LOS ANGELES COUNTY
COMMISSION ON HIV

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Transgender Caucus

Virtual Meeting

Be a part of the HIV movement

Tuesday, September 28, 2021
10:00AM-12:00PM (PST)

Agenda and meeting materials will be posted on

REGISTRATION NOT REQUIRED + SIMUTANEOUS TRANSLATION IN SPANISH AND OTHER LANGUAGES NOW AVAILABLE VIA CLOSED CAPTION FEATURE WHEN JOINING VIA WEBEX. CLICK HERE FOR MORE INFO.

TO JOIN BY COMPUTER: ****registration is not required***

https://tinyurl.com/4rb9mjpw

Meeting password: TRANSGENDER

TO JOIN BY PHONE:

+1-213-306-3065

Access Code/Event #: 2597 883 2722

For a brief tutorial on how to use WebEx, please check out this video: https://www.youtube.com/watch?v=iQSSJYcrglk

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LOS ANGELES COUNTY
COMMISSION ON HIV

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TRANSGENDER CAUCUS (TG)
VIRTUAL MEETING AGENDA

TUESDAY, SEPTEMBER 28, 2021
10:00 AM – 12:00 PM

TO JOIN BY COMPUTER
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mf32224131b9f9280e381e9c93d4d12fe

MEETING PASSWORD: TRANSGENDER
TO JOIN BY PHONE: +1-213-306-3065 **MEETING #/ACCESS CODE:** 2597 883 2722

1. Co-Chairs Report
2. Executive Director/Staff Report
   a. Operational updates
   b. Best Practices Development for Prevention and Care
3. Public Policy Item – Update
   a. AB 453 – Sexual battery: nonconsensual condom removal
4. Transmasculine Health Study
5. Strengthening the Transgender Caucus – Discussion
6. Training | Priority Setting and Resource Allocation Process
7. Meeting Confirmation and Agenda Development for Next Meeting
8. Announcements
9. Adjournment

LOS ANGELES COUNTY
COMMISSION ON HIV

Transgender Caucus Workplan 2021
Updated 9-14-21

PURPOSE OF THIS DOCUMENT: To identify activities and priorities the Consumer Caucus will lead and advance throughout 2021.
PRIORITIZATION CRITERIA: Select activities that 1) represent the core functions of the COH and Caucus, 2) advance the goals of the local Ending the HIV (EHE) Plan, and 3) align with COH staff and member capacities and time commitment.
CAUCUS RESPONSIBILITIES: 1) Facilitate dialogue among caucus members, 2) develop caucus voice at the Commission and in the community, 3) provide the caucus perspective on various Commission issues, and 4) cultivate leadership within the caucus membership and consumer community.

#	Activities & Lead/Champion(s)	Priority Level (High, Medium, Low)	Approach/Comments/Target Deadline
1	Track implementation and funding for AB2218 (Transgender Wellness Fund)	Ongoing	• Collaborate with TransLatin@ Coalition and Public Policy Committee • Track Governor's Budget for full funding @ $15M • Monitor bill in collaboration with Public Policy
2	Track SB 225 - the Bodily Autonomy, Dignity, and Choice Act	Ongoing	Monitoring bill in collaboration with Public Policy Committee
3	Track AB 453 – Sexual battery: nonconsensual condom removal	~~Ongoing~~	~~Monitoring bill in collaboration with Public Policy Committee.~~ Bill passed.
4	Integrate mini training at all meetings on how decisions are made on the Commission. Keep training as a standing meeting agenda item.	Ongoing	Training topics: ~~Commission overview/committee functions and relationship with caucuses;~~ priority setting and resource allocation process; service standards development; Ryan White Care system vs other HIV funding streams; understanding housing services, systems, and funding streams; other topics as determined by Caucus members.
5	Monitor implementation of the DHSP Ending the HIV Epidemic Plan; provide feedback. Keep EHE discussion as a standing meeting agenda item.	Ongoing	

6	Collaborate with the Public Policy Committee on policies specific to Transgender issues	Ongoing	

Assembly Bill 453

Stealthing (Nonconsensual Condom Removal)

Assemblymember Cristina Garcia (D – 58)

BACKGROUND

The latest bedroom trend doesn't have to do with a certain position or technique — and it's not sexy at all. Victims say they do not know what to call the assault and courts have not had occasion to address and name the practice.

"Stealthing", a new name for an ancient, sneaky practice, is the nonconsensual intentional removal or tampering with the condom during sexual intercourse and its occurrence is on the rise. If a condom is used there is an expectation that the condom will stay on unless there is explicit consent to take it off. Some realize their partner had removed the condom at the moment of re-penetration; others may not realize until the partner ejaculated, others find out when they test positive for a sexually transmitted disease (STD) or pregnancy, and some may never find out. Regardless of when, or if, the victim learns of this breach of trust, this practice exposes them to physical risks of pregnancy and disease, and is a grave violation of one's dignity and autonomy.

Recently, California Department of Public Health (CDPH) released 2018 data showing that STDs in the state continue to climb and are at the highest levels in 30 years. In the United States alone, there are nearly 20 million cases of new sexually transmitted infections yearly, half among young people aged 15–24, and account for almost $16 billion in health care costs. Each of these infections is a potential threat to an individual's immediate and long-term health and well-being. This is especially true for women who are not only more susceptible to STDs but they also disproportionately bear the long-term consequences of these infections.

First mentioned in an article by Alexandra Brodsky who actually calls this act rape-adjacent, there have been reports of both straight and gay individuals falling victim to this practice. Deeply rooted in centuries of rape culture based on dominance and control, stealthing is gaining attention in the media. In addition, there are online communities who defend stealthing as a "right" and "train" other men about stealthing best practices, and offer support and advice in their pursuit of nonconsensual condom removal during sex. More should be done to protect men and women from this practice.

This Bill

AB 453 amends the Civil Code law under sexual battery to include nonconsensual condom removal. Those who fall victim to this egregious act will be able to seek damages and equitable relief from the other party.

Conclusion

It is 2021 and yet we still live in a world in which rape is prevalent and in which sexual violence is normalized and excused in the media and popular culture. This "rape culture" is perpetuated through the use of misogynistic language, the objectification of bodies on social media, and the glamorization of sexual violence, thereby creating a society that disregards the safety and rights of all individuals. AB 453 takes another step towards ending the rape culture by allowing victims to seek damages from their sexual partner. There has been a lot of discussion on "consent" in a sexual relationship. If a sexual partner agrees to a sexual act with the understanding that a condom will be used and that condom is removed, consent is also removed. This bill will ensure that the victim can seek damages for any medical bills or mental health support required after the encounter.

Status

Senate Appropriations Committee

Contact

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#TransMasculineHealthLA

A Participatory Research Report

TransMasculine Health Justice: Los Angeles

EXECUTIVE SUMMARY

Transmasculine Health Justice: Los Angeles (TMHJ:LA) calls attention to serious health inequities impacting Transmasculine people on Tongva Land (Los Angeles). This report was assembled as part of a research and organizing initiative led by Gender Justice Los Angeles and based on the principles of research justice, healing justice, and collective care. We analyzed findings from the community-generated Transmasculine Sexual Health & Reproductive Justice Survey that engaged 310 participants in Los Angeles County in 2017. This survey remains the single largest effort to understand and respond to inequities facing Transmasculine people in Los Angeles to date.

The health inequities facing Transmasculine people are preventable. Existing inequities are the result of deliberate power structures that impose a gender binary, restrict bodily autonomy, and create dangerous conditions in health care. TMHJ:LA calls for action towards health justice through: community building, cultural organizing, education, policy change, and community-led research. Our report centers Transmasculine Black, Indigenous, People of Color (BIPOC) who experience health inequities at the intersections of transphobia, anti-black racism, colonization, and xenophobia. We imagine and work for a future where all Transgender, Gender non-conforming, and Intersex (TGI) people can age, heal, evolve, thrive and create families and kinship with dignity.

OUR FINDINGS & FRAMEWORKS

FOR ADVANCING HEALTH JUSTICE FOR TRANSMASCULINE PEOPLE IN LOS ANGELES.

Health justice is universal access to health care grounded in the values of informed consent, bodily autonomy, accessibility, and racial and economic justice. Universal access to health care and medical autonomy is a human right.

Gender-affirming care improves health care systems for everyone. Health justice is investing in trauma-informed care and removing assumptions about gender, sexuality, bodies, and risks.

Transforming trauma requires interrupting violence at its roots. Health justice is preventing and responding to the alarming rates of often invisible violence experienced by TGI people by targeting fundamental causes while resisting systems of state control and policing.

Health inequities are preventable. Health justice requires understanding the connection between systems of power and health inequities, and building on this link to provide health care. Health justice means investing in strategies of collective care by and for TGI people.

We are taking action for health justice. TGI people are sharing knowledge and setting the terms of our own care. The health organizing work of TGI people adds to our collective understanding of how we can heal and be cared for.

HEALTH JUSTICE IS UNIVERSAL ACCESS TO HEALTH CARE GROUNDED IN THE VALUES OF INFORMED CONSENT, BODILY AUTONOMY, ACCESSIBILITY, AND RACIAL AND ECONOMIC JUSTICE.

Health care and medical autonomy are a human right. All people should be able to access health care systems and medical treatments equitably and with respect for human dignity. This requires policies and protections that increase safety, choice, and autonomy in accessing health care.

Achieving health justice for Transmasculine people requires undoing legacies and layers of transphobia, racism, xenophobia, sexism, and ableism in medicine and healthcare practices. Ensuring medical autonomy requires rejecting policies that allow mental and medical health care providers to act as gatekeepers over who, when, and how transmasculine people can access treatment.

Transmasculine participants in Los Angeles faced significant economic inequities and many relied on public health insurance due to workforce exclusions and displacement from families and places of origin. Even when Transmasculine people have health care insurance, many do not have access to safe and meaningful care because of the history of medical racism and entrenched binary gender norms in health care services.

In our survey analysis, we found:

- Most participants had low to extremely low incomes with nearly 70% earning less than $36,000 per year. This was despite the fact that 64% of participants (ages 25 and older) had a four-year college degree, a figure that doubles the estimated 32% of the general population (ages 25 and older) with a four-year degree in Los Angeles County.

- About 1 in 10 participants lacked health care insurance altogether, and these participants were disproportionately immigrants to the United States. Only 41% of participants had a health care insurance plan provided by their employer or school. One-third relied on a public health insurance plan (32%) and nearly 20% relied on a parent's or partner's plan. 47% of participants paid out of pocket for one or more forms of gender-affirming care that were not covered by insurance.

- 90% of participants delayed care in the past year with economic factors playing a significant role. Half had delayed care due to a lack of money (50%) and nearly one-third due to a lack of time off work (31%). Other reasons included anxiety related to past traumatic health care experiences (48%), distrust in providers (38%) and fears of mistreatment due to transphobia (45%), mental health stigma (23%), or racism or xenophobia (17% of BIPOC participants).

- Racism is influencing who has access to gender-affirming medical treatment. The majority of participants sought chest reconstructive surgery (88%). Only 37% of BIPOC participants had already accessed chest surgery compared to 61% of white participants.

- Two-thirds had asked a mental health provider for an authorization letter for gender-affirming care (66%). Among those who had asked, only 1 in 4 received a letter in their first appointment; 49% did not feel like the process was helpful in making medical decisions.

TINCTURE
ROMMY TORRICO

GENDER-AFFIRMING CARE IMPROVES HEALTH CARE SYSTEMS FOR EVERYONE.

HEALTH JUSTICE IS INVESTING IN TRAUMA-INFORMED CARE AND REMOVING ASSUMPTIONS ABOUT SEXUALITY, BODIES, AND RISKS.

The two-gender health care system has traumatized many TGI people and institutionalized inequities in research, policy, practice, and life expectancy. Health justice is not just a matter of changing terminology in health care, but about addressing the role of health care systems in contributing to health and reproductive inequities for Transmasculine people, and especially Transmasculine Black Indigenous, People of Color. Providing gender-affirming health care requires radically transforming our health care systems by reorganizing the ways that services are designed and delivered.

Transmasculine participants reported being ignored, turned away, and mistreated in services that health care services, especially those organized as “men’s health” or “women’s health.” This results in more limited access to preventive sexual and reproductive health services including contraceptives, family planning, and HIV prevention.

In our survey analysis, we found:

- Nearly 1 in 3 Transmasculine survey participants in Los Angeles said that their last pelvic exam was “very uncomfortable” and 1 in 5 said they were unlikely to get one in the future.

- Misgendering in health care settings is common. 80% of Transmasculine participants were referred to by the wrong pronouns by a provider in the past 3 years.

- Two-gender health care services create barriers to accessing contraceptives. About 1 in 5 participants had used emergency birth control in their lifetimes (compared to about 1 and 9 in the general population nationally), including 6% who had used emergency contraception in the past year.

- The majority of participants identified as queer (70%) and most had sexual partners of various genders in their lifetime. Recent efforts to focus HIV prevention resources on “trans men who have sex with men" is insufficient and unnecessarily reinforces binary assumptions about gender and health risks. The majority of survey participants said they have had at least one sexual partner that was transgender, nonbinary, gender nonconforming or two-spirit (63%).

- More BIPOC participants indicated an interest in future fertility treatments (15%) compared to white participants (7%). Social, economic, and health care inequities create barriers to gestational parenting. Only 3% of participants had ever given birth.

TRANSFORMING TRAUMA REQUIRES INTERRUPTING VIOLENCE AT ITS ROOTS.

HEALTH JUSTICE IS PREVENTING AND RESPONDING TO THE ALARMING RATES OF INVISIBLE VIOLENCE EXPERIENCED BY TGI PEOPLE WHILE RESISTING SYSTEMS OF STATE CONTROL AND POLICING.

Transmasculine people are rarely seen as survivors of intimate partner, domestic, or sexual violence, or as people in need of support or resources. We must invest in violence prevention efforts led by TGI people. We need transformative justice and healing strategies that interrupt cycles of trauma, violence and health inequities.

Transmasculine participants, especially BIPOC under the age of 18, had experienced extraordinarily high rates of violence. The root causes of these inequities are layered and complex and include: histories of colonization and displacement from families and places of origin; enforced racialized gender roles; shaming, punishment and criminalization of gender non-conforming children and youth; lack of family acceptance; social isolation; and guarded access to services and public resources. Exposure to violence and abuse are associated with higher rates of homelessness and contact with state systems (e.g., child welfare, jails, prisons). Experiences of trauma are often diagnosed and treated as individual psychiatric or behavioral health problems, rather than collective social problems.

In our survey analysis, we found:

- Transmasculine participants reported high rates of early childhood victimization. 1 in 2 survey participants experienced abuse or violence by a primary caretaker before age 18 (53%). About 5% of survey participants had been in foster care, a figure much greater than the estimated 1% of children in LA County in foster care today.
- Nearly 3 in 4 of all participants experienced sexual violence in their lifetime. 60% of BIPOC participants and 47% of white participants experienced sexual violence as children or adolescents, which dramatically exceeds national estimates on childhood sexual violence experienced by girls (25%) and boys (8%).
- Nearly 1 in 10 participants indicated experiencing patterns of abuse or control from a recent or current intimate partner; and 12% experienced sexual violence in the past year.
- Many participants had experienced housing instability. Nearly one-quarter of participants experienced homelessness in their lifetime (21%) and only 7% owned their own home. About 1 in 4 BIPOC participants had experienced homelessness compared to about 1 in 8 white participants.
- Nearly 1 in 4 participants had been hospitalized for psychiatric reasons in their lifetime, including 12% who had been hospitalized more than one time.

HEALTH INEQUITIES ARE PREVENTABLE.

HEALTH JUSTICE IS UNDERSTANDING THE CONNECTION BETWEEN SYSTEMS OF POWER AND HEALTH INEQUITIES, AND BUILDING ON THIS LINK TO PROVIDE HEALTH CARE.

Histories of trauma, social isolation, stigma, and discrimination have led Transmasculine people to experience some of the highest rates of depression, anxiety, and suicide attempts of any known social group. Access to mental health care services is crucial but does not address root causes. Health justice is creating proactive and collective strategies for holistic well-being.
g.

Transmasculine participants experienced very high rates of anxiety and depression. Many participants delayed seeking health care because of their anxiety or depression, as well as concerns about mistreatment based on mental health stigma. Mistreatment in health care settings can make symptoms worse. Transmasculine people have developed personal and collective care tools and practices within and outside of mainstream medical systems--out of necessity. We can invest in and build on what Transmasculine want and have already created to advance health equity.

In our survey analysis, we found:

- Nearly 65% of participants were prescribed antidepressants and/or anti-anxiety medications in their lifetimes; and 39% were currently experiencing moderate to severe depression.
- Nearly 3 in 4 said they had at least one negative experience with a mental health care provider. Those who said that they had received "excellent" care by a mental health provider in their lifetime were less likely to be experiencing moderate to severe depression now (when compared to those who had not received excellent care).
- About half of participants recently delayed seeking health care due to depression (52%) or anxiety related to past health care (48%). Nearly 1 in 4 said they delayed care in the past year for fear of mistreatment based on their mental health symptoms or diagnoses.
- 92% of participants preferred health care providers that specialize in transgender health and 59% of BIPOC participants said they preferred to see providers of color. Only one-third currently had a primary care provider that specialized in transgender health (34%) and these participants reported fewer barriers to care and lower rates of moderate to severe depression.

WE ARE TAKING ACTION FOR HEALTH JUSTICE AND BUILDING A FOUNDATION FOR CHANGE. THE HEALTH ORGANIZING WORK OF TRANSMASCULINE PEOPLE ADDS TO OUR COLLECTIVE UNDERSTANDINGS OF HOW WE CAN HEAL AND BE CARED FOR.

Health justice means trusting and investing in strategies of collective care by and for TGI people. Our research and foundations for action build on a legacy of health justice organizing by TGI people working to create and circulate health knowledge as a radical practice of love and collective care. We take action through showing up for each other, cultural organizing, changing policy, and transforming institutions by demanding change. We envision a world where TGI people are seen and valued, and where all people can access the kinds of care they want and need.

Transmasculine Health Justice: Los Angeles highlights some of the serious health and health care inequities facing Transmasculine people. As we work to envision and create the futures we want, we lift up some of the many ways Transmasculine people and our allies can and do take action now to reduce harms and build communities of care.

Our foundations for action include:

We need each other and fight for each other. We strengthen our bonds by investing in cultural work, sharing our health knowledge, nurturing intergenerational relationships, and building power and voice.

We invite health care providers to trust us, include us, protect us, join us, and let us lead in a fight for health justice. Health care workers are essential to improving the medical experiences of TGI people. We mobilize change in health care settings by advocating for ourselves and others.

We are fighting for inclusion in social and health policies to prevent and reduce systemic harms and acquire resources to address our specific needs. Health inequities are a structural problem. Trans people and our allies have the power to work collectively to pass protective policies and to repeal dangerous ones, and to redistribute resources to those most in need.

We are resisting research that exploits and pathologizes TGI people and taking control of our narrative through our own research and knowledge making practices. We are building the knowledge we need to address health challenges together.

APRIL 2021

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TMHJ:LA

FULL REPORT AT
TMHEALTHSTUDYLA.ORG

This report was developed by the TMHJ:LA core team and volunteers including trans health researchers and educators, cultural workers, policy advocates, activists, and artists. TMHJ:LA is part of a broader strategy within Gender Justice Los Angeles to build power among gender non-conforming, two spirit, Black, Indigenous, trans people of color in Los Angeles.

Topics for Strengthening the Transgender Caucus

- Commissioner Isabella Rodriguez led a discussion on strengthening the Transgender Caucus. From this discussion a list was compiled of topics they would like to have presented in response to the "call to action". This may come in the format of stand-alone presentations or potentially incorporated into the Annual Meeting. The topics that were recommended are as follows:
  - Transmasculine Health Study recommended by Co-chair Luckie Alexander. The study which will be discussed in further detail at the next TG Caucus meeting. The study can be found at the following link: https://www.tmhealthstudyla.org/Research
  - Transgender individuals living with HIV; most of the focus is on prevention but not on those ***living*** with HIV
  - Mental health and the role it plays in sexual behavior
  - Sex work, sexual violence, and sex trafficking
    - Ties into AB 453
    - Will promote humanizing the transgender community
    - How substance use intersects
    - Survivors of sexual assault
    - How can transgender individuals navigate these relationships?
  - Legal Services
    - Immigration services for those who need the proper paperwork as job security may lead to decreased engagement in sex work
  - Stigma, Discrimination & Barriers to PrEP/PEP
    - Stigma and discrimination lead to low uptick in accessing these services
    - Some transgender individuals are being denied PrEP and told they are not eligible because they do not identify as MSM
    - Messaging/marketing does not include the transgender community
  - Structural biases within medicine and gender-affirming care (Drs. Garner & Rao offered to present and/or provide material).

REFRESHER

PRIORITY SETTING AND RESOURCE ALLOCATION PROCESS (PSRA)

Planning, Priorities and Allocations Committee

August 17, 2021

LOS ANGELES COUNTY
COMMISSION ON HIV

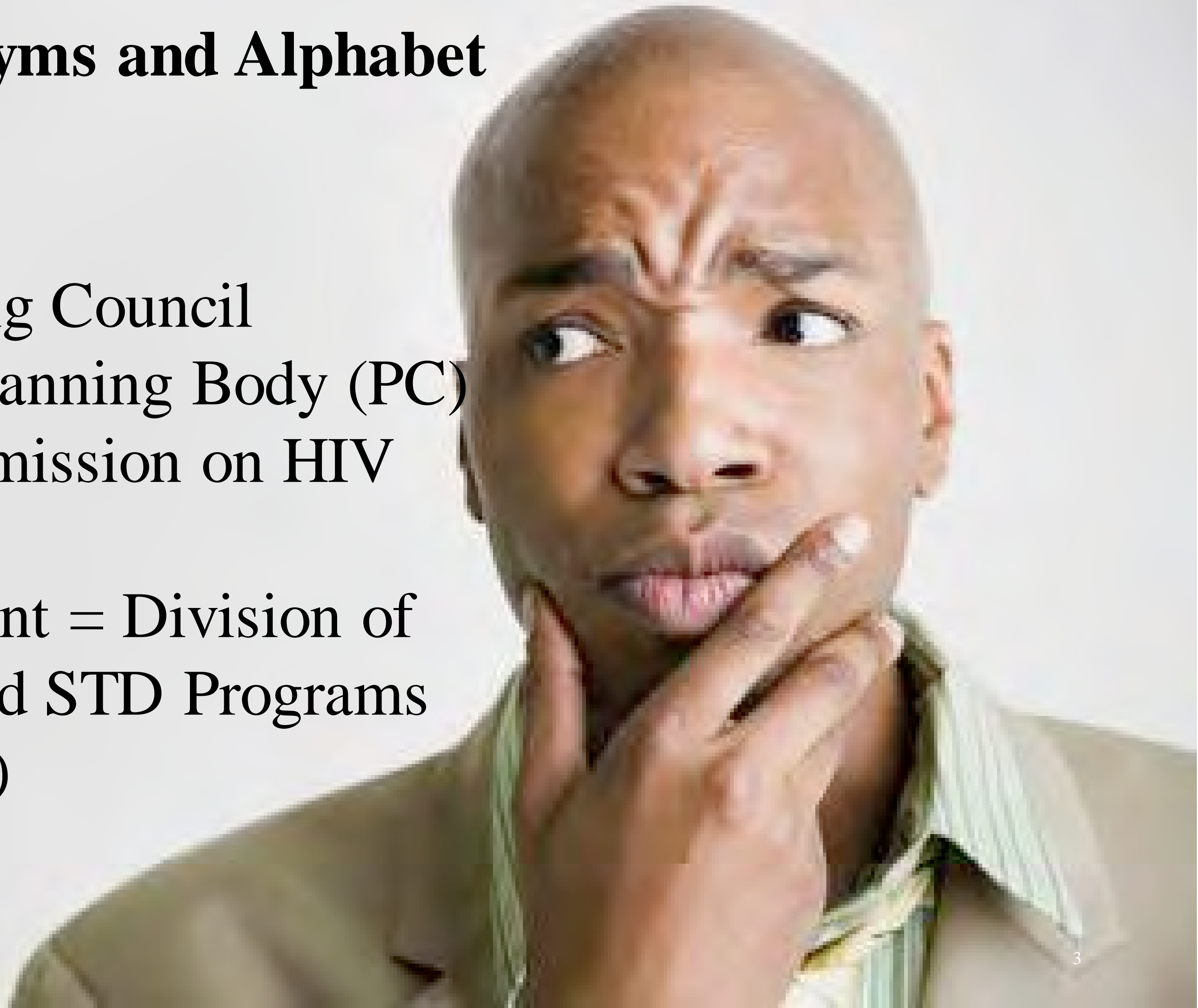
Learning Objectives

Learn about the responsibility of planning councils to use sound information and a rational decision-making process when deciding which services and other program categories are priorities (priority setting) and how much to fund them (resource allocation).

Acronyms and Alphabet Soup:

Planning Council (PC)/Planning Body (PC) = Commission on HIV

Recipient = Division of HIV and STD Programs (DHSP)



More Acronyms

- DHSP – Division of HIV and STD Programs
- PSRA – priority setting and resource allocation
- HRSA – Health Resources Services Administration (federal agency that manages Ryan White dollars)
- RW- Ryan White (the law that carves out $ for PLWH is names after him)
- PY- Program Year (begins March 1of one year and ends February 28 of next year; this is the program year defined by HRSA)
- FY- Fiscal Year (begins July 1 of one year and ends June 30 of the next year; used by LA County)
- NCC- Net County Cost (Los Angeles County funds; non grants)
- MAI- Minority AIDS Initiative
- COH – Commission on HIV
- PLWHA- people living with HIV/AIDS

What is Priority Setting &
Resource Allocation (PSRA)?

Priority Setting and Resource Allocation

The most important task of any Planning Council (decision-making) and Planning Body (advisory), with decisions made based on data, and only by PC/PB members

Priority setting and resource allocation must be based on data and *not* anecdotal information or impassioned pleas.

Priority Setting | Service Ranking

Process of deciding which HIV/AIDS services are the most important in providing a comprehensive system of care for all PLWH in the Eligible Metropolitan Area (in our case, Los Angeles County)

Priority Setting

- Must address needs of *all* PLWH regardless of:
  - Who they are
  - Where they live in the County
  - Stage of disease
  - Whether they currently receive services
- Priorities should be set without regard to the availability of funds (RWHAP Part A or other funds)

Directives

GUIDANCE TO THE RECIPIENT (DHSP) ON HOW TO MEET PRIORITIES

INVOLVES INSTRUCTIONS FOR THE RECIPIENT TO FOLLOW IN DEVELOPING REQUIREMENTS FOR PROVIDERS FOR USE IN PROCUREMENT AND CONTRACTING

USUALLY ADDRESSES POPULATIONS TO BE SERVED, GEOGRAPHIC AREAS TO BE PRIORITIZED, AND/OR SERVICE MODELS OR STRATEGIES TO BE USED

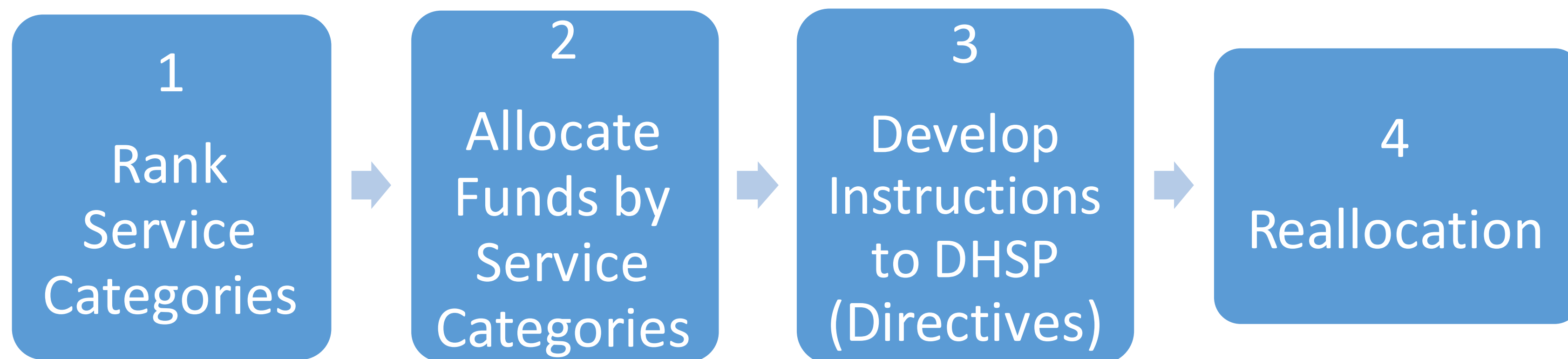
Resource Allocation

- Process of determining how much RWHAP Part A program funding will be allocated to each service category
- PC instructs the recipient on how to distribute the funds in contracting for service categories
- Some lower-ranked service categories may receive larger allocations than higher-ranked service categories due to cost per client and services available through other funding streams

Reallocation

- Process of moving program funds across service categories after the initial allocations are made. This may occur:
  - right after grant award (partial and final award), since the award is usually higher or lower than the amount requested in the application
  - during the program year, when funds are underspent in one category and demand is greater in another

Order of Decision-Making



Ranking DOES NOT equal Level of Allocation by Percentage

Directives are informed by COH Committees, Caucuses, Task Forces, data, PLWH and provider input.

What are the Ryan White Service Categories?

These are the services ranked by the Commission during the PSRA process.

Core Medical Services

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support Services

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Legal Services
7. Linguistic Services
8. Medical Transportation
9. Non-Medical Case Management Services
10. Other Professional Services
11. Outreach Services
12. Permanency Planning
13. Psychosocial Support
14. Referral for Healthcare and Support Services
15. Rehabilitation
16. Respite Care
17. Substance Abuse (residential)

Service Category Ranking

Prioritization: rank service categories based on consumer need (ONLY!)

What services are needed from most to least?

Note: Funding availability is not a consideration; only consumer need.

Steps in the PSRA Process

Needs Assessment

- Joint effort of PC/PB and recipient (led by PC)
- Includes:
  - Epidemiologic profile
  - Estimates of the number and characteristics of PLWHA with unmet need and of individuals with HIV/AIDS who are unaware of their status
  - Assessment of service needs and barriers to care
  - Resource inventory
  - Profile of provider capacity and capability
  - Assessment of unmet need/service gaps

PSRA Tips

- There is no one "right" way to set priorities and allocate resources.
- PSRA process must be documented in writing and used to guide deliberations and decision making.
  - A grievance can be filed if the planning council deviates from its established process.
- Agree on the PSRA process, its desired outcomes, and responsibilities for carrying out the process.

Steps in the Priority Setting and Resource Allocations Process

1

- Review core medical and support service categories, including HRSA service definitions

2

- Review data/information from DHSP

3

- Agree on how decisions will be made; what values will be used to drive decisions.

Steps in the Priority Setting and Resource Allocations Process

4

- Rank services by priority

5

- Allocate funding resources to services by percentage

6

- Provide instructions to DHSP on how to best meet the priorities (Directives)

Data for Decision-Making

Data to Support Decision-Making

- Needs assessment findings
- Cost-effectiveness data
- Actual service cost and utilization data
- Priorities of PLWH who will use services
- The amount of funds provided by other sources
- Use of RWHAP Part A funds to work with other services providers

Leveraging Other Resources

Understand service categories and amounts of funding provided by sources other than RWHAP Part A

- Program Income from RWHAP Parts B, C, D, F
- Housing Continuum of Care/HOPWA
- SAMHSA
- Medicaid/Medicare
- Net County Cost (NCC)
- County-wide resources
- Centers for Disease Control and Prevention
- Other grants

Expenditure Review

- Prior Program Year Final Expenditures for Ryan White Part A and Minority Initiative (MAI) funds
- Current PY estimates for Part A, MAI and Part B Expenditures
- Future RFP funding needs
- Current and future PY Expanded Service Categories with anticipated expenditures increases.
- Total PY Budget Amounts for Part A, B and MAI
- Net County Cost (NCC) Budget for services/ supportive care