LOS ANGELES COUNTY
COMMISSION ON HIV

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SPECIAL MEETING

Planning, Priorities, and Allocations Committee Meeting

Thursday, December 14, 2023
2:30pm-4:30pm (PST)

510 S. Vermont Ave
9th Floor Terrace Conference Room
Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/planning-priorities-and-allocations-committee

Members of the Public May Join in Person* or Virtually.
For Members of the Public Who Wish to Join Virtually, Register Here:

https://tinyurl.com/54t936a5

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2538 792 5673

As a building security protocol, attendees entering from the first-floor lobby **must notify security personnel that they are attending a Commission on HIV meeting to access the Terrace Conference Room (9th flr) where our meetings are held.*

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. *If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

To access meeting materials via the QR code: (1) Open your camera app on your smart device, (2) Select the rear-facing camera in Photo or Camera mode, (3) Center the QR code that you want to scan on the screen and hold your phone steady for a couple of seconds, and (4) Tap the notification that pops up to open the link.

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

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

PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

THURSDAY, DECEMBER 14, 2023 | 2:30 PM – 4:30 PM***
****PLEASE NOTE SPECIAL DATE AND TIME*****

510 S. Vermont Ave
Terrace Level Conference Room, Los Angeles, CA 90020

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://tinyurl.com/54t936a5
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2538 792 5673

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros MBA, Co-Chair	Lilieth Conolly	Felipe Gonzalez
Michael Green, PhD	Ish Herrera	William King, MD, JD	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray, MSW	Jesus "Chuy" Orozco	Dechélle Richardson (Alternate)
Redeem Robinson	Harold Glenn San Agustin, MD	LaShonda Spencer, MD	Lambert Talley (Alternate)
Jonathan Weedman			
QUORUM: 9			

AGENDA POSTED: December 11, 2023.

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx.

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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 the Commission Office 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 Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos setenta y dos 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 at 510 S. Vermont Ave. 14th Floor, Los Angeles, CA 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		2:30 PM – 2:33 PM
2.	Roll Call & Conflict of Interest Statements		2:33 PM – 2:35 PM
3.	Approval of Agenda	**MOTION #1**	2:35 PM – 2:37 PM
4.	Approval of Meeting Minutes	**MOTION #2**	2:37 PM – 2:40 PM

II. PUBLIC COMMENT

2:40 PM – 2:45 PM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS

6. 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

7. Executive Director/Staff Report 2:45 PM – 2:53 PM
    a. Recap Commission on HIV Annual Conference
    b. Bylaws Review Taskforce Updates

8. Co-Chair Report 2:53 PM – 3:10 PM
    a. 2024 Co-Chair Nominations
    b. January PP&A Meeting
    c. Approval of Los Angeles County HIV &STI Status Neutral Service Delivery Framework **MOTION #3**
    d. Prevention Planning Workgroup Co-Chair Recognition
    e. Current Allocations and Priorities, Draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework and 2024 Draft Workplan

9. Division of HIV and STD Programs (DHSP) Report 3:10 PM – 3:55 PM
    a. Fiscal Year 2022 Utilization Report - General and Specialty Oral Health Services
    b. Programmatic and Fiscal Updates

V. DISCUSSION ITEMS 3:55 PM—4:20 PM

10. Los Angeles Homeless Services Authority (LAHSA) Data Report

VI. NEXT STEPS 4:20 PM – 4:25 PM

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 4:25 PM – 4:30 PM

13. Opportunity for members of the public and the committee to make announcements.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.

MOTION #3	Approve the Los Angeles County HIV & STI Status Neutral Service Delivery Framework, as presented or revised.

VIII. ADJOURNMENT 4:30 PM

14. Adjournment for the meeting of December 14, 2023.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 6.12.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Public comment is limited to 2 minutes per person. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. 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 approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
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) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 11/20/23

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts. ***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
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**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	No Affiliation	No Ryan White or prevention contracts
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ish**	Unaffiliated consumer	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
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	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
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			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
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PATEL	**Byron**	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
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (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	No Ryan White or prevention contracts
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
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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Commission member presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges. Members of the public may confirm their attendance by contacting Commission staff. Approved meeting minutes are available on the Commission's website and may be corrected up to one year after approval. Meeting recordings are available upon request.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
September 19, 2023

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Derek Murray	P
Al Ballesteros, MBA, Co-Chair	P	Jesus "Chuy" Orozco	P
Lilieth Conolly	P	Dechelle Richardson	P
Felipe Gonzalez	P	Reverend Redeem Robinson	LOA
Michael Green, PhD, MHSA	EA	Harold Glenn San Agustin, MD	P
Ismael "Ish" Herrera	EA	LaShonda Spencer, MD	P
William King, MD, JD	P	Lambert Talley	P
Miguel Martinez, MPH, MSW	P	Jonathan Weedman	P
Anthony M. Mills, MD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon			
DHSP STAFF			
Sona Oksuzyan, MD, MPH			

*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. Click HERE.

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:05pm.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, Dr. Mills, K. Donnelly, J. Weedman, M. Martinez, Dr. King, L. Conolly, F. Gonzalez, D. Murray, C. Orozco, D. Richardson, Dr. San Agustin, Dr. Spencer, L. Talley

3. **Approval of Agenda**
   MOTION #1: Approve the Agenda Order **(✓Passed by consensus.)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(✓Passed by consensus.)**

II. PUBLIC COMMENT

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

   There were no public comments.

III. COMMITTEE NEW BUSINESS

6. **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.**

   J. Weedman shared that the 5th Supervisorial District will be hosting a World AIDS Day breakfast event and invited the committee members to attend. More information to follow as the event approaches.

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **Bylaws Review Taskforce Updates**
      - C. Barrit, Commission on HIV (COH) Executive Director, reported that the Bylaws Review Taskforce (BRT) continues to make progress on review and update of the bylaws document. The BRT will meet Sept. 21st and plan to review the remaining portion of the document. Commission staff continue to work with County Counsel (CoCo) to ensure any suggested changes are within County guidelines and federal requirements.

   b. **Los Angeles Homeless Services Authority (LAHSA) Data Request Update**
      - C. Barrit noted that the first data request that was received in August was incomplete and Commission staff requested additional filters be added to the data. The updated data was received two weeks ago, and Commission staff are working on preliminary analysis. Initial analyses will be shared with the committee at a future Planning, Priorities, and Allocations (PP&A) Committee meeting.

   c. **RWP FY 2024 Non-Competing Progress Report Deadline**
      - C. Barrit reminded the committee that approximately two and a half years ago the Ryan White Program (RWP) changed from an annual application to a three-year funding cycle and noted this cycle aligns with the committees planning process. She noted the next Non-Competing Progress Report for the upcoming 2024 fiscal year is due on October 2nd to the

Health Resources and Services Administration (HRSA) and explained that the portion of the report that the Planning Council (PC) was responsible for was the Letter of Assurance that outlines responses to five questions from HRSA as related to planning processes, priority setting and resource allocation, training for members and the assessment of the administrative mechanism. The Letter of Assurance has been signed by Commission co-chairs and was submitted to the Division of HIV and STD Programs (DHSP). See meeting packet for more details.

8. Co-Chair Report

a. New Member Welcome

- K. Donnelly welcomed new PP&A committee members, Dr. Harold Glen San Agustin, and Lambert Talley. He noted new member Ismael "Ish" Herrera was absent due to illness.

b. Sexual Health and Older Adults September 22 Event

- K. Donnelly reminded Commissioners of the upcoming Sexual Health and Wellness for Older Adults event organized by the Aging Caucus. The event is geared toward providers to better serve their older patients, but all are welcome to attend. The event will be held on Friday, September 22 from 10am to 2pm at the Vermont Corridor. Approximately 90 have RSVPed for the event. See meeting packet for event flyer.

9. Division of HIV and STD Programs (DHSP) Report

a. Fiscal Year 2022 Expenditures and Utilization Report

- DHSP staff, Sona Oksuzyan, provided a report on Mental Health and Substance Abuse Residential Services utilization for fiscal year 2022. See meeting packet for more details.
- It was noted that there has been a decline in Mental Health services within the RWP in program year 32 despite recent data showing the need for more mental health services for people living with HIV. It was noted that more data was needed to better understand the trend downward, but some possible explanations include lack of providers, Medi-Cal expansion, coverage by RWP Parts C & D over RWP Part A, and the Department of Health Services and/or other programs covering costs.
- Wendy Garland, DHSP staff, reminded the committee that the numbers only reflect RWP clients and that most services are covered by Medi-Cal, noting that the numbers indicate utilizing the RWP as the payor of last resort. She noted that currently, the RWP covers the same mental health services that are also covered by Medi-Cal and if the committee wants to see different populations served, then the Commission on HIV (COH) will need to identify and cover mental health services that are not covered by Medi-Cal. For example, W. Garland noted psychotherapy is not covered by Medi-Cal. W. Garland also noted that DHSP is currently working to identify other ways that mental health services can be provided acknowledging the need for services and noted that there was also a shortage of providers.
- A. Ballesteros commented that a key challenge faced providers with Ryan White funded mental health services is the fee for service model. A fee for service model hampers the

ability of providers to hire a full-time mental health professional. DHSP needs to allow for a line-item budget for mental health services and staff similar to Part C grants. He explained most agencies cannot afford to hire a mental health provider under the fee for service structure noting that billing is not enough to cover salary and benefits and would result in the agency running in a deficit. He suggested that this may be another reason why mental health services utilization is low under RWP Part A and asked that DHSP consider switching to a line-item budget. He noted mental health providers were previously structured as line-items and it would help increase capacity and access.

- Dr. San Agustin recommended getting feedback from clients as to why people are no longer seeking mental health services to help identify both positive factors that keep patients engaged in care and negative factors that contribute to stopping care.
- F. Gonzalez noted that more needs to be done to support the mental health needs of women of color.
- C. Orozco commented that the ability to fund permanent supportive housing for HOPWA clients is due to the increased need for mental health services.
- D. Murray recommended identifying what is covered under Medi-Cal and what is not to increase services within the RWP. C. Barrit noted that the committee can identify new services to support that are not supported by Medi-Cal and coordinate with the Standards and Best Practices Committee to then develop service standards for service delivery.
- L. Talley commented that, based on his experience, a lot of clients are unaware of the mental health services that are available to them and that more needs to be done to increase awareness.
- L. Conolly noted that more providers need to be trained in offering compassionate care, particularly for women who are often needing mental health support beyond HIV, such as dealing with raising children as a single provider.
- M. Martinez noted many communities of color utilize a paraprofessional model to provide needed support and escalate to licensed professionals based on acuity and asked if the service standards allow for this type of model. It was noted that RWP regulations specifically state licensed mental health professionals.
- Carlos Vega-Matos reported that though telehealth is offered many young individuals cannot access this service due to incompatibility with software and lack of privacy within their living situations to engage in services. He recommended access to technology be tracked in the future.
- A. Ballesteros recommended the committee request that DHSP pilot the transition of mental health services as a line-item budget vs a fee for service model, explore ancillary services, such as the use of paraprofessionals, that can help support/round out mental health services, and identifying factors that contribute to drop off in mental healthcare.
- M. Martinez recommended requesting a presentation from the Department of Mental Health (DMH) on mental health services for people living with HIV and other priority populations.
- D. Murray requested information on what services are being provided in residential

substance use facilities as well as what specific substances clients being treated for. A. Ballesteros added that, based on the report, the average daily rate for services is approximately $70/day and requested a report back from DHSP on what services are provided. He noted this rate is much lower than the average daily rate for services under the Substance Abuse Prevention and Control (SAPC) program. W. Garland indicated that she will check the SAPC rate and specific services provided under residential substance use.

- Dr. Spencer suggested comparing mental health services utilization data with under Part C and D providers.

b. Programmatic and Fiscal Updates

- No report was provided.

V. DISCUSSION

10. Prevention Planning Workgroup (PPW) August 23 Meeting Recap & Status Neutral Recommendations

- Dr. King and M. Martinez, Prevention Planning Workgroup (PPW) co-chairs, reported that the PPW continue to make progress on Prevention Standards recommendations and provided a presentation on proposed status neutral recommendations and integration of prevention within the PP&A Committee. See meeting packet for details.
- Recommendations included adding medical home within Quality Care and community engagement and outreach into the graphic. It was noted that many patients seek HIV and STI services outside of their primary care providers but that securing a medical home is important for clients that do not have one.
- D. Murray asked if integrating prevention into the committee and commission would require revisions to the bylaws or any other formal process. C. Barrit noted current bylaws already articulate the charge of the PP&A Committee and the COH as an integrated planning body. However, she recommended developing a written status neutral priority setting and resource allocation process to ensure a strong prevention component to the Committee's deliberations and decision making.
- A recommendation was made to continue the PPW as a committee to ensure prevention discussions and priorities continue. M. Martinez commented that continuing as a committee will continue to have prevention separated from care and would undermine the goal of the status neutral framework.

11. Review Community Listening Sessions Questionnaire Feedback

- L. Martinez, Commission staff, reported that minor changes to the Community Listening Sessions Questionnaires were made based on feedback received. She noted the review was another opportunity for committee members to provide any additional feedback before the questionnaires are finalized.
- A recommendation was made to add an option to decline to respond to sexual orientation and gender identity questions in addition to adding a column in the client/consumer questionnaire

table regarding being unaware but needing services. See meeting packet for more details.

12. Recap Department of Health Services (DHS) HIV Cascade Data Presentation

- K. Donnelly postponed the discussion to the next PP&A Committee meeting due to time constraints.

13. Recap Cities/Health Districts Harm Reduction Report

- K. Donnelly postponed the discussion to the next PP&A Committee meeting due to time constraints.

VI. NEXT STEPS

- **Task/Assignments Recap**
  - **a.** Review FY 33 RWP Expenditures
  - **b.** Review and Analyze LAHSA Data
  - **c.** Recap HIV & STDs Surveillance and Data Challenges for LA County Native American Communities

- **Agenda Development for the Next Meeting**
  - **a.** Continue RWP Utilization Reports
  - **b.** Review FY33 RWP Expenditures
  - **c.** LAHSA Data Review

VII. ANNOUNCEMENTS

- **Opportunity for Members of the Public and the Committee to Make Announcements**
  There were no announcements.

VIII. ADJOURNMENT

- **Adjournment for the Meeting of September 19, 2023.**
  The meeting was adjourned by K. Donnelly at 3:58pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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Commission member presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges. Members of the public may confirm their attendance by contacting Commission staff. Approved meeting minutes are available on the Commission's website and may be corrected up to one year after approval. Meeting recordings are available upon request.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
October 17, 2023

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Derek Murray	EA
Al Ballesteros, MBA, Co-Chair	P	Jesus "Chuy" Orozco	EA
Lilieth Conolly	P	Dechelle Richardson	EA
Felipe Gonzalez	P	Reverend Redeem Robinson	LOA
Michael Green, PhD, MHSA	EA	Harold Glenn San Agustin, MD	P
Ismael "Ishh" Herrera	P	LaShonda Spencer, MD	P*
William King, MD, JD	EA	Lambert Talley	P
Miguel Martinez, MPH, MSW	P	Jonathan Weedman	EA
Anthony M. Mills, MD	A		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Lizette Martinez			
DHSP STAFF			
Sona Oksuzyan, MD; Victor Scott, Pamela Ogata			

*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. Click HERE.

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:10pm.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, K. Donnelly, M. Martinez, L. Conolly, F. Gonzalez, Dr. San Agustin, I. Herrera, L. Talley

3. **Approval of Agenda**
   MOTION #1: Approve the Agenda Order **(No vote held; quorum was not reached.)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(No vote held; quorum was not reached.)**

II. PUBLIC COMMENT

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

   There were no public comments.

III. COMMITTEE NEW BUSINESS

6. **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.**

   There was no new business.

IV. REPORTS

7. **Execute Director/Staff Report**

   a. **Commission on HIV Annual Conference**
   - C. Barrit, Commission on HIV (COH) Executive Director, shared a brief reminder of the upcoming COH Annual Conference on Thursday, Nov.9th at the Vermont Corridor. She asked committee members to promote the event and noted the agenda would be posted as the event date nears. See meeting packet for details.

   b. **Bylaws Review Taskforce Updates**
   - C. Barrit reported that the Bylaws Review Taskforce (BRT) needs a new co-chair with the departure of co-chair, Everardo Alvizo. She noted that the BRT is schedule to meet on Oct. 18th and will continue its review and update of the bylaws document. The BRT plans to have a revised document for the Operations Committee to review by the end of the year.

   c. **CDC/HRSA Integrated HIV Plan Feedback Meeting**
   - C. Barrit reminded the committee that the Health Resources and Services Administration (HRSA) had provided written feedback to the Integrated HIV Plan in May and a follow up meeting with the Planning Council (the Commission on HIV) and the Division of HIV and STD Programs (DHSP) on Sept. 18th. The meeting consisted of a review of the written feedback and highlighted two areas of improvement: community engagement and data sharing. C. Barrit noted that the COH has already started taking steps to address the areas of improvement and will continue to find opportunities for engagement and data sharing.

See meeting packet for details.

8. Co-Chair Report

a. Debrief Prevention Planning Workgroup September 27 Meeting

- K. Donnelly reported that the Prevention Planning Workgroup (PPW) last met on September 27th and noted that the group has completed a lot of work and is ready to sunset with the intent of incorporating prevention and suggested recommendations into the Planning, Priorities and Allocations (PP&A) Committee. PPW and PP&A co-chairs are meeting on Oct. 19th to further discuss opportunities for prevention integration within PP&A. The next PPW meeting will be held virtually on Wednesday, October 25th from 4pm-5:30pm.

b. November and December Meeting Schedule

- K. Donnelly noted that the November PP&A lands on the week of Thanksgiving on Tuesday, Nov. 21st. He recommended postponing the November PP&A meeting to Dec. 14th from 2:30-4:30pm at the Vermont Corridor. He noted the Consumer Caucus is holding a retreat on Dec. 14th from 11am-2pm and the rescheduled PP&A meeting would follow the retreat. He also announced that the December PP&A meeting is cancelled.

c. 2024 Co-Chair Nominations

- K. Donnelly announced an open call for PP&A co-chair nominations for the 2024 year. He noted nominations would remain open until January 2024 and reminded the group that self-nomination was allowed. The committee will vote during the January PP&A meeting.
- Felipe Gonzalez was nominated but did not accept nor decline the nomination.

d. 2024 Committee Priorities and Workplan Planning

- K. Donnelly reported that the committee will need to develop their workplan for next year. He noted that the next Ryan White Program (RWP) funding cycle will be in 2024 and that the 2023 workplan included the priority setting and resource allocation (PSRA) process which was postponed to 2024 to sync with the RWP 3-year funding cycle and grant application. He provided a brief overview of the workplan and asked the group if there were any additional recommendations and requested prevention integration be added to the 2024 workplan. See meeting packet for details.
- M. Martinez recommended incorporating prevention in the priority setting and resource allocation process. K. Donnelly commented that priority setting, and resource allocation are two separate processes, but that priority setting does have an opportunity to include status neutral approaches. He noted that resource allocation is limited to RWP funds.
- C. Barrit commented that she will be sharing a summary of suggestions for incorporating status neutral into the PSRA process at an upcoming PP&A meeting.
- M. Martinez requested more information on prevention funding streams and service categories provided from DHSP to help inform the PSRA process. Additionally, he asked if

DHSP would be receptive to prevention related recommendations. He noted this would help inform status neutral strategies and planning.

- A. Ballesteros agreed and suggested requesting a report from DHSP outlining Ending the HIV Epidemic funding and service categories similar to RWP funding and service categories.
- It was noted that DHSP had previously provided the committee with a funding stream table highlighting the programs funding sources and the activities supported by each grant. The table will be reviewed again at an upcoming committee meeting.

9. Division of HIV and STD Programs (DHSP) Report

a. Fiscal Year 2022 Utilization Report - Housing, Emergency Financial Assistance and Nutrition Services

- DHSP staff, Dr. Sona Oksuzyan, provided a report on Housing, Emergency Financial Assistance and Nutrition service utilization for fiscal year 2022. See meeting packet for more details.
- For Housing Services, it was noted that, on average, clients remained housed for the majority of the year.
- More clarification on what each housing service covers was requested noting that the amount of spending on these services seemed very high given the small number of people that utilized the services.
    - Housing for Health (H4H) services are used to find permanent supportive housing for PLWH. H4H includes a bundle of services including permanent supportive housing, rental subsidies, or a bed. This service is covered for two years with an option to extend for an additional year.
    - Residential Care Facilities for Chronically Ill (RCFCI) is for PLWH who are sick and require nurses to care for them within the facility. It pays for an individual's bed and the care/management of their condition.
    - Transitional Residential Care Facilities (TRCF) pays for an individual's bed and the care/management of their condition.
- Carlos Vega-Matos commented that RCFCIs are regulated by the State of California that require specific staffing patterns of nurses, must provide meals, and are explicitly for clients who fall below the Karnofsky Scale of human functioning (inability to carry out basic daily functions of living). He added that TRCFs were created approximately 8-10 years ago to create a space for patients that did not need as intense of services as RCFCIs. TRCFs do not require the same staffing patterns as RCFCIs, patients must meet specific cognitive function, and clients are linked to needed services outside of the TRCF. TRCFs are limited to two years with the possibility of one year extension but are meant to be temporary.
- Dr. San Agustin commented that the 1.6% housing services utilization among RWP clients seems alarmingly low and asked how many RWP clients were eligible for these services. It was noted that the report focused on service utilization and not eligibility.
- It was noted that approximately 6-8% of RWP clients have unmet housing needs and the

current housing services serves about a quarter to a third of these clients.

- A. Ballesteros commented that he recalled the decision to increase allocation to housing services was intended to help the general population of RWP clients with unmet housing needs and not intended to be limited for the three specific categories. M. Martinez recalled that discussions were to increase access for all RWP clients with unmet housing needs but, at that time, only the three types of services (H4H, RCFCIs and TRCFs) were available at the time. He noted that current discussions should include efforts to expand housing services to all RWP clients who are eligible for Medical Care Coordination (MCC) and other services.
- L. Conolly asked for clarification on the amount of funds allocated to the Emergency Financial Assistance (EFA) service category. It was noted that EFA began in 2021 and was originally funded through Ending the HIV Epidemic (EHE) at $1.5 million and transitioned to the RWP in program year 32 with an allocation amount remaining at approximately $1.6 million.
- Dr. San Agustin noted that for all services, RWP clients experienced better health outcomes when accessing needed services vs not accessing services. He asked if there was a reason behind this trend. Dr. Oksuzyan noted that clients who accessed the supportive services were initially accessing medical care and were referred to services which showed regular engagement in care. M. Martinez commented that these services are challenging to navigate, and data reflect better outcomes for those who have learned how to navigate these systems. L. Conolly added that in addition to the challenge of navigating systems, available services are often not shared with consumers and that providers determine who is eligible for a program/service based on their biases/perception.
- M. Martinez requested that a meeting should be dedicated to looking at housing and looking at priority populations as the committee prepares for the priority setting and resource allocation process.
- A. Ballesteros commented that previous discussions on reallocation of RWP savings and how to identify people that were not reflected in the data but in need of services such as young people who were both HIV+ and HIV-. Discussions focused on reviewing MCC funds and identifying ways to find housing services for individuals that were on PrEP or PEP and were homeless as well as transgender populations.
- Additional discussions centered identifying individuals within the RWP care continuum that were healthy in terms of HIV but were at risk of losing their housing and offering some form of ongoing assistance to prevent them from entering into homelessness instead of waiting for them to get sick or become unhoused. A. Ballesteros noted that the group envisioned a program beyond EFA that would provide permanent, ongoing support for the PLWH who struggle to pay for housing and prevent homelessness. He noted the group did not identify ways to overcoming existing barriers, particularly how to pay landlords.
- C. Barrit commented that the discussions mentioned took place before the COVID-19 pandemic and before the EFA program was established. She noted that when the program around H4H was presented and the Memorandum of Understanding (MOU) was being worked out between DHSP and the Department of Health Services (DHS) that Minority

AIDS Initiative (MAI) funding would look at the flexible subsidy pool, Brilliant Corners housing (how many people are going to those housing units), and how many people are going into the intensive case management component of the housing program. She noted it would be useful to get the flexible subsidy data from the H4H program, if available, as she noted this funding is intended to prevent individuals from falling off current housing. DHSP noted that they would look to identify any missing data. C. Barrit also requested information on whether individuals who participate in any form of permanent supportive housing if the RWP pays for housing services in perpetuity or do they transfer the funding support to the H4H program. She noted the vision of utilizing MAI funding was to serve as a resource for individuals to enter into the program and into the housing pipeline.

- L. Talley recommended establishing partnerships with the Los Angeles Housing Services Authority (LAHSA) and Children of the Night to open up opportunities to youth and young adults.
- M. Martinez noted that there are new, innovative models being used to support housing individuals who are experiencing homelessness that are cheaper and that the Commission should be looking at these models. He also noted movements toward guaranteed basic income as another model to reference when the committee works towards the intention of creating housing stability for unhoused PLWH. He added that many are being funded by government entities and suggested inviting these agencies to present at a meeting so the committee.
- A. Ballesteros added that there should be a program to help young individuals who pay for a room in a shared living space for a year or two instead of the more expensive traditional models.

b. Programmatic and Fiscal Updates

- V. Scott provided a review of the Ryan White Program Year 33 Expenditures. The total RWP Part A award is approximately $42.9 million, Part B award is approximately $5.4 million, Minority AIDS Initiative (MAI) award of $1.7 million and an MAI carryover from RWP Year 32 of $685,000. See meeting packet for more details.
- DHSP is in the process of reviewing and analyzing current expenditures to date to identify opportunities to shift and adjust funding based on underspending and potential carryover, if and where needed. Potential spending plans and estimated carryover will be sent to HRSA in December.
- Spending for all awards is on trend with program year 32 expenditures but noted underspending in Mental Health and Childcare services. He noted there are currently no funded agencies for childcare services.
- DHSP is seeing less expenditures in Ambulatory/Outpatient Medical due to the DHS pull out of the RWP funding streams and Medi-Cal expansion.
- C. Barrit asked if there is potential to fund the new Spanish Mental Health program using RWP Part A funds that is currently funded by Ending the HIV Epidemic (EHE) funds. V. Scott noted there was potential to shift funding if needed but that would not be determined until federal funding for EHE is allocated in the next year.

V. DISCUSSION

10. Prevention Integration and Status Neutral Planning

- M. Martinez opened the discussion on prevention integration and status neutral planning by posing the question of how the group can incorporate prevention into the structure of PP&A agendas, discussions and the PSRA process.
- K. Donnelly noted siloed funding for prevention and care continue to be a barrier.
- M. Martinez asked the group if there were any trainings or capacity building needs that would need to be addressed to help inform status neutral programming and prevention integration moving forward.
- A. Ballesteros asked if the group had a solid understanding of how prevention work is operationalized within agencies and how well recommendations are implemented. It was noted that the services standards set by the COH's Standards and Best Practices Committee are included in DHSP Requests for Proposals (RFPs) and are operationalized to loosely guide the implementation of services. It is the responsibility of the funder, DHSP, to monitor implementation.
- A. Ballesteros expressed concern about the ability of providers to link non-HIV+ clients to needed services. F. Gonzalez noted that navigators and coordinators need to learn about services/programs that are available to all populations and not just programs for individuals diagnosed with HIV. A. Ballesteros noted that in the current system, HIV- individuals will not be treated the same way as HIV+ individuals due to the lack of resources for this group.
- M. Martinez recommended framing strategies around priority populations and using diverse funding streams that target priority populations to create innovative approaches that address all the health needs of an individual regardless of HIV status.
- A. Ballesteros recommended increasing funding to agencies specifically for capacity building for providers around both HIV+ and HIV- services. Dr. San Agustin added that many providers continue to lack knowledge around some HIV/STI prevention services and that they also need assistance beyond increasing knowledge but also in implementing strategies/activities.
- There was an additional recommendation to engage priority populations outside of the COH and in spaces where they feel safe and heard. There was a push to engage with agencies currently doing innovative work by commissioners engaging in their spaces rather than inviting them into the COH.

VI. NEXT STEPS

11. Task/Assignments Recap

a. Follow Up on Housing Questions Based on the Utilization Report
b. Review DHSP Funding Table
c. Review and Analyze LAHSA Data

12. Agenda Development for the Next Meeting

a. Review Updated Priority Setting and Resource Allocation Document

b. Fiscal Year 2022 RWP Utilization Report - General and Specialty Oral Health Services
c. LAHSA Data Review

VII. ANNOUNCEMENTS

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

K. Donnelly announced the following events and encouraged commissioners to participate:

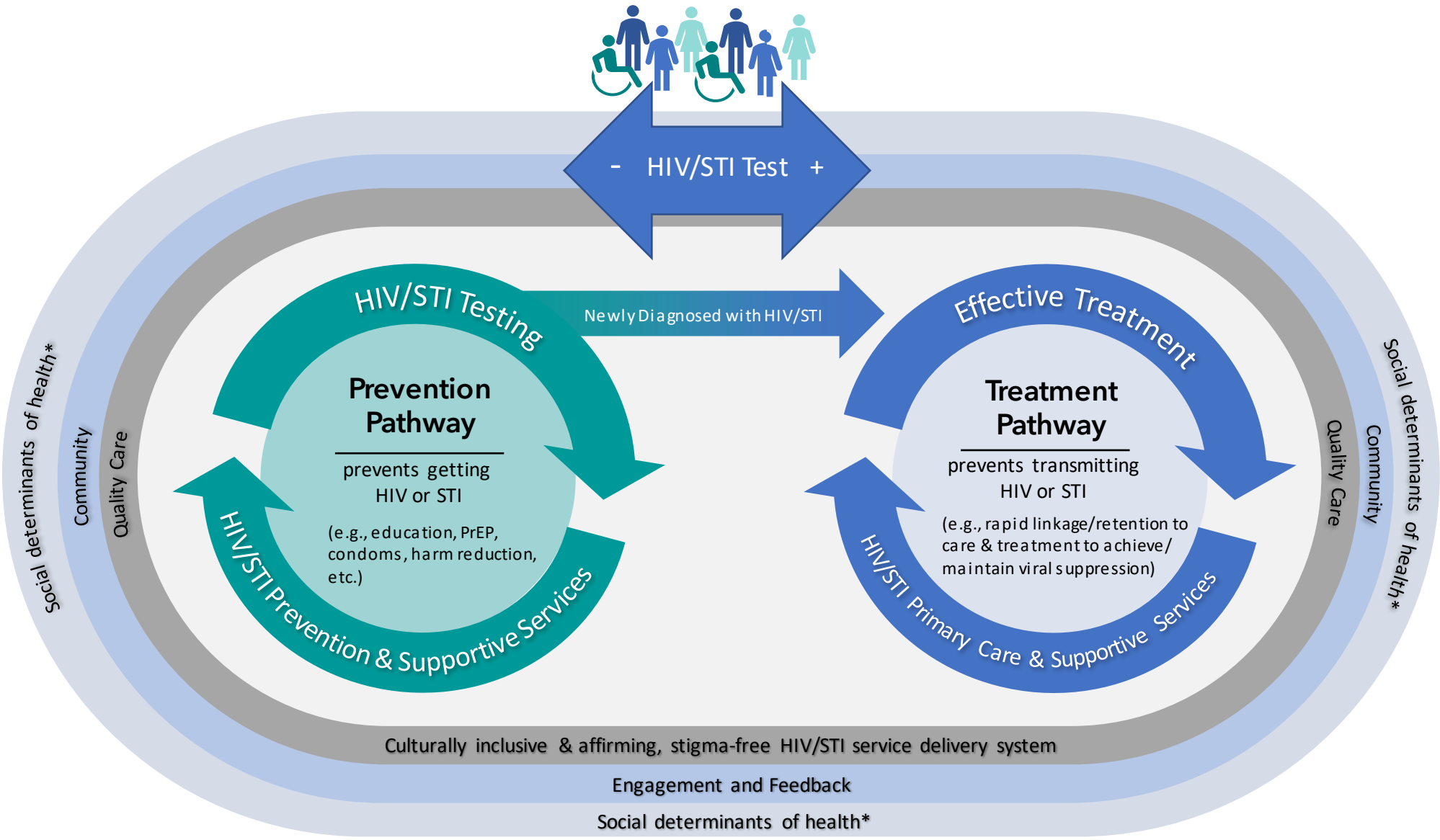
- *Taste of Soul – Saturday, Oct. 21st in Inglewood. The Black Caucus will have a booth as well as committee member, Dr. William King.*
- *The Transgender Health Summit – Thursday, Nov. 2nd at The Village at Ed Gould Plaza*
- *Commission on HIV Annual Conference – Thursday, Nov. 9th at the Vermont Corridor*

VIII. ADJOURNMENT

14. Adjournment for the Meeting of October 17, 2023.

The meeting was adjourned by K. Donnelly at 4:00pm.

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 10/18/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

See Healthy People 2030 for more details on the social determinants of health.

Los Angeles County Department of Public Health Division of HIV and STD Programs Proposed Revisions to FY 2023 (PY 33) Allocations

APPROVED BY COH 06.08.23

	Part A Award	MAI Award	Part A/MAI Totals
Total Award	**$ 42,984,882**	**$ 3,675,690**	**$ 46,660,572**
Admin Ceiling	$ 4,298,488	$ 367,569	**$ 4,666,057**
CQM	$ 859,698	$ -	**$ 859,698**
Direct Services	$ 37,826,696	$ 3,308,121	**$ 41,134,817**

		Allocations Approved by the Commission on HIV		Allocations Proposed by the Division of HIV and STD Programs						
	Service Category	**FY 2023 Approved Part A Allocations (approved 1/13/22)**	**FY 2023 Approved MAI Allocations (approved 1/13/22)**	**FY 2023 Part A Recommendation**	**RecommendedFY 2023 Part A %**	**FY 2023 MAI Recommendation**	**Recom-mended FY 2023 MAI %**	**Total FY 2023 Part A/MAI Recommended $**	**Recom-mended Total FY 2023 Part A/MAI %**	Notes
SERVICES (71.1%)	Outpatient/Ambulatory Medical Services	25.51%	0.00%	$ 7,033,345	18.59%	$ -	0.00%	**$ 7,033,345**	**17.10%**	Reduction in Part A allocation to account for addition of EIS, EFA and Outreach allocations and estimated YR 33 AOM expenditures.
	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	AIDS Pharmaceutical Assistance (local)	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Oral Health	17.60%	0.00%	$ 6,658,822	17.60%	$ -	0.00%	**$ 6,658,822**	**16.19%**	No change.
	Early Intervention Services	0.00%	0.00%	$ 3,160,651	8.36%	$ -	0.00%	**$ 3,160,651**	**7.68%**	Allocation includes Linkage and Reengagement Program and new DPH Clinic Health Services program. Funding will help support a status-neutral approach using Part A funds.
	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Home Health Care	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.

CORE	Home and Community Based Health Services	6.78%	0.00%	$ 2,565,974	6.78%	$ -	0.00%	**$ 2,565,974**	**6.24%**	No change.
	Hospice Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Mental Health Services	4.07%	0.00%	$ 1,290,874	3.41%	$ -	0.00%	**$ 1,290,874**	**3.14%**	Reduction in Part A allocation due to estimated YR 33 expenditures. Spanish Mental Health Telehealth and other mental health assesments will be supported using EHE funds.
	Medical Nutritional Therapy	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Medical Case Management (MCC)	28.88%	0.00%	$ 9,162,605	24.22%	$ -	0.00%	**$ 9,162,605**	**22.27%**	Reduction in Part A allocation by to account addition of EIS, Out reach and EFA allocations and estimated YR 33 MCC expenditures.
	Substance Abuse Services Outpatient	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
ES (28.9%)	Case Management (Non-Medical) Benefits Specialty	2.44%	0.00%	$ 923,917	2.44%	$ -	0.00%	**$ 923,917**	**2.25%**	No change.
	Case Management (Non-Medical) TCM - Jails	0.00%	12.61%	$ -	0.00%	$ 417,154	12.61%	**$ 417,154**	**1.01%**	No change.
	Child Care Services	0.95%	0.00%	$ 360,299	0.95%	$ -	0.00%	**$ 360,299**	**0.88%**	No change.
	Emergency Financial Assistance	0.00%	0.00%	$ 1,569,808	4.15%	$ -	0.00%	**$ 1,569,808**	**3.82%**	EFA allocation added. EFA was previously funded under HRSA EHE but now funded with Part A to ensure RWHAP target populations are reached with the program.
	Food Bank/Home-delivered Meals	8.95%	0.00%	$ 3,386,813	8.95%	$ -	0.00%	**$ 3,386,813**	**8.23%**	No change.
	Health Education/Risk Reduction	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Housing Services RCFCI	0.58%	0.00%	$ 220,719	0.58%	$ -	0.00%	**$ 220,719**	**0.54%**	No change.
	Housing Services TRCF	0.38%	0.00%	$ 145,065	0.38%	$ -	0.00%	**$ 145,065**	**0.35%**	No change.

Los Angeles County Department of Public Health Division of HIV and STD Programs Proposed Revisions to FY 2023 (PY 33) Allocations

SUPPORT SERVIC	Housing Services /Rental Subsidies with CM	0.00%	87.39%	$ -	0.00%	$ 2,890,967	87.39%	**$ 2,890,967**	**7.03%**	Permanent Supportive Housing/Rental Subsidies costs beyond allocation to be supported using MAI carryover or other funding sources.
	Legal Services	1.00%	0.00%	$ 379,213	1.00%	$ -	0.00%	**$ 379,213**	**0.92%**	No change.
	Linguistic Services	0.65%	0.00%	$ 246,819	0.65%	$ -	0.00%	**$ 246,819**	**0.60%**	No change.
	Medical Transportation	2.17%	0.00%	$ 721,771	1.91%	$ -	0.00%	**$ 721,771**	**1.75%**	Part A allocation reduced due to estimated YR 33 expenditures
	Outreach Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Psychosocial Support Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	New Buddy Program is supported using EHE funds.
	Referral	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Rehabilitation	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Respite Care	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Substance Abuse Residential	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Treatment Adherence Counseling	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Overall Total			**$ 37,826,696**		**$ 3,308,121**		**$ 41,134,817**		
	Admin			**$ 4,298,488**		**$ 367,569**		**$ 4,666,057**		
	CQM			**$ 859,698**		**$ -**		**$ 859,698**		
				$ 42,984,882		**$ 3,675,690**		**$ 46,660,572**		

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Recommendations for Service Category Rankings
For Program Years (PY) 33 and 34

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1	1	1	Housing	S	Housing
			Permanent Support Housing		
			Transitional Housing		
			Emergency Shelters		
			Transitional Residential Care Facilities (TRCF)		
			Residential Care Facilities for the Chronically Ill (RCFCI)		
2	2	2	Non-Medical Case Management	S	Non-Medical Case Management Services
			Linkage Case Management		
			Benefit Specialty		
			Benefits Navigation		
			Transitional Case Management		
			Housing Case Management		
3	3	3	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
			Medical Subspecialty Services		
			Therapeutic Monitoring Program		
4	4	4	Emergency Financial Assistance	S	Emergency Financial Assistance
5	5	5	Psychosocial Support Services	S	Psychosocial Support Services
6	6	6	Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
7	7	7	Mental Health Services	C	Mental Health Services
			MH, Psychiatry		
			MH, Psychotherapy		

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
8	8	8	Outreach Services	S	Outreach Services
			Engaged/Retained in Care		
9	9	9	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
10	10	10	Early Intervention Services	C	Early Intervention Services
11	11	11	Medical Transportation	S	Medical Transportation
12	12	12	Nutrition Support	S	Food Bank/Home Delivered Meals
13	13	13	Oral Health Services	C	Oral Health Care
14	14	14	Child Care Services	S	Child Care Services
15	15	15	Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
16	16	16	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
17	17	17	Health Education/Risk Reduction	S	Health Education/Risk Reduction
18	18	18	Home Based Case Management	C	Home and Community Based Health Services
19	19	19	Home Health Care	C	Home Health Care
20	20	20	Referral	S	Referral for Health Care and Support Services
21	21	21	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
22	22	22	Language	S	Linguistics Services

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
23	23	23	Medical Nutrition Therapy	C	Medical Nutrition Therapy
24	24	24	Rehabilitation Services	S	Rehabilitation Services
25	25	25	Respite	S	Respite Care
26	26	26	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27	27	27	Hospice	C	Hospice

Footnote:
1 – Service rankings approved 9/09/2021
2 – PY 33 & 34 Executive Committee Recommendations approved 11/16/2021 and Executive Committee Approved 12/09/2021

LOS ANGELES COUNTY COMMISSION ON HIV

2024 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly & Alvaro Ballesteros
Committee Adoption Date:	Revision Dates:

GOAL: To focus and prioritize key activities for Planning, Priorities and Allocations Committee for 2024
Objective: Reduce the number of new HIV and STD infections while increasing HIV care outcomes for PLWH in LA County.

#	TASK	ACTIVITIES/DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Achieve consensus and a common vision of how to conduct planning, priority, setting and resource allocations (PSRA) using a status neutral approach.	1. Develop status neutral PSRA process document by building upon paradigms, values, priority populations, and identifying ways to complement/enhance funded RW services categories to create stronger, more integrated prevention services.	January - February	• Weave in service needs discussions around priority areas such as housing, mental health, substance use, and STDs and resources available **Resources:** Target HIV slides/webinar recording, NYC speakers, COH Comprehensive HIV Prevention and Care Framework, Prevention Planning Workgroup
2	Use status neutral PRSA process to prepare for FY 25, 26, 27 Ryan White funding cycle and grant application. Use agreed upon status neutral PRSA process to prepare HRSA grant application.	1. Utilize agreed upon status neutral PSRA process to plan for the RWP and CDC grant applications. 2. Review unmet need estimates report from DHSP. 3. Identify additional data needed to inform planning process. 4. Develop status neutral programmatic elements to include in grant applications.	May - December	Target months may change depending on when Notices of Funding Opportunity are released. **Resources:** NOFO, unmet need estimates, service utilization report for prevention and care programs/services,

LOS ANGELES COUNTY COMMISSION ON HIV

2024 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		5. Harness input from Caucuses, workgroups, and Committees. 6. Incorporate a status neutral lens within program directives.		
3	Conduct Community Listening Sessions with RWP consumers, providers, and high-risk populations	1. Conduct regional Community Listening Sessions regarding HIV and STI prevention and care services. 2. Identify successes and challenges to HIV and STI prevention and care services. 3. Utilize information gathered to inform PSRA process and program directives.	January - April	**Resources:** Community Listening Session discussion items, questionnaires, and analyses
4	Monitor the implementation of the CHP	1. The Committee will work with DHSP and various partners to implement and monitor progress toward meeting the goals and objectives of the CHP. 2. Develop progress report.	ongoing	**Resources:** CHP and EHE plans, DHSP updates, County departments, CDPH,
ONGOING ACTIVITIES				
	1. Continue to track expenditures and service needs as reallocation RW and CDC funding as needed. 2. Continue to monitor status of program directives, service utilization, Part A, MAI, and other funding sources. 3. Continue to collaborate with PPW to strengthen integrated prevention and care planning. 4. Monitor and discuss systems of care changes and impact on care and prevention planning.			

ORAL HEALTH SERVICES
GENERAL AND SPECIALTY ORAL CARE

BACKGROUND

As a Ryan White Program (RWP) Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives grant funds from the Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB) to increase access to core medical and related support services for people living with HIV (PLWH)[1]. The amount of the award is based on the number of PLWH residing in LAC. DHSP receives additional funding from HRSA-HAB to reduce disparities in health outcomes among persons of color living with HIV through the Minority AIDS Initiative (MAI) and discretionary funds from the LAC Department of Public Health (net county costs [NCC]). DHSP received a total of $45.9 million from HRSA-HAB in fiscal year 2022 that included $42.1 million for Part A and $3.8 million for MAI.

HRSA-HAB and the Centers for Disease Control and Prevention (CDC) require that local HIV planning bodies develop integrated HIV prevention plans in collaboration with the health department to guide prevention and care efforts within the jurisdiction[2]. HIV surveillance and supplemental surveillance along with program service data and unmet need estimates are used to identify priority populations of focus. In LAC, the populations of focus overlap with priority populations identified in the local "Ending the HIV Epidemic" strategic plan and shown in bold[3]. These include:

1. **Latino Cisgender Men Who Have Sex with Men (MSM)**
2. **Black Cisgender MSM**
3. **Cisgender Women of Color**
4. **Transgender Persons**
5. **Youth Aged 13-29**
6. PLWH ≥ Age 50
7. **Persons Who Inject Drugs (PWID)**
8. RWP Clients Who Were Unhoused

Though not identified as priority populations in the integrated or Ending the HIV Epidemic (EHE) plans, we include RWP clients 50 years of age and older and those experiencing homelessness as an important subpopulation living with HIV with need for RWP services in LAC.

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[1] Ryan White HIV/AIDS Programs Parts & Initiatives. (2022). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/about/parts-and-initiatives

[2] Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026.(2021). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf

[3] Ending the HIV Epidemic Plan for Los Angeles. (2021). In lacounty.hiv. Retrieved July 19, 2023, from https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

This report series summarizes utilization of medical and support services by RWP clients in Contract Year 32 (March 1, 2022-February 28, 2023) to inform the planning and allocation activities of the LAC Commission on HIV (COH). To inform focused discussion, we will present services in the following service clusters:

1. Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services
2. Mental Health and Substance Abuse (Residential) services
3. Housing, Emergency Financial Assistance (EFA), and Nutrition Support (NS) services
4. **General and Specialty Oral Health services**
5. Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

The data presented is intended to provide priority highlights of who is accessing RWP services in LAC (demographic and socio-economic characteristics, priority populations), the types of services accessed, funding sources, and how these services are delivered (in-person or telehealth). The detailed source tables are included in the appendix for reference.

Outcomes and Indicators

The following information will be used to describe service utilization and estimate expenditures. Each of the five service clusters will include:

- HIV Care Continuum Outcomes (engagement in care, retention in care (RiC) and viral suppression (VS) among priority populations:
    - Engagement in HIV care =≤1 viral load or CD4 test in the contract year
    - Retention in HIV care =≤2 viral load or CD4 tests at least 90 days apart in the contract year
    - Viral suppression =Most recent viral load test <200 copies/mL in the contract year
- RWP service utilization and expenditure indicators by service category:
    - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
    - Service units per client=Total service units/Number of clients
    - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
    - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

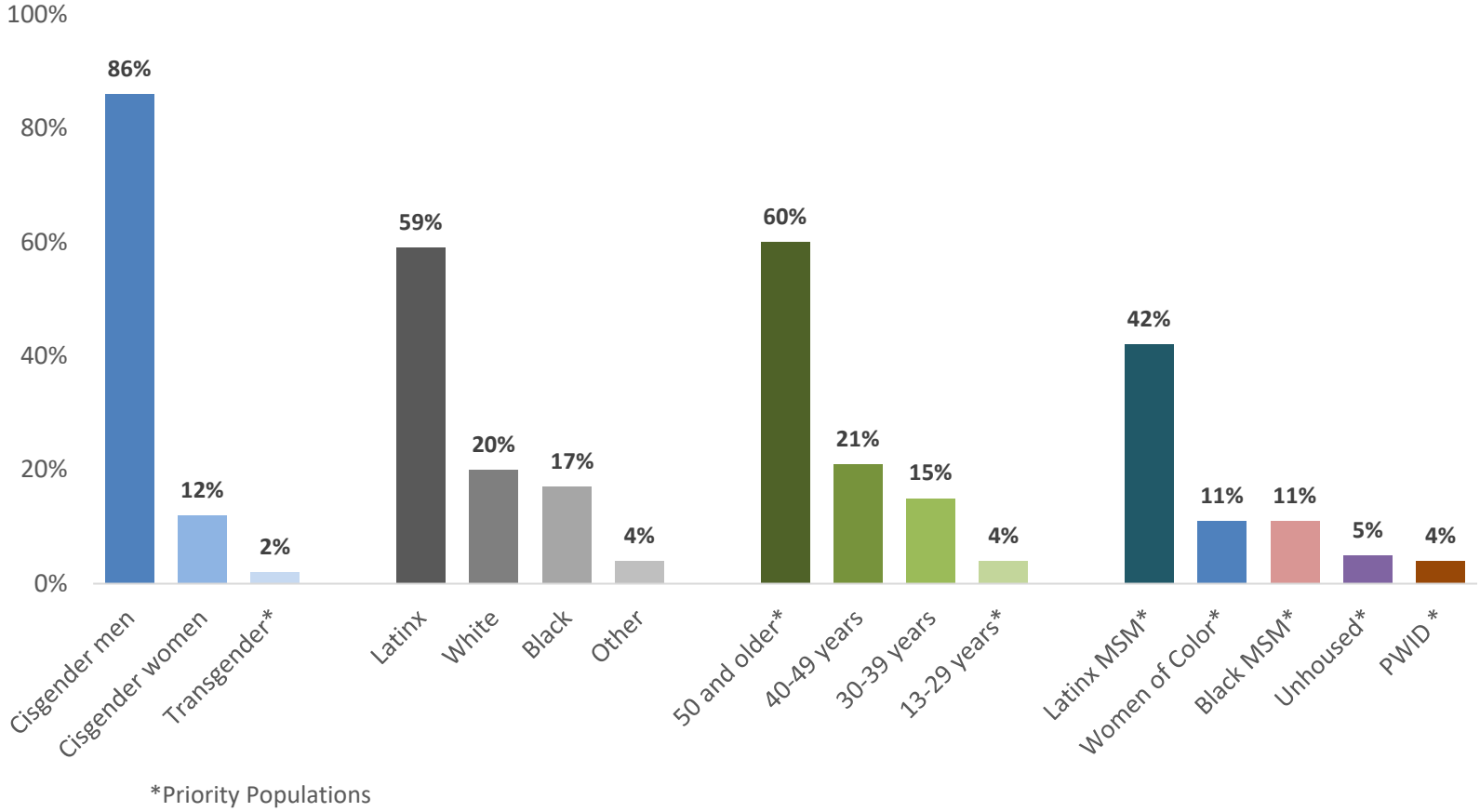
- HIV Casewatch (local RWP data reporting system)
    - Client characteristics and service utilization data reported by RWP contracted service agencies
    - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

ORAL HEALTH SERVICES

Population Served:

- In Year 32, a total of 4,270 clients received Oral Health (OH) Services in Year 32. In LAC this category includes:
  - General Oral Care (GOC) that served 4,001 clients
  - Specialty Oral Care (SOC) that served 3,580 clients
- Most OH Services clients were cisgender men, Latinx, and aged 50 and older (Figure 1)
- Among the priority populations, the largest percent served were PLWH ≥ age 50, followed by Latinx MSM

Figure 1. Key Characteristics of RWP Clients in Oral Health Services in LAC, Year 32

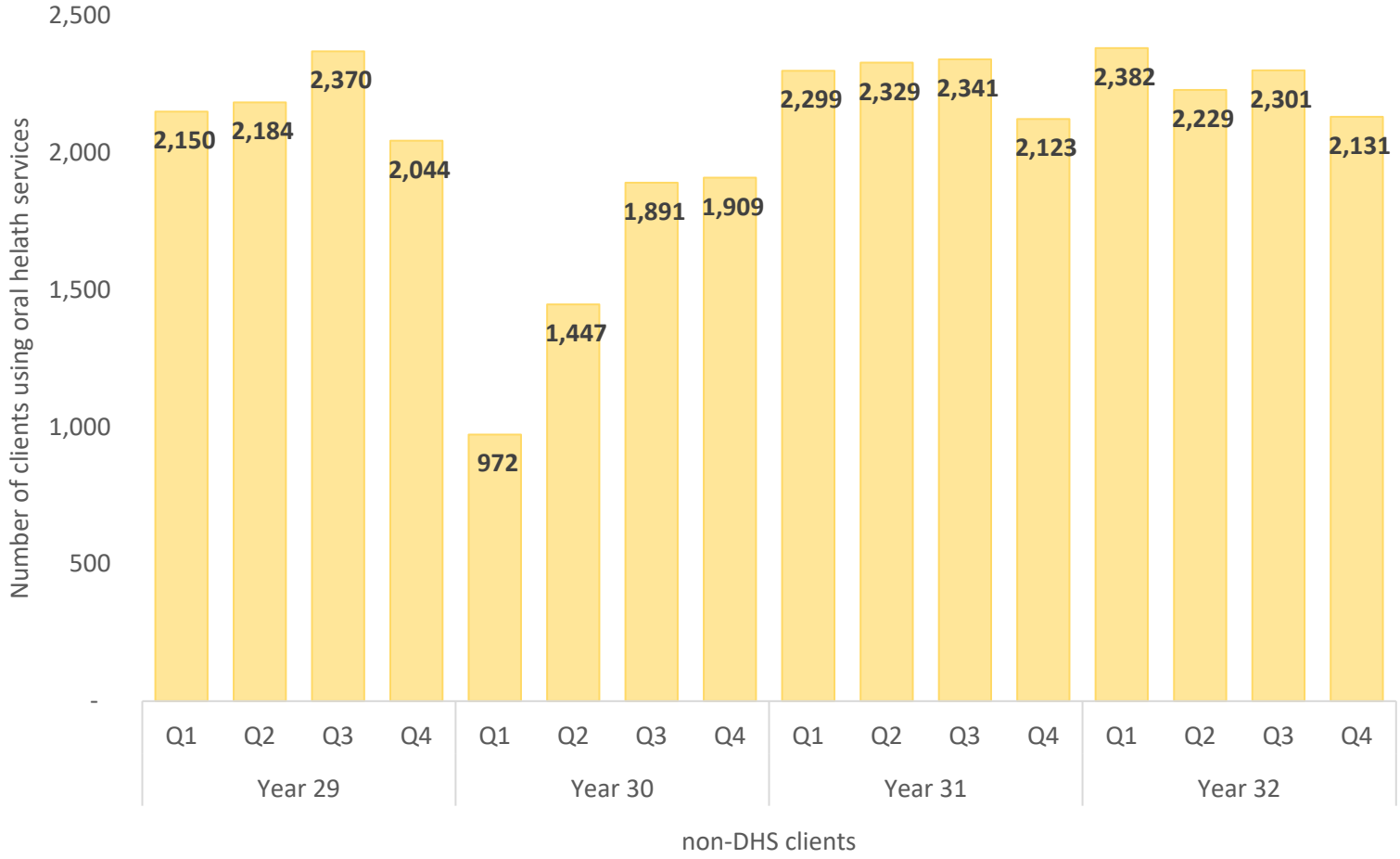


*Priority Populations

Service Utilization

Figure 2 below shows the number of RWP clients accessing Oral Health (OH) services from Year 29 through Year 32 by quarter. The total number of OH clients sharply decreased in Year 30 during the COVID-19 pandemic. The number of OH clients started gradually increase in the second half of Year 30 and continued to increase in Years 31 and 32. All oral health services were provided in-person.

Figure 2. RWP Clients Accessing Oral Health (OH) Services by Quarter in LAC, RWP Years 29-32



Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
  - Expenditures is what DHSP pays for staff time and resources, not for procedures.
- Percentage of RWP Clients Accessing Oral Health services in Year 32: **29%**
- Unit of Service: **Procedures**

Table 1. Oral Health Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total procedures	% of procedures	Procedures per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total Oral Health clients	***4,270***	***100%***	***45,174***	***100%***	***11***	***$1,746***	***$7,456,098***
General Oral Care	*4,001*	*94%*	*28,041*	*62%*	*7*	*$1,360*	*$5,439,733*
Specialty Oral Care	*3,580*	*84%*	*17,133*	*38%*	*5*	*$563*	*$2,016,365*
PLWH ≥ age 50	2,545	60%	27,405	61%	**11**	**$1,777**	$4,523,274
Latinx MSM	1,802	**42%**	20,129	**45%**	**11**	**$1,844**	$3,322,349
Women of Color	483	11%	5,151	11%	**11**	**$1,760**	$850,187
Black MSM	478	**11%**	4,159	**9%**	9	**$1,436**	$686,455
Unhoused in the contract year	223	5%	1,937	4%	9	**$1,434**	$319,707
Persons who inject drugs (PWID)	165	4%	1,717	4%	10	$1,718	$283,396
Youth aged 13-29	156	4%	1,365	3%	9	$1,636	$145,577
Transgender Persons	89	2%	882	2%	10	$1,444	$225,297

Table 1 Highlights

- *Population Served:* The largest number and percent of OH clients were PLWH ≥ age 50 (60%), followed by Latins MSM clients (42%).
- *Service Utilization:*
  - PLWH ≥ age 50 had received most of OH procedures (61%), followed by Latinx MSM (45%).
  - Utilization of procedures per client was the highest among PLWH ≥ age 50, Latinx MSM, and women of color (11 procedures/client each)
  - Procedures per client were the lowest among youth aged 13-29 clients, Black MSM and unhoused in the contract year (9 per client each).
  - The percent of OH procedures was slightly higher relative to their population size among Latinx MSM clients (42% vs 45%).
  - The percent of OH procedures was slightly lower relative to their population size among Black MSM (11% vs 9%).
- *Expenditures:*
  - Expenditure per client were highest among PLWH ≥ age 50, Latinx MSM, and women of color.
  - Expenditures per client were the lowest among clients who were unhoused in the contract year, Black MSM and transgender clients.

HIV Care Continuum (HCC) Outcomes

Table 2 below shows HCC outcomes for RWP clients receiving oral health (OH) services in Year 32. OH clients had substantially higher engagement, retention in care, and viral suppression compared to RWP clients who did not accessing OH service.

Table 2. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use Oral Health Services (OH) in LAC, Year 32

HCC Measures	OH clients		Non-OH clients	
	N=4,270	%	N=10,502	%
Engaged in HIV Care [a]	4,189	98%	9,657	92%
Retained in HIV Care[b]	3,689	86%	6,692	64%
Suppressed Viral Load at Recent Test[c]	4,004	94%	8,273	79%

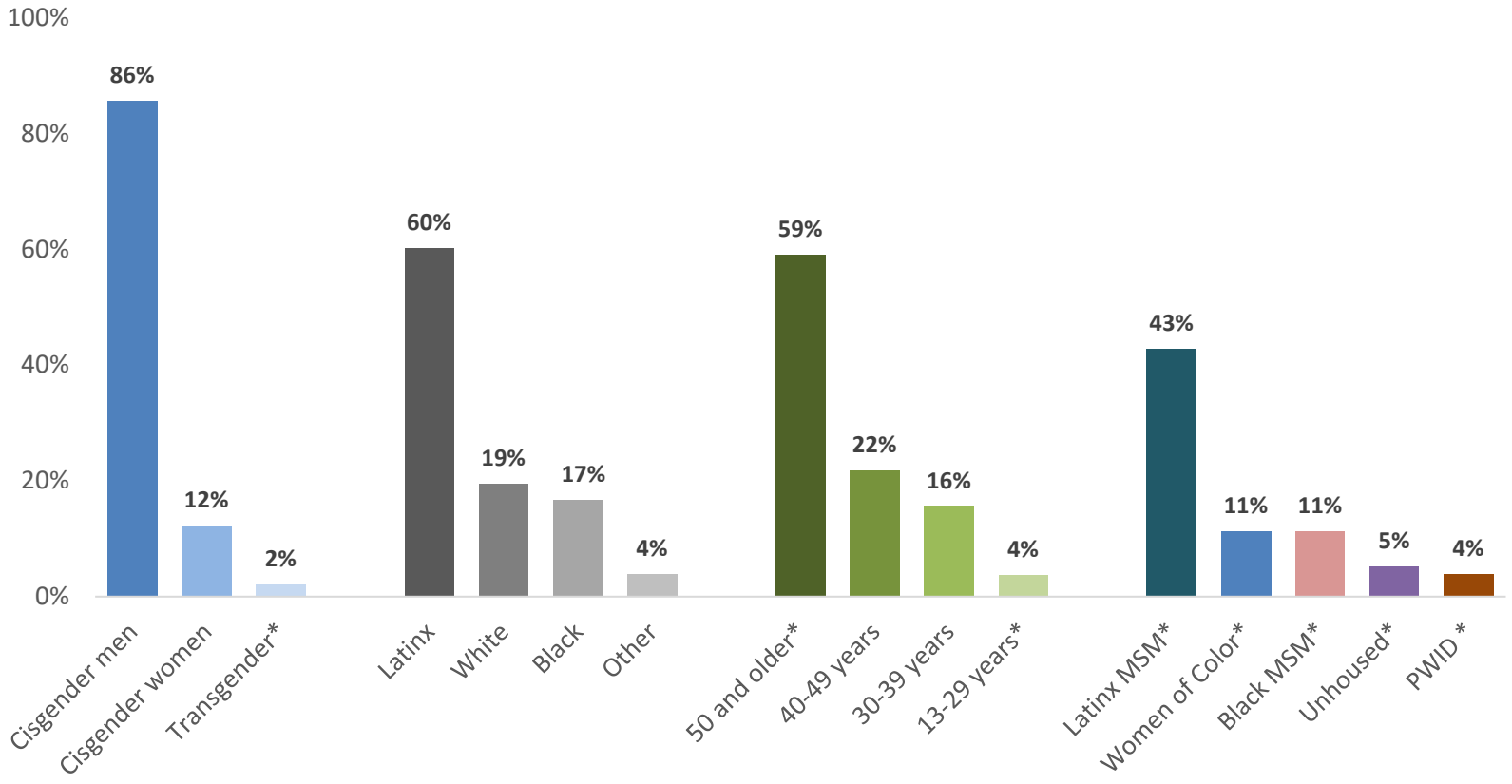
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

GENERAL ORAL CARE SERVICES

Population Served:

- In Year 32, a total of 4,001 clients received general oral Care (GOC) services:
- Most GOC clients were cisgender men, Latinx and Black, and aged 50 and older (Figure 3)
- PLWH ≥ age 50 represented the largest percent among priority populations (59%), followed by Latinx MSM (43%).

Figure 3. Demographic Characteristics and Priority Populations among General Oral Care Clients in LAC, Year 32

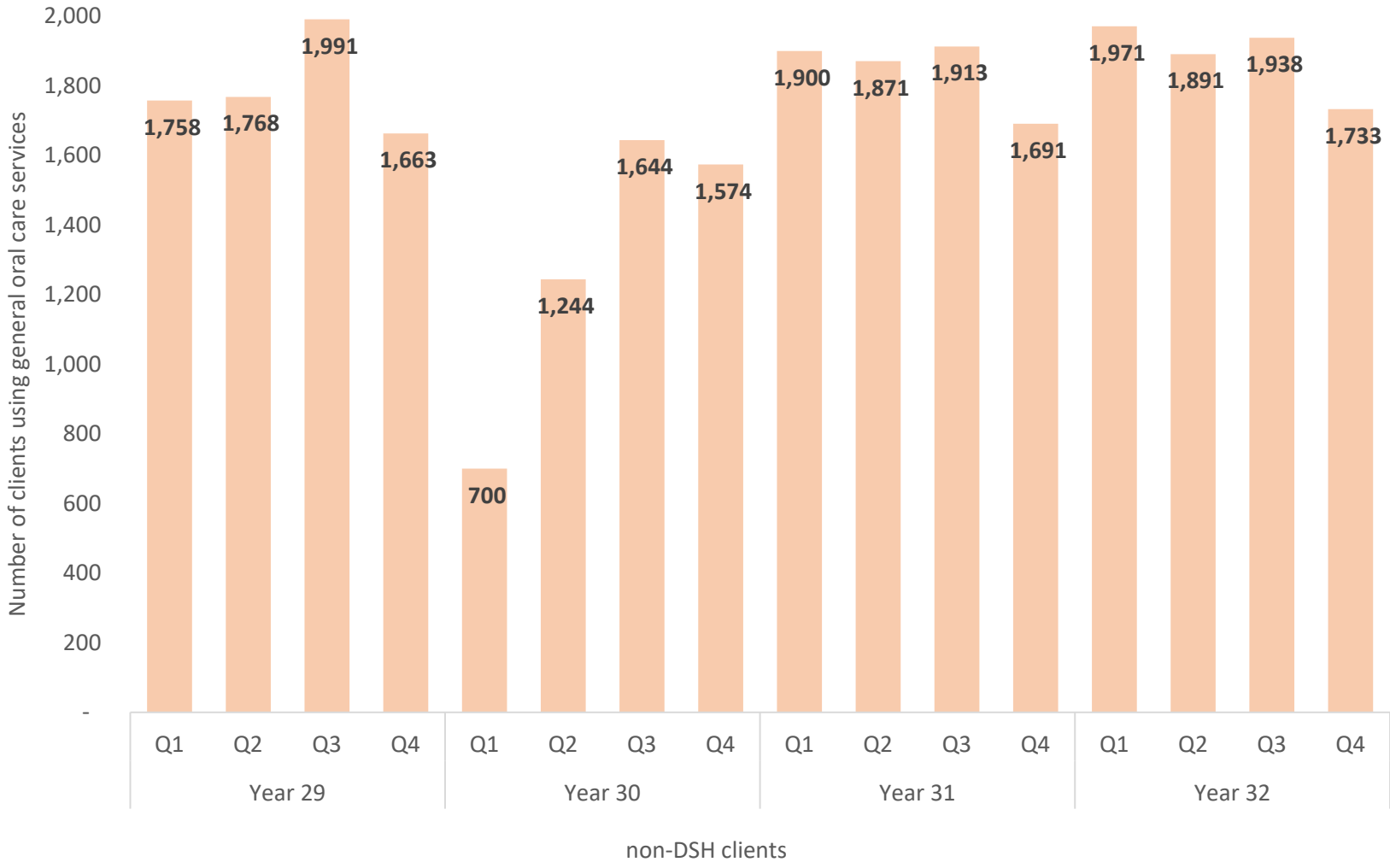


*Priority Populations

Service Utilization

The figure below presents the number of clients using general oral care (GOC) services from Year 29 through Year 32 by quarter. The total number of GOC clients sharply decreased in Year 30 during the COVID-19 pandemic. In the second part of Year 30 the number of GOC clients started to increase gradually and continued to increase in Years 31 and 32. All general oral care services were provided in-person.

Figure 4. RWP Clients Accessing General Oral Care (GOC) Services by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
  - Expenditures is what DHSP pays for staff time and resources, not for procedures.
- Percentage of RWP Clients Accessing GOC in Year 32: **27%**
- Unit of Service: **Procedures**

Table 3. General Oral Care Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Unique Clients	% of Clients	Total Procedures	% of Procedures	Procedures per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
General Oral Care	***4,001***	***100%***	***28,041***	***100%***	***7***	***$1,360***	***$5,439,733***
PLWH ≥ age 50	2,362	59%	16,713	60%	7	$1,374	$3,245,315
Latinx MSM	1,713	**43%**	12,955	**46%**	**8**	**$1,469**	$2,515,590
Women of Color	451	11%	3,349	12%	7	**$1,442**	$650,306
Black MSM	446	**11%**	2,554	**9%**	**6**	**$1,112**	$495,933
Unhoused in the contract year	206	5%	1,188	4%	6	**$1,120**	$230,685
Persons who inject drugs (PWID)	152	4%	1,005	4%	7	$1,284	$195,150
Youth aged 13-29	147	4%	866	3%	6	$1,144	$168,159
Transgender Persons	83	2%	592	2%	7	$1,385	$114,954

Table 3 Highlights

- *Population Served:* Most GOC clients were PLWH ≥ age 50 (59%), followed by Latinx MSM (43%) Year 32.
- *Service Utilization:*
  - PLWH ≥ age 50 and Latinx MSM received the highest number and percentage of GOC procedures.
  - Procedures per client were the highest among Latinx MSM compared to all GOC clients and other subpopulations.
  - Per client utilization was lowest among Black MSM, youth aged 13-29, and clients who were unhoused in the contract year.
  - The percent of GOC procedures was slightly higher relative to the populations size among Latinx MSM (43% vs 46%).
  - The percent of GOC procedures was slightly lower relative to the population size among Black MSM client (11% vs 9%).
- *Expenditures:*
  - Per client expenditures were highest Latinx MSM ($1,469), followed by women of color ($1,442).
  - Black MSM and unhoused in the contract year clients had the lowest expenditures per client ($1,112 and $1,120, respectively).

HIV Care Continuum (HCC) Outcomes

Table 4 below compares HCC outcomes for RWP clients who did and did not access GOC services in Year 32. A larger percent of clients in GOC were engaged in care, retained in care, and achieved viral suppression compared to those clients not using GOC services.

Table 4. HIV Care Continuum Outcomes for RWP Clients That Used General Oral Care and Did Not Use Oral Health Services in LAC, Year 32

HCC Measures	GOC clients		Non-OH clients	
	N=4,001	Percent	N=10,502	Percent
Engaged in HIV Care[a]	3,933	98%	9,657	92%
Retained in HIV Care[b]	3,469	87%	6,692	64%
Suppressed Viral Load at Recent Test [c]	3,764	94%	8,273	79%

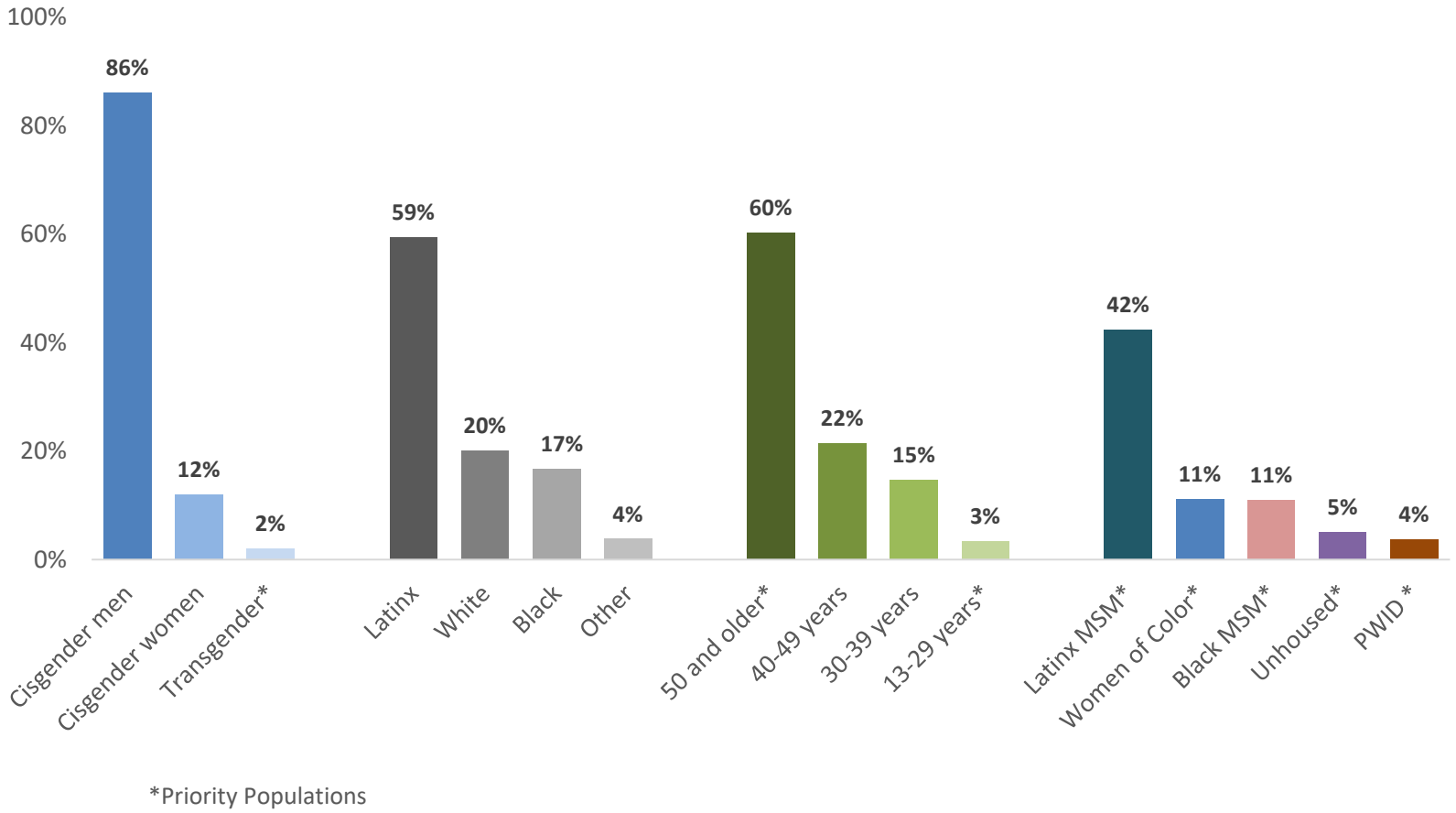
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

SPECIALTY ORAL CARE SERVICES

Population Served:

- In Year 32, a total of 3,580 clients received Specialty Oral Care (SOC) services.
- Most SOC clients were cisgender men, Latinx and Black, and PLWH ≥ age 50 (Figure 5).
- PLWH ≥ age 50 represented the largest percent among priority populations (60%), followed by Latinx MSM (42%).

Figure 5. Demographic Characteristics and Priority Populations among Specialty Oral Care Service Clients in LAC, Year 32

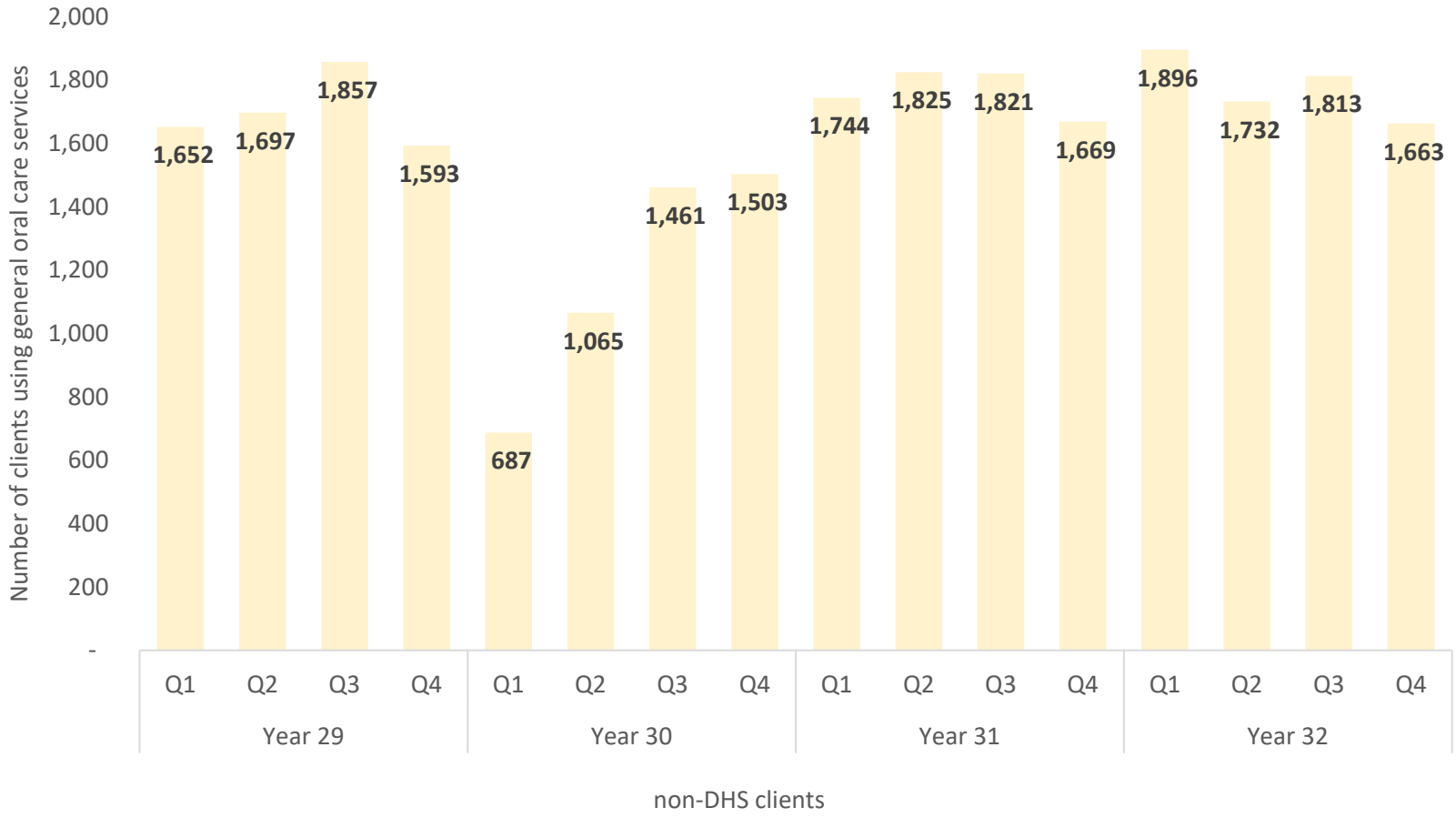


*Priority Populations

Service Utilization

The figure below presents the number of clients using specialty oral care (SOC) services from Year 29 through Year 32 by quarter. The total number of SOC clients sharply decreased in Year 30 during the COVID-19 pandemic. In the second part of Year 30 the number of SOC clients started gradually increase and continued to increase in Year 31 and 32. All specialty oral care services were provided in-person.

Figure 6. RWP Clients Accessing Specialty Oral Care (SOC) Services by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
  - Expenditures is what DHSP pays for staff time and resources, not for procedures.
- Percentage of RWP Clients Accessing SOC services in Year 32: **24%**
- Unit of Service: **Procedures**

Table 5. Specialty Oral Care Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Unique Clients	% of Clients	Total Procedures	% of Procedures	Procedures per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Specialty Oral Care	***3,580***	***84%***	***17,133***	***100%***	***5***	***$563***	***$2,016,365***
PLWH ≥ age 50	2,362	59%	16,713	60%	7	$509	$1,202,952
Latinx MSM	1,713	**43%**	12,955	**46%**	**8**	**$544**	$932,463
Women of Color	451	11%	3,349	12%	7	**$534**	$241,051
Black MSM	446	**11%**	2,554	**9%**	**6**	**$412**	$183,829
Unhoused in the contract year	206	5%	1,188	4%	6	**$415**	$85,509
Persons who inject drugs (PWID)	152	4%	1,005	4%	7	$476	$72,337
Youth aged 13-29	147	4%	866	3%	6	$424	$62,332
Transgender Persons	83	2%	592	2%	7	$513	$42,610

Table 5 Highlights

- *Population Served:* Most SOC clients were PLWH ≥ age 50 (59%), followed by Latinx MSM (43%) Year 32.
- *Service Utilization:*
  - PLWH ≥ age 50 and Latinx MSM received the highest number and percentage of GOC procedures.
  - Procedures per client were the highest among Latinx MSM compared to all GOC clients and other subpopulations.
  - Per client utilization was lowest among Black MSM, youth aged 13-29, and clients who were unhoused in the contract year.
  - The percent of GOC procedures was slightly higher relative to the populations size among Latinx MSM (43% vs 46%).
  - The percent of GOC procedures was slightly lower relative to the population size among Black MSM client (11% vs 9%).
- *Expenditures:*
  - Per client expenditures were highest among Latinx MSM ($544), followed by women of color ($534).
  - Black MSM and unhoused in the contract year clients had the lowest expenditures per client ($412 and $415, respectively).

HIV Care Continuum (HCC) Outcomes

Table 6 below compares HCC outcomes for RWP clients who did and did not use NS services in Year 32. A larger percent of clients in NS services were engaged in care, retained in care, and achieved viral suppression compared to those clients not using NS services.

Table 6. HIV Care Continuum Outcomes for RWP Clients That Used Specialty Oral Care and Did Not Use Oral Health Services in LAC, Year 32

HCC Measures	SOC clients		Non-OH clients	
	N=3,580	Percent	N=10,502	Percent
Engaged in HIV Care[a]	3,509	98%	9,657	93%
Retained in HIV Care[b]	3,092	86%	6,692	69%
Suppressed Viral Load at Recent Test [c]	3,364	94%	8,273	83%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

Overlap of Oral Health Services Provided

General and Specialty Oral Care services are not mutually exclusive. To explore the degree of overlap across GOC and SOC services in Year 32, a cross tabulation was constructed (Table 7). Among GOC clients, approximately 83% also accessed SOC. Among SOC clients, nearly 93% also accessed GOC.

Table 7. Cross tabulation of RWP Clients Received General and Specialty Oral Care Services in LAC, Year 32

Count *% of row population*	**General Oral Health**	**Specialty Oral Health**
General Oral Health	*4,001*	3,311 83%
Specialty Oral Health	3,311 93%	*3,580*

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 8.

Table 8. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Main client population served	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to AOM, MCC, and MH services stopping at DHS sites • However, number of clients at remaining agencies was steady	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) Numbers of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) Number of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32.	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) • Number of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32
Service units per client	N/A (units vary)	• Procedures	• Procedures	• Procedures
Total expenditures	$45.9 million	• $7,456,098 (Part A) • $1,746 per client	• $5,439,733 (part A) • $1,360 per client	• $2,016,365 (Part A) • $ 563 per client
HCC outcomes	• HCC outcomes were higher among RWP clients compared to PLWH in LAC	HCC outcomes were higher among OH (including GOC and SOC) clients compared to clients not accessing those services		

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Latinx MSM	• The second largest priority population in RWP (38%) • Largest percent of uninsured clients	• Second largest priority population (42%) and accounted for about 45% of services provided • Highest number of OH procedures per client • Highest expenditure per client	• Second largest priority population (43%) and accounted for 46% of GOC services provided • Highest number of GOC procedures per client • Highest expenditure per client	• Second largest priority population (43%) and accounted for 46% of SOC services provided • Highest number of SOC procedures per client • Highest expenditure per client
Black MSM	• About 15% of RWP clients • Over 2/3 living ≤ FPL	• Represented 11% of HS clients and only 9% of services provided • Lowest number of procedures per client • Lowest expenditures per client	• Represented 11% of HS clients and only 9% of GOC services provided • One of lowest number of GOC procedures per client • Lowest expenditures per client	• Represented 11% of HS clients and only 9% of SOC services provided • One of lowest number of SOC procedures per client • Lowest expenditures per client
Youth 13-29 years old	• 11% of RWP clients • The lowest percent of RiC among priority populations	• The second smallest population by number and percent of clients • The second lowest percent of procedures from the total and procedures per client	• The second smallest population by number and percent of GOC clients • One of lowest numbers of GOC procedures per client • The third lowest expenditures per client	• The second smallest population by number and percent of SOC clients • One of lowest numbers of SOC procedures per client • The third lowest expenditures per client
PLWD ≥ age 50	• 43% of RWP clients • The highest percent of RiC and VS and the second highest percent of engagement among priority populations • The highest percent of PWID • Second highest percent of unhoused in the contract year	• Highest utilizers of OH services across categories by percent of clients (~ 60%) and services provided (~ 60%) • Second highest expenditures per client	• Expenditures per client slightly higher than the average for all GOC clients.	• Expenditures per client lower than the average for all SOC clients.
Women of color	• 9% of RWP clients • The highest percent of engagement in care • The second highest percent of RiC among priority populations	• Represented 11% of OH clients and same percent of services provided • The third highest per client number of days and expenditures	• Represented 11% of GOC clients and 12% of services provided • The second highest per client number of procedures and expenditures	• Represented 11% of SOC clients and 12% of services provided • The second highest per client number of SOC procedures and expenditures

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Transgender clients	• 3% of all RWP clients • Highest percent of clients unhoused in the contract period • Second largest percent of people living ≤ FPL	• Represented the smallest number and percent of OH clients (2%) and services provided (2%)		
		• Per client expenditure much lower than overall average and the third lowest among priority populations	• Per client expenditure slightly higher than overall average for GOC clients	• Per client procedures slightly higher than average for all SOC clients • Per client expenditures lower than overall average for SOC clients
Unhoused in the contract year	• 12% of all RWP clients • Largest percent of clients living ≤ FPL and PWID	Similar utilization of OH services across categories by clients who were unhoused in the contract year: • Represented 5% percent of clients and 4% of OH services provided		
		• Lowest per client expenditures among priority populations	• The second lowest per client expenditures among priority populations	• The second lowest per client expenditures among priority populations
PWID	• 4% of RWP clients • Second highest percent of clients unhoused in the contract year	Similar utilization of OH services across categories of clients who are PWID: • Represented 4% percent of OH clients and 4% services provided		
		• Slightly lower number of OH procedures per client than the average for all OH clients	• Slightly lower expenditures per client than the average for all GOC clients	• Per client procedures slightly higher than average for all SOC clients • Lower expenditures per client than the average for all SOC clients

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YR 33 AND PART B YR 33 EXPENDITURES BY RWP SERVICE CATEGORIES
Expenditures reported by December 5, 2023

1	2	3	4	5	6	7	8	9	10
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 3,258,491	$ -	$ 3,258,491	$ 5,879,947	$ -	$ 5,879,947	$ -	$ -	$ 3,258,491
MEDICAL CASE MGMT (Medical Care Coordination)	$ 5,545,556	$ -	$ 5,545,556	$ 10,060,657	$ -	$ 10,060,657	$ -	$ -	$ 5,545,556
ORAL HEALTH CARE	$ 4,192,938	$ -	$ 4,192,938	$ 7,421,917	$ -	$ 7,421,917	$ -	$ -	$ 4,192,938
MENTAL HEALTH	$ 73,645	$ -	$ 73,645	$ 208,964	$ -	$ 208,964	$ -	$ -	$ 73,645
EARLY INTERVENTION SERVICES	$ 2,259,753	$ -	$ 2,259,753	$ 2,752,478	$ -	$ 2,752,478	$ -	$ -	$ 2,752,478
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 1,479,038	$ -	$ 1,479,038	$ 2,697,882	$ -	$ 2,697,882	$ -	$ -	$ 1,479,038
CHILD CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 909,768	$ -	$ 909,768	$ 1,425,340	$ -	$ 1,425,340	$ -	$ -	$ 909,768
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 276,839	$ 276,839	$ -	$ 276,839	$ 276,839	$ -	$ -	$ 276,839
HOUSING-RCFCI, TRCF	$ 336,381	$ -	$ 336,381	$ 360,299	$ -	$ 360,299	$ 2,129,907	$ 4,239,220	$ 2,466,288
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,765,535	$ 1,765,535	$ -	$ 2,855,147	$ 2,855,147	$ -	$ -	$ 1,765,535
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	$ 456,225	$ 670,000	$ 456,225
MEDICAL TRANSPORTATION	$ 299,713	$ -	$ 299,713	$ 460,470	$ -	$ 460,470	$ -	$ -	$ 299,713
LANGUAGE SERVICES	$ 3,300	$ -	$ 3,300	$ 5,198	$ -	$ 5,198	$ -	$ -	$ 3,300
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 1,801,956	$ -	$ 1,801,956	$ 3,741,136	$ -	$ 3,741,136	$ -	$ -	$ 1,801,956

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 33 AND PART B YR 33 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by December 5, 2023

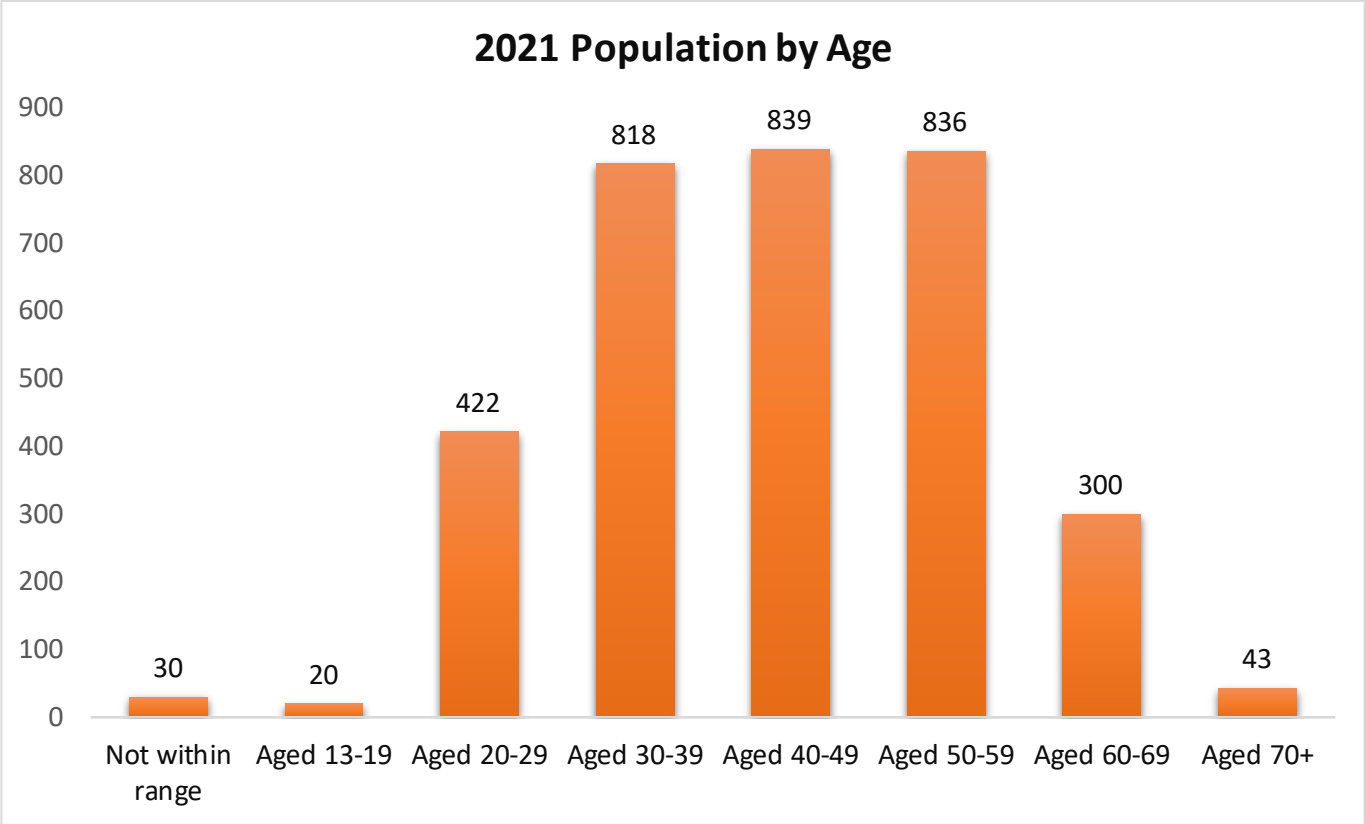
EMERGENCY FINANCIAL ASSISTANCE	$ 1,265,056	$ -	$ 1,265,056	$ 2,045,472	$ -	$ 2,045,472	$ -	$ -	$ 1,265,056
LEGAL	$ 323,213	$ -	$ 323,213	$ 537,628	$ -	$ 537,628	$ -	$ -	$ 323,213
SUB-TOTAL DIRECT SERVICES	$ 21,748,808	$ 2,042,374	$ 23,791,182	$ 37,597,388	$ 3,131,986	$ 40,729,374	$ 2,586,132	$ 4,909,220	$ 26,870,039
YR 33 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 2,853,518	$ 179,782	$ 3,033,300	$ 4,298,488	$ -	$ 4,298,488	$ 278,420	$ 537,589	$ 3,311,720
YR 33 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 282,855	$ -	$ 282,855	$ 713,795	$ -	$ 713,795	$ -	$ -	$ 282,855
TOTAL EXPENDITURES	$ 24,885,181	$ 2,222,156	$ 27,107,337	$ 42,609,671	$ 3,131,986	$ 45,741,657	$ 2,864,552	$ 5,446,809	$ 30,464,614
TOTAL GRANT AWARD				**$ 42,984,882**	**$ 3,675,690**	**$ 46,660,572**		**$ 5,446,809**	
VARIANCE				$ (375,211)	(543,704)			0	
MAI Carryover from YR 32 to YR 33	$ 685,010								
Estimated MAI Carryover from YR 33 to YR 34	$ 1,603,925								

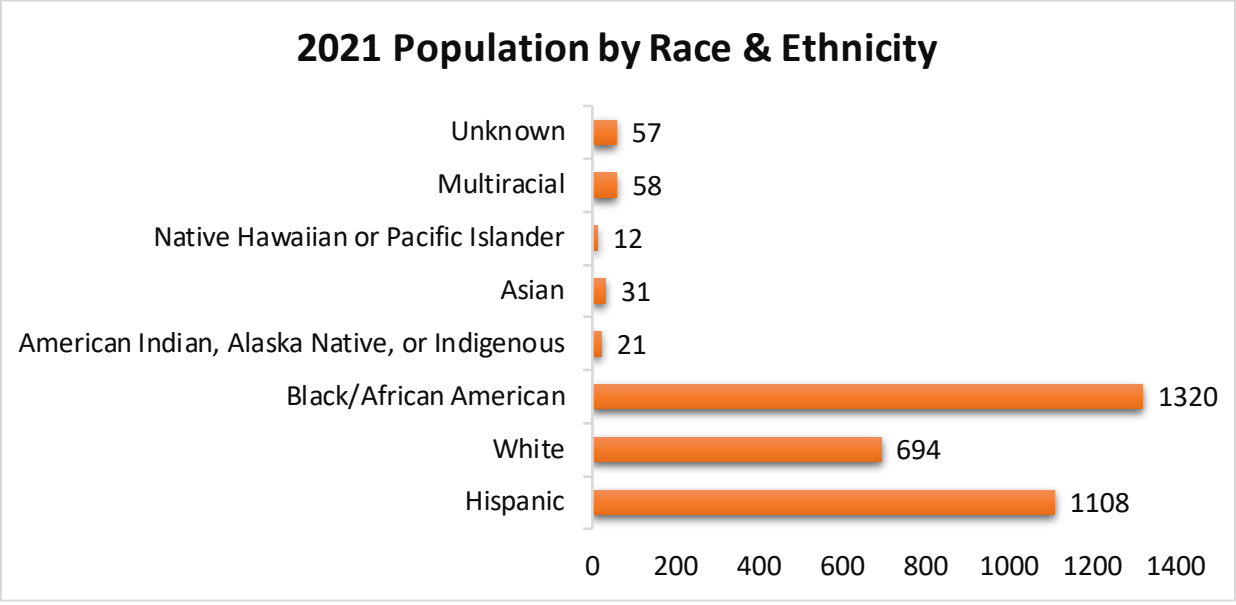
LOS ANGELES COUNTY COMMISSION ON HIV

Planning, Priorities, and Allocations Committee

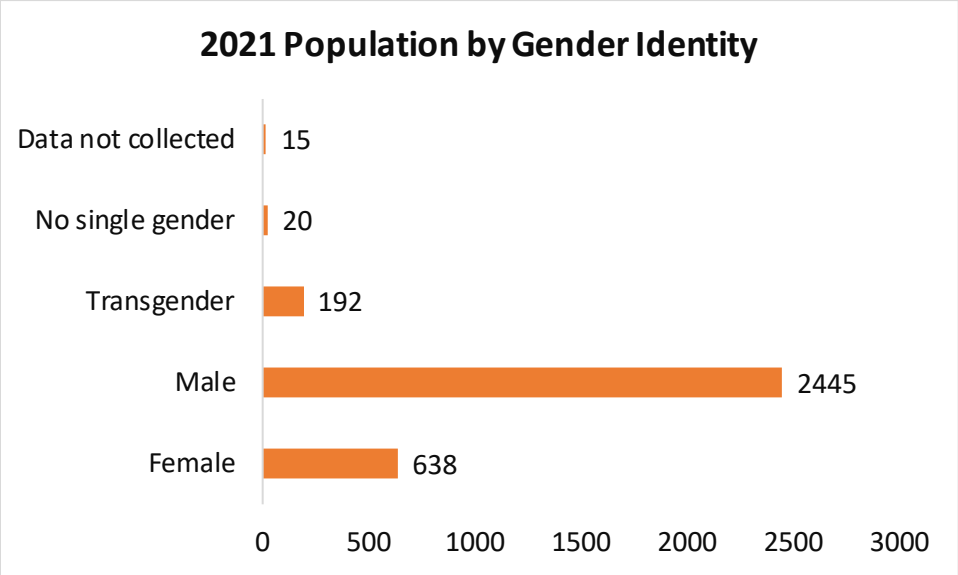
Los Angeles Housing Services Authority (LAHSA) Report 2023

Year 2021 – 3,419 Total PLWH

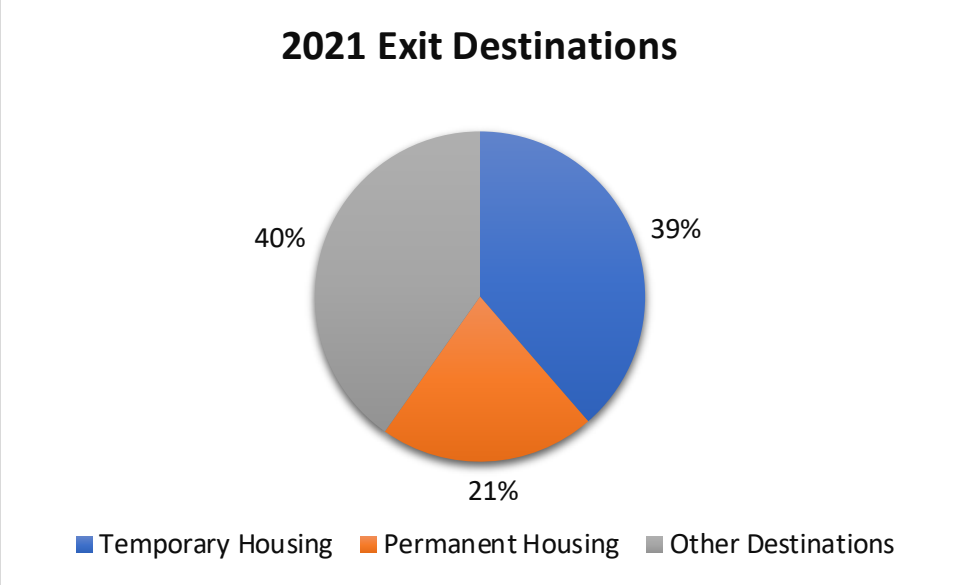




Unknown – includes if client refused to answer, if client did not know, or if data was not collected



Housing Services – 502 PWLH left LAHSA system

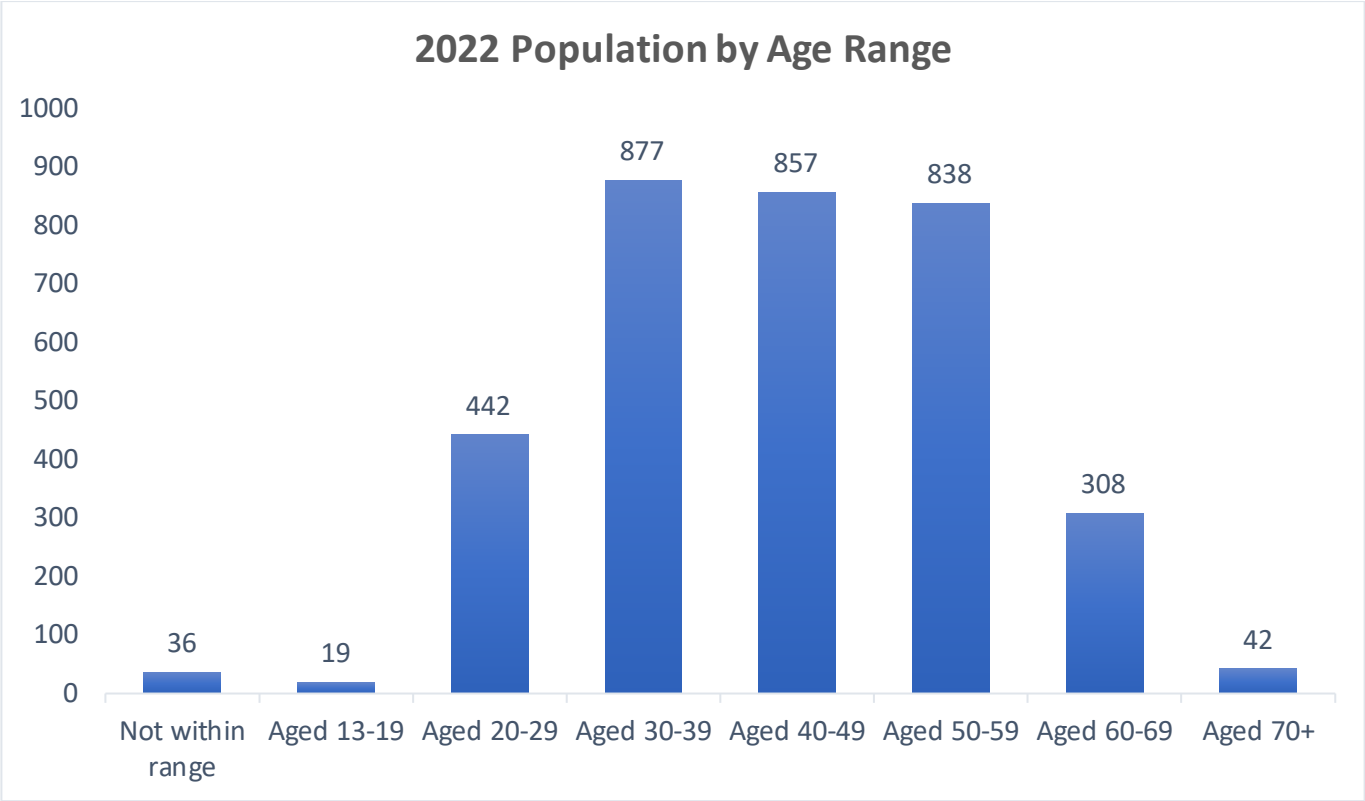


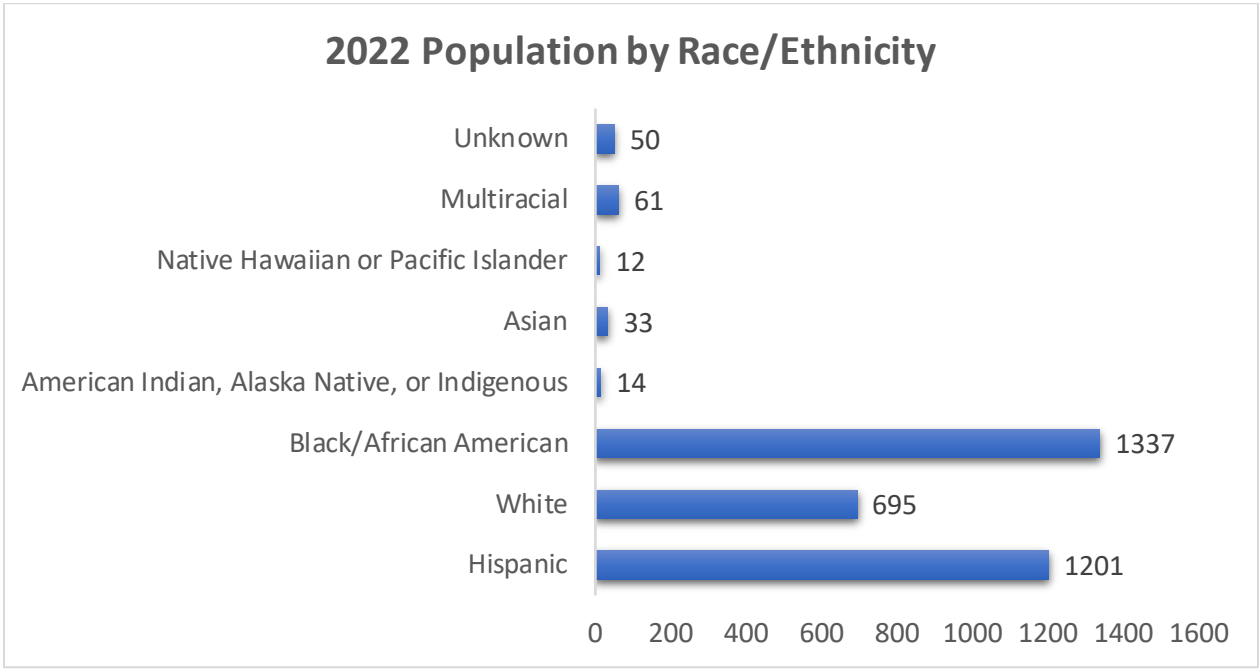
Permanent Situation – includes rental with or without subsidy, permanent tenure with friends or family, among other items

Temporary Situation – includes emergency shelters, hotels or motels paid for with a voucher, foster care, jail, temporary tenure with friends or family, among other items

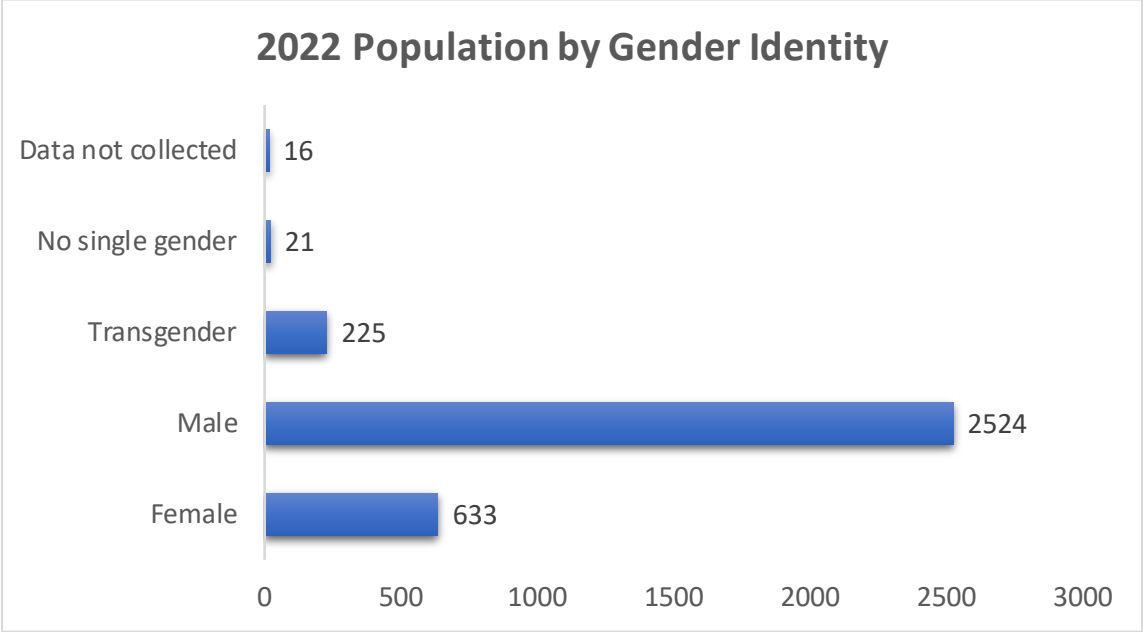
Other Destinations – is used in situations when the data isn't collected, the client refuses, or the client is deceased

Year 2022 - 3,310 Total PLWH





Unknown – includes if client refused to answer, if client did not know, or if data was not collected



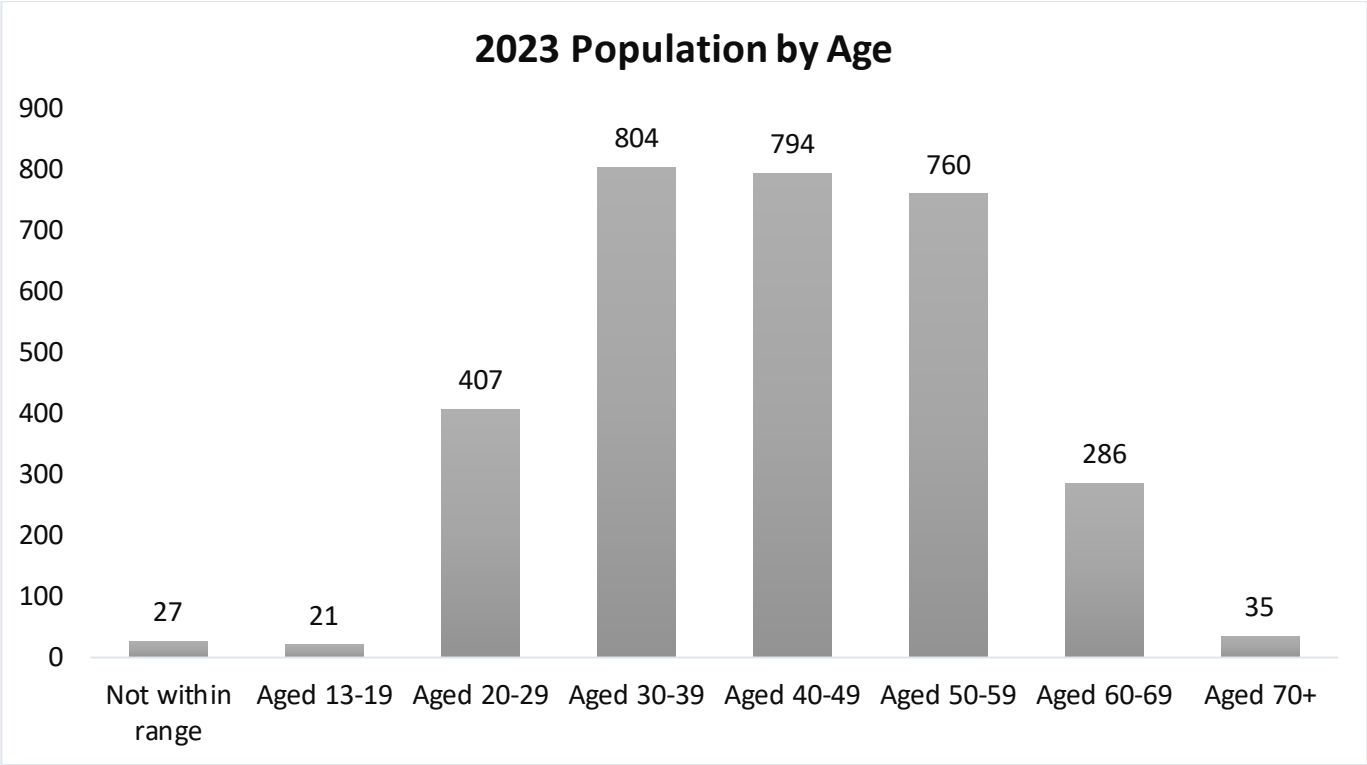
Housing Services – 438 PWLH left LAHSA system

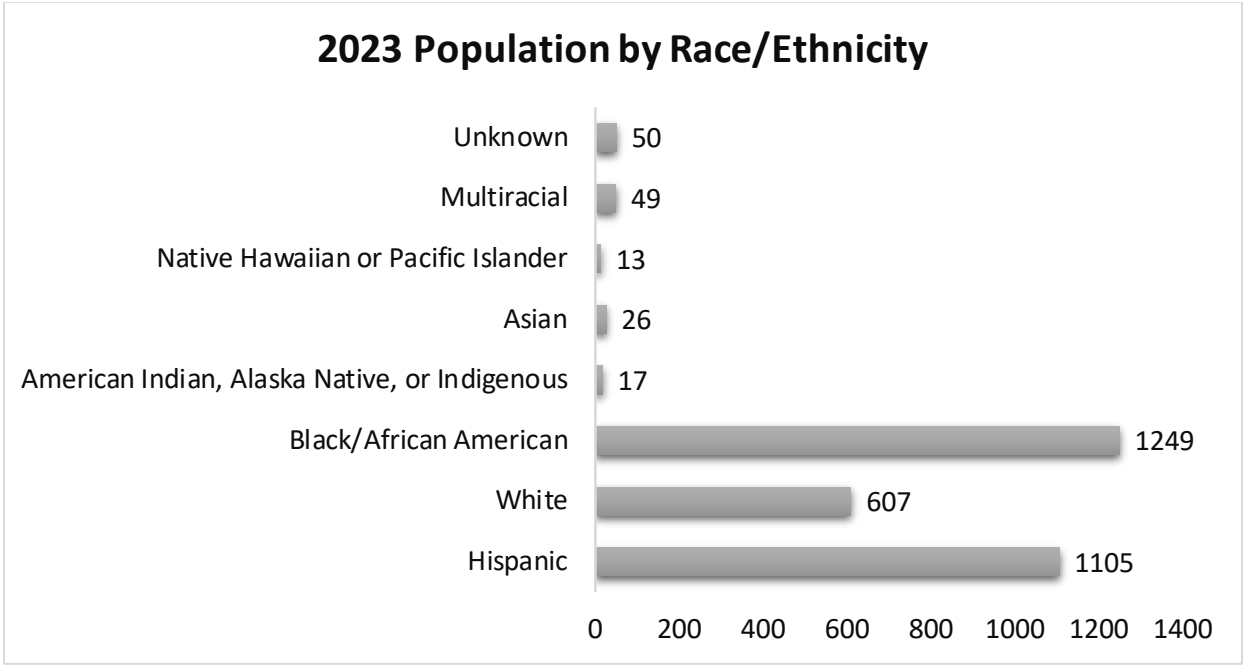
Permanent Situation – includes rental with or without subsidy, permanent tenure with friends or family, among other items

Temporary Situation – includes emergency shelters, hotels or motels paid for with a voucher, foster care, jail, temporary tenure with friends or family, among other items

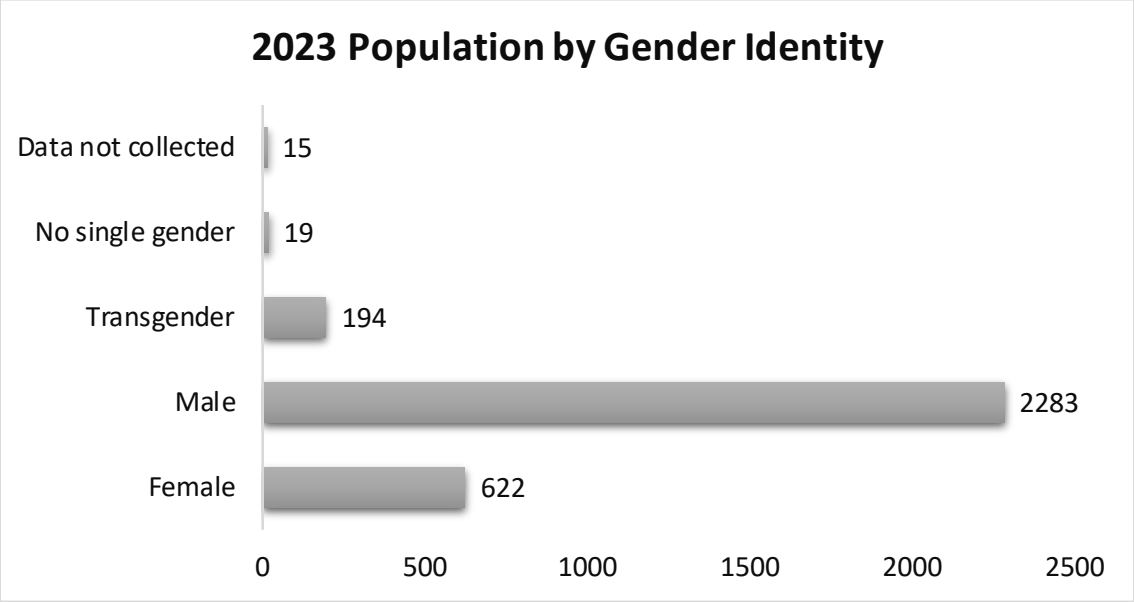
Other Destinations – is used in situations when the data isn't collected, the client refuses, or the client is deceased

Year 2023 (through August 2023) – 3,133 Total PLWH

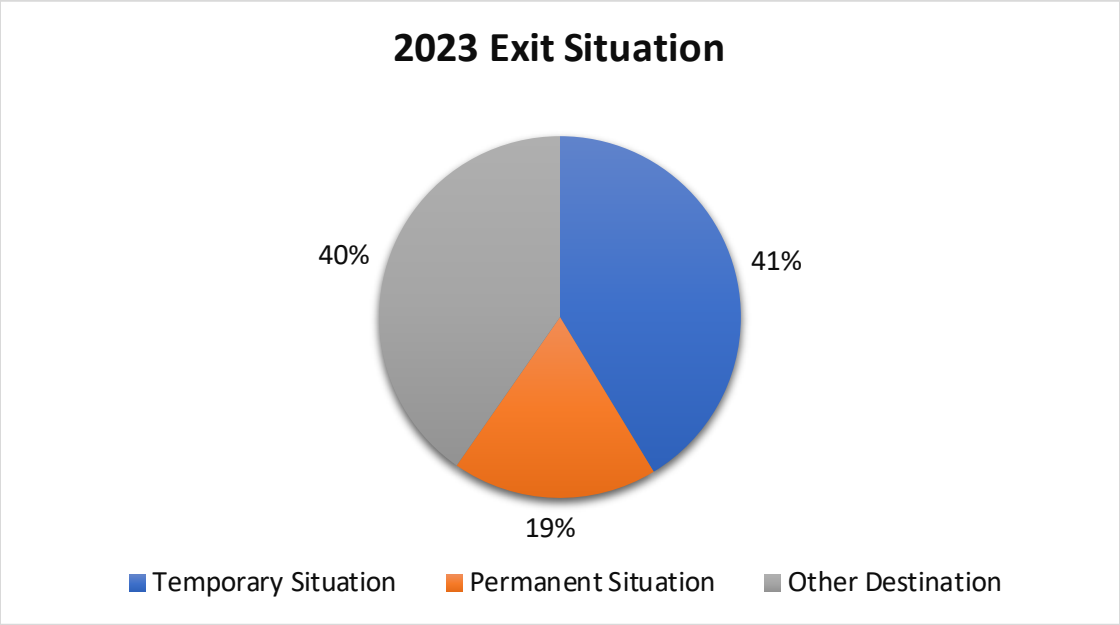




Unknown – includes if client refused to answer, if client did not know, or if data was not collected



Housing Services – 438 PWLH left LAHSA system



Permanent Situation – includes rental with or without subsidy, permanent tenure with friends or family, among other items

Temporary Situation – includes emergency shelters, hotels or motels paid for with a voucher, foster care, jail, temporary tenure with friends or family, among other items

Other Destinations – **i**s used in situations when the data isn't collected, the client refuses, or the client is deceased

What are you seeing as key areas of needs for PLWH engaged in the LAHSA service system? What resources are available to PLWH under the LAHSA service system?

Funding can be utilized to fund shelter beds that are specifically for PLWH. We are not aware of any targeted resources available under the LAHSA services systems for PLWHA. An area of need is would be having our Rehousing System Providers trained in the Best Practices to serve PLWH and of the extent of available Housing and Harm Reduction resources available within PLWH Services System.

How can the County coordinate better with LAHSA to leverage some of the ideas articulated in the letter?

Some useful resources would be funding case managers that specifically are educated and aware of resources available for PLWH and having buy-in and involvement from upper management and leadership across county departments to prioritize or target shelter, permanent housing and supportive services resources for this population.

April 12, 2023

Dear Recipients:

In recent years, numerous HIV outbreaks among people experiencing homelessness and housing instability have been identified[i]. Housing status is a social determinant of health that has a significant impact on HIV prevention and care outcomes. The experiences of homelessness and housing instability are linked to higher viral loads and failure to attain or sustain viral suppression[ii] among people with HIV. The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) clients with unstable or temporary housing have lower levels of viral suppression than those with stable housing (77.3% clients versus 90.8%) clients [iii]. Homelessness and housing instability are also associated with increased vulnerability for HIV acquisition. Stable housing provides a foundation from which people can participate in HIV prevention services and is associated with reductions in behaviors associated with getting or transmitting HIV[iv].

The National HIV/AIDS Strategy for the United States (2022-2025) sets a bold target to decrease homelessness and housing instability for people with HIV by 50 percent. The Strategy also calls for improved coordination among federal, state, and local governments and community-based organizations to quickly detect and respond to HIV outbreaks[v]. As such, the Centers for Disease Control and Prevention (CDC) Division of HIV Prevention, the U.S. Department of Housing and Urban Development (HUD) Office of HIV/AIDS Housing (OHH), and HRSA's HIV/AIDS Bureau (HAB) have partnered on recent responses to HIV outbreaks among people experiencing homelessness and housing instability.

Based on the lessons learned through our joint outbreak response efforts, CDC, HUD, and HRSA encourage communities to take the following actions to effectively prepare for and respond to these outbreaks:

- Health departments and housing providers should integrate and assess HIV prevention, care, and housing data on individuals impacted by outbreaks to

determine the extent to which they are experiencing homelessness or housing instability and to identify gaps and coordinate service delivery to improve housing stability and health outcomes.

- Personnel involved with outbreak response should assess HIV prevention, care, and treatment needs and leverage all available resources to establish integrated models of service delivery that meet people where they are.
- Individuals engaged in local outbreak response efforts should identify and leverage housing resources to assist people experiencing homelessness and housing instability in their community in addition to those available through HUD's Housing Opportunities for Persons With AIDS (HOPWA) program. Although HOPWA is a critical housing program for people with HIV, current funding does not meet the need for housing services for this population. In addition, HOPWA is unable to serve people who do not have HIV. Information on non-HOPWA housing resources can be found in the attached APPENDIX Federal Support for Housing Services and HIV Outbreak Response.
- Housing providers should implement Housing First and other low-barrier housing models that offer flexibility, individualized support, and client choice in the provision of housing assistance and supportive services, including integration with substance use disorder services.
- Housing providers should explore shared housing arrangements to foster social connection, decrease housing costs, and expand available units to people with HIV and those without HIV who need prevention services.
- Housing providers should use grant funds for housing navigator positions to partner with HIV prevention and care outreach workers to provide linkage and referrals to housing programs and resources for people experiencing homelessness or housing instability.

These recommendations are based on experiences in communities with HIV outbreaks among people experiencing homelessness and housing instability. In these communities, people with HIV may also experience a variety of additional challenges, including substance use, mental health disorders, other infectious and non-infectious diseases, incarceration, food insecurity, unemployment, trauma and loss, and stigma[vi]. Some communities experienced difficulties in responding to these outbreaks due to a lack of low-barrier or Housing First housing options, including insufficient options for people with a history of incarceration or people who actively use injection drugs. Another barrier to HIV prevention efforts was limited capacity for substance use disorder services. In addition, the jurisdictions reported a need for flexible housing assistance models to serve those at different

stages of homelessness or housing instability, regardless of their HIV status, to transition to safe, stable housing with social support.

The lessons learned from these recent outbreak response efforts underscore the need for ongoing collaboration among state and local public health, healthcare, housing, and social services providers to prepare for and respond to HIV outbreaks, reduce HIV transmission, and improve HIV care and viral suppression outcomes. In at least two of these communities, Homeless Management Information System (HMIS) data provided important insights to HIV surveillance staff in identifying needs and guiding efforts to determine eligibility for and link people to appropriate housing and services as available.

In all the communities that experienced outbreaks, the assessment of service gaps played a critical role in addressing both immediate and long-term service needs. State and local health departments worked with service providers to expand service delivery, including co-location of services, training and capacity development at sites, and the establishment of new partnerships with trusted providers in the community. Many of these activities can be done before an outbreak occurs, as identifying gaps and developing new models of service delivery strengthen the overall system of care for all people regardless of HIV status.

As we work to end the HIV epidemic, collaboration among public health, healthcare, housing, and social services providers is critical for effective detection and response to outbreaks and the prevention of future outbreaks among people experiencing homelessness or housing instability. Community efforts to provide safe and stable housing, reduce new HIV infections, and increase access to care and support for people with HIV, are necessary in order to achieve the goals of the National HIV/AIDS Strategy and the Ending the HIV Epidemic in the U.S. (EHE) Initiative. We look forward to our continued federal collaboration and work with our state and local partners to take actions to end the HIV epidemic in the United States.

Sincerely,

/Jonathan Mermin/
Jonathan H. Mermin, MD, MPH
Rear Admiral and Assistant Surgeon General, USPHS
Director

National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

/Jemine A. Bryon/
Jemine A. Bryon
Deputy Assistant Secretary
Office of Special Needs
Housing and Urban Development

/Laura Cheever/
Laura Cheever, MD, ScM
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration

APPENDIX
Federal Support for Housing Services and HIV Outbreak Response

HUD

It is especially important that HUD-funded organizations engage in HIV outbreak response efforts to house and stabilize people with HIV and people who do not have HIV but would benefit from prevention services. Grant funding under HUD's Housing Opportunities for Persons With AIDS (HOPWA) program can be used to support a range of housing assistance types and supportive services for low-income people with HIV and their families. Grant funding under HUD's Continuum of Care (CoC) and Emergency Solutions Grants (ESG) programs can be used to provide emergency, transitional, and permanent housing, outreach, and supportive services to individuals and families experiencing homelessness who are either HIV-positive or those who need HIV prevention services. In addition, these programs can fund housing search activities for eligible individuals and families.

The HOPWA, CoC, and ESG programs allow for shared housing arrangements where one or more individuals or households agree to share the space and cost of a permanent rental housing unit. The benefits of shared housing models include increased social connection and decreased isolation, reduced housing costs, and opportunity to access better housing options. These programs also promote the adoption of Housing First principles by funded housing providers, which include having few programmatic prerequisites, low-barrier admission policies, quick and successful connection to permanent housing, proactively offered but voluntary supportive services, and a focus on housing stability.

HUD staff and technical assistance (TA) providers can offer guidance and support to communities encountering an HIV outbreak among people experiencing homelessness or housing instability. Individuals engaged in outbreak detection and response efforts should contact their local HUD Office of Community Planning and Development (CPD), which can provide information and facilitate connections to local housing and service providers and can coordinate with Office of HIV/AIDS Housing and other HUD staff to provide guidance and technical assistance to assist with outbreak response efforts on the HUD Exchange TA portal. HMIS Privacy and Security Standards: Emergency Data Sharing for Public Health or Disaster Purposes includes information for communities covered under HMIS Privacy and Security Standards of the capabilities and limitations of sharing client information during public health or disaster emergencies.

As people of color are overrepresented in both the HIV epidemic and in the numbers of people experiencing homelessness, HUD recognizes the need for communities to better understand and address these issues. The Racial Equity page on the HUD Exchange website includes resources, data toolkits, and research reports related to identifying disparities and implementing responses to address the overrepresentation of people of color in the homeless system.

Congress appropriated significant additional resources to HUD to help communities respond to COVID-19 and the resulting economic crisis, including funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan (ARP) that are being utilized to address homelessness and housing instability. The HOPWA and ESG programs were allocated supplemental grant funds under the CARES Act that communities may use for COVID-19 preparedness and response activities, including rental assistance, homelessness prevention, and supportive services for people with HIV and people experiencing homelessness. ARP funding is being administered through HUD's HOME Investment Partnerships (HOME) program and has the purpose of assisting individuals or households who are homeless or at risk of homelessness and other vulnerable populations by providing housing, rental assistance, supportive services, and non-congregate shelter, to reduce homelessness and increase housing stability.

HRSA

RWHAP funding can be used for a variety of support services, including housing, that help people with HIV stay in HIV care and treatment. RWHAP recipients determine which services to fund depending on community needs and resources. The allowable support services, such as housing, can help bridge gaps that exist in the current services and help limited resources stretch further.

The RWHAP AIDS Education and Training Center (AETC) Program provides training that is critical to capacity development in areas experiencing an HIV outbreak or at risk for an outbreak. Available training includes HIV testing, preexposure prophylaxis (PrEP), HIV treatment, and integrating mental health and substance use treatment into HIV care, as well as other topics that can help address service needs. Communities have been able to successfully expand HIV care and treatment in non-traditional settings that have resulted in integrated models, such as one-stop shops.

In 2017, HRSA and HUD released a joint statement to funded organizations encouraging the sharing of data across systems to better coordinate and integrate

medical and housing services for people with HIV. In 2019, the agencies released a toolkit for service providers with best practices for sharing data and improving service coordination.

The Bureau of Primary Health Care's (BPHC) National Health Care for the Homeless Program supports community-based organizations to provide high-quality, accessible health care, including HIV prevention services, to people experiencing homelessness.

CDC

CDC's Division of HIV Prevention provides technical assistance and support for responding to HIV clusters and outbreaks. CDC support can include assistance with epidemiologic analysis and interpretation, connection with peers across the country doing similar work, identification of promising best practices and innovative delivery of prevention activities, and assistance with planning and implementing response activities for specific clusters or outbreaks. Organizations with needs or interests related to HIV outbreak response in their community should contact their state or local health department, who can facilitate collaboration with CDC as needed.

CDC also funds a Capacity Building Assistance (CBA) Provider Network to provide free CBA services to state and local health departments, community-based organizations, and healthcare organizations to support their implementation of high-impact HIV prevention initiatives. Providers can provide support in several areas, including addressing social determinants of health, HIV services for disproportionately impacted populations, such as those experiencing homelessness or unstable housing, and cluster detection and response. More information on each organization funded can be found in the CBA Provider Service Directory. Additionally, online, virtual, and in-person trainings are available, including a training on homelessness for public health providers.

CDC funds state and local health departments to implement evidence-based, high-impact programs to improve access to HIV and other health and social services; this includes a range of activities related to detecting and responding to HIV clusters and outbreaks. CDC also prioritizes hearing from and collaborating with people with HIV through roundtables, town halls, and ongoing community listening sessions focused on issues that intersect with HIV and affect health outcomes, including housing.

Through the Ending the HIV Epidemic in the U.S. Initiative (EHE), CDC funds 32 state and local health departments to implement locally tailored and integrated solutions to meet the unique needs of their communities, including flexibilities to use funds to support housing. CDC also funds over 100 community-based organizations and their clinical partners to deliver comprehensive HIV services to communities disproportionately affected by HIV. In addition, CDC supports the Housing Learning Collaborative, a virtual learning community to build capacity of EHE jurisdictions to develop and implement innovative programs to respond to housing-related needs. CDC published an issue brief on the role of housing in Ending the HIV Epidemic and federal efforts to address housing and HIV more broadly.

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