World Health Organization's (WHO) definition of equity.
2 Compassion moved to second position per April 20, 2021 committee meeting decision.
3 Wording change per April 20, 2021 committee meeting decision.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816
FAX (213) 637-4748 • HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

October 9, 2020

To: Mario J. Perez, Director of HIV and STD Programs (DHSP), Department of Public Health

From: Alvaro Ballesteros and Bridget Gordon, Co-Chairs, Commission on HIV

Re: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32

In keeping with the Commission on HIV's commitment to engage in multi-year priority setting and resource allocation planning for the next three years, the PP&A Committee has developed a set of program directives for program years (PY) 30, 31, and 32. The multi-year service rankings and allocations aim to assist DHSP in your programmatic planning and initiating the solicitations process so that services are in place by the start of the upcoming Ryan White program years.

Part A Planning Councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Recipient should consider in allocating funds under a grant based on numerous factors including: "size and demographics of the population of individuals with HIV disease;" "priorities of the communities with HIV disease;" and "capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)
This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure

alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

Based on epidemiological data, the disproportionately impacted populations in Los Angeles County are **young MSM (YMSM), African American MSM, Latino MSM, and transgender persons**. Given the physiologic role that sexually transmitted diseases (STDs) play in HIV transmission, it is recognized that maximizing HIV prevention will require significant reduction in syphilis and gonorrhea cases, among these aforementioned groups and **women of color** (LACHAS, pg. 14).

The 2019 HIV Surveillance Report notes following areas of disparities:

- Largest gaps in awareness of HIV-positive status existed for persons aged <35 years, where over 50% of HIV-infected persons aged 13-24 years and one third of HIV-infected persons aged 25-34 years were unaware of their infection. Disparities also existed for persons who inject drugs (PWID), with over one-third of HIV-infected PWID unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

- There are continued disparities in HIV diagnosis by population and geographic location. Rates of new HIV diagnosis are higher among men than women. Across age groups, young men aged 20-29 years and women aged 30- 39 years had highest HIV diagnosis rates. Black men and women had higher rates of HIV diagnosis compared with other race/ethnicity groups. Among men the highest rates of diagnoses were seen in the Central, South, and Hollywood-Wilshire Health Districts, and the highest rates for women were seen in the Central, South, and Southeast Health Districts.

- Populations with lowest achievements in linkage to care were females, Blacks, adolescents, persons aged ≥ 60 years, and persons with injection drug use (IDU) or heterosexual transmission risk. Health Districts with greatest need for interventions to improve linkage to HIV care services were Antelope Valley, El Monte, and South Health Districts where linkage rates were ≤ 70%.

- Approximately 9 in 10 people living with diagnosed HIV were on HIV treatment. Of those, 8 in 10 had adhered to their drugs in the past 3 days. Treatment coverage was lowest for Black populations and persons aged < 40 years, while adherence was lowest for younger persons aged <30 years and the Latinx population.

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income

and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

It is important to note that during the Committee's service ranking deliberations, the consumers, ranked housing as their number one service need for PY 31 and 32. This speaks to the need for keeping PLWH stably housed to support their retention to care, viral suppression and overall health. Medical/outpatient care also remains a top priority for consumers.

The program directives below expand on the directives sent to DHSP on April 23, 2019:

1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

    - Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.
    - In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.
    - Assess available resources by health districts by order of high prevalence areas.
    - Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.
    - Fund mental health services for Black/African American women that are responsive to their needs and strengths.
    - Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
    - It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional

locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

6. Continue to support the expansion of medical transportation services.

7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distribution of eligibility cards as stated by DHSP representatives.

8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children.

   Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

In order to inform the Commission's planning efforts around HIV/STD prevention and care services, we direct DHSP to provide written fiscal reports and status updates on these directives to the PP&A Committee and full Commission on a regular basis.

In support of the recommendations from the PP&A Committee, Standards and Best Practices (SBP) will continue updating and/or developing service standards for the following service categories. These service categories were prioritized by the PP&A Committee as recommended by DHSP and because of the feasibility of releasing solicitations in 2020-2022. Status updates on the development of service standards are noted below.

1. **Universal Service Standards -**Completed; updated and approved on 9/12/19
2. **Non-Medical Case Management –** Completed; updated and approved on December 12, 2019
3. **Psychosocial Support -**in progress and on the 9/10/20 Commission agenda for approval
4. **Emergency Financial Assistance –** Completed; approved by the Commission on 6/11/20
5. **Childcare** - in progress; public comment period 9/11-9/23; target month for Commission approval is October/November

The Commission is committed to ongoing collaborations with DHSP and we seek your feedback on how we can work together to implement these directives. We thank DHSP for ongoing regular progress reports on implementing directives and efforts to maximize Ryan White funds and activities to end the HIV epidemic. Furthermore, we appreciate feedback from DHSP in updating service standards. Thank you, we appreciate the ongoing partnership and support from you and your staff.

cc: Raquel Cataldo, PP&A Co-Chair
Kevin Stalter and Erika Davies, SBP Committee Co-Chairs
Miguel Martinez and Jason Brown, 2019 PP&A Committee Co-Chairs

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

(REVISED) Black/African American Community (BAAC) Task Force Recommendations

October 10, 2019

Introduction

The BAAC Task Force was formed in response to the Commission on HIV's (COH) February 14, 2019 National Black HIV/AIDS Awareness Day (NBHAAD) Panel discussion in an effort to address the disproportionate impact of HIV/AIDS in the Black/African American (AA) communities of Los Angeles County.

The BAAC Task Force convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the COH on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs in all subsets of the Black/AA community utilizing a community-wide mobilization effort.

Healthcare Disparities in the Black/AA Community

The United States Census Bureau estimates Black/AA living in Los Angeles County (LAC) at 9% or approximately 909,500 as of 2018.(1) In 2017, there were 51,438 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) were Black/AA.**(2)

In 2016, **the highest overall rate of HIV diagnoses was among African Americans (56 per 100,000)**, followed by Latinos (19 per 100,000), whites (12 per 100,000), and Asians (6 per 100,000). These differences in rates were also observed by sex, most notably among **African American females (17 per 100,000) where the rate of HIV diagnoses** was 8 times higher than that of white females (2 per 100,000) and 5 times higher than the rate for Latinas (3 per 100,000). Among **males**, the rate of HIV diagnoses among **African Americans (101 per 100,000)** was 5 times higher than among whites (22 per 100,000) and 3 times higher than the rate for Latinos (34 per 100,000).(2)

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).(2)

Black/AA Care Continuum as of 2016[3]

Demographic Characteristics	Diagnosed/Living with HIV	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
Race/Ethnicity						
African American	**9,962**	**54.2%**	**65.9%**	**49.7%**	**50.3%**	**53.0%**
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.10%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%

The Ryan White (RW) program in LAC served 15,747 individuals between March 1, 2018 and February 28, 2019. Three-thousand three-hundred sixty (3,360) were Black/AA during the same period.[4]

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

General/Overall Recommendations:

1. Provide on-site cultural sensitivity and education training – to include addressing implicit bias and medical mistrust within the Black/AA community – for all County-contracted providers and adopt cultural humility into the local HIV provider framework. *Decision makers must realize their own power, privilege and prejudices and be willing to accept that acquired education and credentials alone are insufficient to address the HIV epidemic in the Black/AA community.*

2. Revise messaging County-wide around HIV to be more inclusive, i.e., "If you engage in sexual activity . . . you're at risk of HIV" in an effort to reduce stigma.

3. Incorporate universal marketing strategies for HIV prevention that appeal to all subsets of the Black/AA community in an effort to reduce stigma and increase awareness.

4. Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant.

5. Support young people's right to the provision of confidential sexual health care services.

6. Increase Pre-exposure Prophylaxis (PrEP) advertising within the Black/AA community to increase awareness. Marketing materials must depict the very community it is attempting to reach - specifically, Black/AA youth, women, transgender individuals, and gender nonconforming populations.

7. Initiate or partner in culturally informed research that aims to address the needs of the Black/AA communities. Researchers, whenever possible, must mirror the affected community it purports to study. Community reflectiveness in academic and CBO partnerships should include training in instrument development, data interpretation, presentations and publications.

8. Increase use of local statistics regarding new infections and disparities to educate and plan for the community; request Department of Public Health data be organized by Health Districts and zip codes to better target and identify communities in need.

9. Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive services.

10. Proactively reach out to engage CBOs that are connected to the local Black/AA community.

11. End the practice of releasing Request for Proposals (RFPs) that have narrowly defined "Proposer's Minimum Mandatory Requirements." *This discriminatory practice purposely disqualifies existing relevant CBOs and other agencies that provide intersection health and human services.* When issuing RFAs, RFPs, or RFSQs, establish a demonstration/data pilot by creating a 15% funding carve-out for CBO's/ASO's, whose qualifications are below the "Minimum Mandatory Requirements", but at an agreed upon standard, to identify the proven and effective grassroots/community empowerment efforts that reach specified Black/AA audiences. This will allow DHSP in collaboration with the Commission to determine the efficacy of methodologies for outreach, linkages to care, retention in care, and other sensitive treatment and prevention interventions that are effective in reducing new HIV cases.

12. Continue to evaluate for effectiveness and increase the investment in Vulnerable Populations Grants that target subset populations of the Black/AA community (i.e. Trans men/women, women & girls, MSM) to address barriers and social determinates of health.

13. Engage agencies already funded as well as those not currently funded to focus on a Countywide PrEP Education and Outreach mini-grant process that will target all various subset populations of the Black/AA community, i.e. Trans community, women & girls, MSM.

14. Increase mobilization of community efforts to include:
    a. Increase community awareness fairs and social media campaigns intended to promote health and wellness in the Black/AA community, with concentration in high incidence areas;
    b. Condom distribution in spaces where adults congregate;
    c. HIV education and access to prevention tools in schools, spiritual communities, social clubs, neighborhood associations, etc.;
    d. Fund one social marketing campaign that addresses stigma and internalized homophobia as it relates to health and wellness around HIV;
    e. Support efforts that will ensure additional research and evaluation support be made available to agencies that provide services to the Black/AA community and to increase their capacity to link and collaborate with research institutions; and
    f. Provide training and incentives for CBOs within high incidence areas to prescribe PreP and nPep.

Population-Specific Recommendations:

Black/African American Trans Men:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.
2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.
3. Include Trans men in program decision making.
4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.
5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

6. Create a pilot/demonstration project using the information obtained from the various data sources listed above.

Black/African American Trans Women:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans women community to address barriers and social determinants of health to better provide more targeted programming.
2. Increase efforts in collecting epidemiological data through surveillance on Trans women for purposes of planning more targeted programming.
3. Use William's Institutes' research/data using SOGI (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans women-specific programming.
4. Include and prioritize Trans women in program decision making.
5. Address stigma and the increasing violence against Trans women.

Black/African American Women and Girls: *(DHSP defined Black/AA women and girls as either childbearing women between the ages of 15-44 and those 50 Years and Older)*

The Ryan White (RW) program in LAC served 501 Black/AA women during the period of March 1, 2018 to February 28, 2019. This is approximately 31.82% of those receiving RW services.(4)

1. Evaluate existing PrEP and prevention access and messaging for impact on intervention groups and community health; assess dissemination methodologies and refine outreach and engagement strategies.
2. Allocate resources to create a PrEP Center for Excellence targeting women and their families, sexual and social networks.
3. Conduct an inventory of County-wide HIV/STD interventions and initiatives that target African American women at risk of and living with HIV that focus on education, employment services, empowerment, co-infections, treatment as prevention (TAsP), sexual reproductive health, intimate partner violence, and mental health.
4. Obtain data for all populations of women, especially those who are pregnant or such age groups affected by the high rates of STIs; include women-specific data in summits, reports, and community forums.

5. Reorganize and adopt educational approaches to care and prevention that incorporate information and knowledge on how preventative methods can benefit the woman within the context of her life. Such approaches include but should not be limited to:
   a. Integrate train-the-trainer models for community health outreach workers and testing staff that use motivational and empowerment strategies as a tool for risk reduction. Generating collective approaches and solutions that promote honesty and integrity within self and relationships with others is paramount. Hold agencies accountable to host honest adult conversations and have the courage to meet people where they are and build on what they know.
   b. Generate collective approaches and solutions that promote honesty and integrity of self and relationships with others is paramount; and
   c. Train community health outreach workers in all HIV Testing Sites to have conversations that validate the experience and power dynamics women confront within their relationships. Most often partners are missing from engagement, enrollment, and retention strategies. Include sexual and social networks in education, outreach, testing and other interventions that support family sustainability as a method of retention.

6. Allocate money to partner with institutions to support three demonstration projects at $250,000 each led and facilitated by and for Black women:
   a. Ensure agencies have tools available to demonstrate accountability and cultural competence. Staff should be linguistically and culturally representatives of the community and any intervention include a navigation component to address barriers to recruitment, uptake and retention of prevention and care based programming.
   b. All protocols should explicitly embrace the experience of women who have sex with men of known or unknown status as well as those diagnosed with HIV/AIDS. Further, qualitative interviews or Audio Computer-Assisted Self-Interview (ACASI) instruments should include an assessment of historical care and prevention participation as well as barriers to continuous engagement and participation.

7. Strategically reflect the needs of women in the jurisdictional stigma reduction efforts by funding projects that reduce stigma and increase access to female controlled HIV preventive tools such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), and the Female Condom 2 (FC2). Support agencies to integrate comprehensive opportunities for education, research and a complement to other strategies that give women the power to take control of their lives and situations in which have historically had little to no influence.

8. Expand the availability of community-based mental health services as a part of a continuous effort to treat women holistically: HIV and mental health education and awareness should accompany a range of holistic services that recognize that a woman may have multiple traumas that inform her choices. Increased collaborations between community and the private sector which is necessary to build awareness and reduce cultural and social based stigmas associated with mental health care. Increased education and training of non-HIV/AIDS service providers in hopes of offering a full circle of multidisciplinary services to those in need.

9. Develop a standard requiring all contracted organizations offer living wages as an incentive to hiring persons with lived experience. Initiating programming for Black women enables organizations to invest in their peers. Further, increased access to professional development opportunities and resources (ex. Income) enables them to self-sustain and decrease the impact that social correlates of health such as poverty have on informed sexual decision making.

<u>Black/African American Men Who Have Sex with Men (MSM):</u>

The Ryan White (RW) program in LAC served 2,093 Black/AA MSM during the period of March 1, 2018 to February 28, 2019. This was approximately 13.3% of those receiving RW services. (4)

1. Continue to increase the investment in innovative layered interventions that target young MSM and address barriers and social determinates of health like the Vulnerable Populations Grant.

2. Develop and release of Request for Application/Request for Proposal (RFA/RFP) that focuses on HIV positive MSM of all ages who are sexually active and at risk of co-infections.

3. Increase funding and resources in treatment as prevention, social support efforts, housing and mental health services.

4. Address Chemsex within the Black/AA MSM community through CBO led group sessions, evidence-based medicine directed intervention and medication assisted treatment.

Conclusion

Only by genuinely addressing the recommendations as provided above can the Los Angeles County HIV/AID Strategy (LACHAS) goals be met. Many of the recommendations provided are in alignment with the LACHAS and the County's Comprehensive HIV Plan (CHP), however, there must be very intentional and targeted efforts made to address social determinants, primarily stigma and racism, in the Black/AA communities. It is not enough to implore the same strategies of old; we must modernize methodologies in our marketing strategies to reach subpopulations within the Black/AA communities who do not identify according to current messaging. Messaging must be *truly* inclusive – "if you are sexually active, you are at risk".

The adage is true – "to reach them, you have to meet them where they are" - HIV and sexual health education along with HIV prevention interventions must be accessible in schools, jails, churches, barber/beauty shops, and social venues where Black/AA communities gather; while providers must be trained and educated to understand the various cultural nuances that can either stigmatize and subsequently discourage or create a culturally welcoming environment for Black/AA communities to access HIV prevention, care and treatment services.

On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

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Endnotes

1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19) Los Angeles County; Utilization by Service Category among Ryan White Priority Populations in Year 28