LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE Virtual Meeting

Tuesday, October 19, 2021

1:00PM-4:00PM (PST)

(Please note extended meeting time)

Agenda + Meeting Packet will be available on the Commission's website at:

http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

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Revised (10/06/2021)

LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, OCTOBER 19, 2021|1:00 PM – 4:00 PM

(*Please note extended time.*)

To Join by Computer: https://tinyurl.com/tek7beu2

**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001

Access code: 2590 989 6670

Planning, Priorities and Allocations Committee Members:			
Frankie Darling Palacios, Co-Chair	Kevin Donnelly, Co-Chair	Everardo Alvizo, LCSW	Al Ballesteros, MBA
Felipe Gonzalez	Joseph Green	Karl T. Halfman, MS	William King, MD, JD
Miguel Martinez, MPH, MSW	Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD
Damone Thomas	Guadalupe Velasquez, (LOA)	DHSP Staff	
QUORUM:	8		

AGENDA POSTED: October 14, 2021

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. For a schedule of Commission meetings, please click here.

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 hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. 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 Commission on HIV at (213) 738-2816 or via email at hivcomm@lachiv.org.

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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, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

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

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

1. Approval of Agenda **MOTION #1**

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

II. PUBLIC COMMENT 1:04 P.M – 1:15 P.M.

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

III. COMMITTEE NEW BUSINESS 1:15 P.M. – 1:20 P.M.

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:20 P.M. – 1:50 P.M.

a. Commission and Committee Updates
b. Primer on Allowable Services for Ryan White Part A and MAI Funding.

6. CO-CHAIR REPORT 1:50 P.M. – 2:10 P.M.

a. Holiday Meeting Schedule (November 16, 2021 and December 21, 2021)
b. "So, You Want to Talk about Race" by I. Oluo Reading Activity
Excerpts only from Chapters 14 or 15

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 2:10 P.M. – 2:45 P.M.

a. Minority AIDS Initiative (MAI) Expenditure and Client Demographics
   i. Three years of MAI Expenditures and Demographics by Service Category
b. Emergency Financial Assistance (EFA) Expenditure and Client Demographics
   i. EFA Expenditures and Demographics

V. DISCUSSION 2:45 P.M. – 3:25 P.M.

a. Proposed Ryan White Part A and MAI Program Year (PY) 33 and 34 Service Category Rankings **MOTION #3**
b. Proposed Ryan White Part A and MAI PY 33 and 34 Service Category Funding Allocations **MOTION #4**

8. COMPREHENSIVE HIV PLAN (CHP) 3:25 P.M. – 3:45 P.M.

a. Overview and Federal Guidance
b. Address Integrated Plan Questions, Activities for Completing the Plan, Ways to
c. Reduce Duplication of Effort and Steps for Plan Alignment

VI. NEXT STEPS 3:45 P.M. – 3:55 P.M.

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

VII. ANNOUNCEMENTS 3:55 P.M. – 4:00 P.M.

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

VIII. ADJOURNMENT 4:00 P.M.

a . Adjournment for the Meeting of October 19, 2021.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve Meeting Minutes as presented.
MOTION #3:	Approve Proposed Ryan White Part A and MAI PY 33 and 34 Service Category Rankings, as presented, or revised, and move to the Executive Committee for Approval.
MOTION #4:	Approve Proposed Ryan White Part A and MAI PY 33 and 34 Service Category Funding Allocations, as presented, or revised, and move to the Executive Committee for Approval.

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 10/04/21

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

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

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
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
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

September 21, 2021

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Frankie Darling Palacios, Co-Chair	P	William King, MD, JD	A
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Everardo Alvizo, LCSW	P	Anthony M. Mills, MD	P
Al Ballesteros, MBA	P	Derek Murray	P
Felipe Gonzalez	P	Mario Perez, MPH	P
Bridget Gordon	P	LaShonda Spencer, MD	P
Joseph Green	A	Damone Thomas	P
Michael Green, PhD, MHSA	P	Guadalupe Velasquez	A
Karl T. Halfman, MS	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Carolyn Echols-Watson, Jose Rangel-Garibay and Sonja Wright			
DHSP STAFF			
True Beck, Pamela Ogata, and Victor Scott			

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

Meeting agenda and materials can be found on the Commission's website at

http://hiv.lacounty.gov/Portals/HIV/Commission%20Meetings/2021/Packet/PPAVrt%20Merged%20WebEx%20Mtg%20Packet%20-%2009212021.pdf?ver=2dXZqRbmg9G1rkxf6WShAA%3d%3d

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST
Kevin Donnelly, Committee Co-Chair, called the meeting to order at approximately 1:07 PM. Members introduced themselves and stated their conflicts of interest.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

Motion #1: Approved the Agenda Order. (**Passed by Consensus**)

2. **APPROVAL OF MEETING MINUTES**
MOTION #2: Approval of August 14 and August 21, 2021 meeting minutes. The Committee was reminded meeting minutes can be amended up to 1 year after approval. **(Passed by Consensus)**

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

There were no new business items identified.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. County/Commission Operational Updates

- C. Barrit provided an update on the Commission's role in preparing PY 32 (March 1, 2022-February 2023) Health Resources and Services Administration (HRSA) Part A application. The grant application is now for multiple year program years (PY 32, 33 & 34). The application includes the Commission's operating budget and approved service rankings and funding allocations. The application is due to HRSA in early October 2021.
  There was discussion of Commission review the application.
- ➢ P. Ogata will coordinate a meeting time for select Commissioners to review the application prior to submission.
- C. Barrit provided Commissioner's information on in-person meetings and Assembly Bill (AB) 361. The legislation allows virtual meetings to continue as long as there is a declared statewide emergency. Virtual meetings will follow the temporary suspension of a selected Brown Act provisions described in the Governor's Executive Orders. Standardized guidance from the Board of Supervisors (BOS) Executive Office (EO) is being prepared. Official notification is anticipated Friday, September 24, 2021. It is likely the Committee and full Commission meetings will continue to be virtual.

b. Commission and Committee Updates

- The Standards and Best Practices (SBP) Committee is developing a best practices document that will involve seeking input from caucuses, workgroups, and task forces. The document will focus on how these entities can help identify best practices that impact highly affected populations, such as women of color, and the transgender community. The document will include a template that standardizes feedback from the community in an effort to create a comprehensive list of best practices, which could also help inform program directives. Those directives can be used to direct DHSP when implementing programs. Commissioners will have an opportunity to review and refine the document prior to finalization.

- C. Barrit identified the guidance for the Integrated HIV Prevention and Care Plan or the Comprehensive HIV Plan (CHP) in the meeting packet beginning on page 26. The plan is due to HRSA in December 2022.

6. <u>CO-CHAIR REPORT</u>

a. Comprehensive HIV Plan (CHP)

K. Donnelly initiated a discussion on the Committees' process for completing the Commission portion of the CHP. Specifically, how to collect community input. The Committee agreed equity, justice, and racism in healthcare should be included in the Committee's thinking and writing of the CHP. Further, the Committee should be mindful of the significant impact HIV has on people of color. The lack of local medical care and transportation, homelessness, and income inequality were noted as some of the disparities.

The CHP is a primary joint function of the planning council and the grantee; this is the third iteration of the plan (2022-2026). The tentative CHP timeline includes a public comment period by October of 2022 and a plan submission by December 2022. A consultant will coordinate input and write the plan. Input from Commission entities (committees, caucuses, work groups, task forces) and the community will be included in the CHP.

➤ E. Alvizo will introduce the plan to the Long Beach Comprehensive Planning group. K. Donnelly will assist in the presentation. The group meets on October 13, 2021.

The Committee discussed previous methods of data collection. When preparing the 2016-2021 CHP, information gathering included focus groups and community listening sessions. Commissioners determined the questions for the focus groups. CHP workgroups were established and included community members.

The Committee discussed the use of existing plans and DHSP program and financial reports should be used as part of the base for the new plan. Existing plans identified include the End the Epidemic (EHE) plan, Los Angeles County (LAC) HIV/AIDS Strategy for 2020 and Beyond and the CHP for 2016-2021. The Black/African American Community Task Force, Aging Task Force, and the Women's Caucus recommendations were noted for inclusion in the plan as well.

The CHP guidance specifies goals and objectives that must be included in the plan. The importance of aligning the new CHP with the EHE plan was stressed. The Committee discussed mental health and substance abuse services for inclusion in the CHP. The guidance compels the planning body to review integrated healthcare systems and ensure access to care and prevention services. The Committee identified the new CHP as an opportunity to address issues not previously addressed in the existing CHP and EHE as well as identify partnerships to further strengthen and enhance prevention and healthcare service delivery.

➤ The Committee will need to determine strategies to ensure these plans align.

There was discussion about all Commission entities agendizing the CHP and reporting

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recommendations to the PP&A Committee for inclusion in the CHP.

- K. Donnelly requested Committee members review the Integrated Plan guidelines and return with questions, activities for plan completion, suggestions on reduction in duplication of effort and CHP alignment ideas. This discussion will be agendized on the October 19, 2021 PP&A meeting.

b. "So, You Want to Talk about Race" by I. Oluo Reading Activity – Excerpts only from Chapters 12 or 13

Frankie Darling Palacios provided the reading for the meeting.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Minority AIDS Initiative (MAI) Expenditure and Client Demographics
DHSP previously reported approximately 83% of MAI funding was expended on services provided to people of color and 17% to non-people of color (white people).
The following are discussion highlights:

- The Committee wants to know how to prevent MAI funds from being expended on non-people of color in the future.
- The Committee voiced its frustration with MAI fund usage and people of color not having access to services. People of color access to services is further limited by funds being applied to services for non-people of color.
- It was suggested MAI expenditures for non-people of color be shifted to other sources of funding such as Net County Costs (NCC).
- DHSP is preparing the Ryan White (RW) care utilization report for 2020. This document can assist in providing clarity on the MAI funding expended on non-people of color.
- DHSP noted service providers determine program eligibility which may impact how MAI funding is expended.
- It was noted, MAI legislation was to address the health disparities of Black and Brown communities.
- DHSP has committed to change practices related to the funding of MAI services moving forward, but requested the Commission provide direction on program and funding for MAI funds separate from Part A funds.
- DHSP noted the majority of clients served with Ryan White funds are people of color.
- Dr. Green briefly reviewed the expenditure report for the period of March 1, 2021 through September 2021 (included in the meeting packet.) He indicated the report is a rough projection of expenditures for PY 31 due to incomplete billing. However, MAI funds are anticipated to be fully expended.
- It was noted outpatient services such as clinical services are funded through RW.
- Housing was noted as the number 1 disparity and MAI funding is used to fund the service.
- Temporary and permanent supportive housing for PY 31 appears grossly underspent on the fiscal report provided by DHSP.
- Committee members commented eligibility requirements/restrictions are too burdensome and more priority should be placed on people of color in the eligibility process. This could assist in reducing housing disparities among people of color.
- DHSP has had internal discussion regarding the housing program and the challenges to simplify client eligibility/access. A review of county funding for housing services and how to maximize

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resources to reach the greatest number of PLWH in need of housing or are in danger of losing housing has been discussed.

- Two issues emerged around housing, allocation of funds and how the funds are expended.
- DHSP recommended the Committee discussed developing specific interventions and/or services to address disparities people of color in LAC.
- The Committee agreed to propose specific recommendations for MAI funds to direct funding to the communities intended.

➢ The Committee agreed to continue discussing the use of MAI funds and its demographic impact at the October 19, 2021 meeting. It will include a review of the expenditure information provided in the packet.

b. Emergency Financial Assistance Expenditure and Client Demographics

➢ The item is agendized for the October 19, 2021 meeting.

V. DISCUSSION

a. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Rankings
Item agendized for the October 19, 2021 meeting.

b. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Funding Allocations
Item agendized for the October 19, 2021 meeting. The Committee will address this motion separating funding allocations for Part A and MAI.

VI. NEXT STEPS

a. Task/Assignment Recap

➢ The Committee requested DHSP provide utilization of MAI funds for the past three years beyond the PY 30. The data is to include expenditures and demographics by service category.

➢ The Committee requested a primer on what services are allowable for Ryan White Part A and MAI funding.

b. Agenda Development for the Next Meeting

➢ Comprehensive HIV plan and how to move forward

➢ October 19, 2021 meeting will be extended by one hour.

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

a. Adjournment:
The meeting ended at approximately 3:16 PM.

DRAFT

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
TUESDAY, OCTOBER 19, 2021 MEETING
RYAN WHITE (RW) UNALLOWABLE AND ALLOWABLE COSTS

SCOPE OF COVERAGE: Direct care and treatment services.

UNALLOWABLE RW COSTS:

- Payments for any item or service that can be paid for by another payment source (e.g., Medicaid (Medi-Cal), Children Health Insurance Program (CHIP), Medicare, other local or State-funded HIV/AIDS programs, and/or private sector funding, including private insurance)
- Cash payments to clients; cash incentives and cash intended as payment for RW core medical and support services.
- Other unallowable costs include:
  - Clothing
  - Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
  - Funeral and Burial Expenses
  - Property Taxes
  - Pre-Exposure Prophylaxis (PrEP)
  - Non-occupational Post-Exposure Prophylaxis (nPEP)
  - Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
  - International travel
  - The purchase or improvement of land
  - The purchase, construction, or permanent improvement of any building or other facility

ALLOWABLE RW COSTS:

To be an allowable cost under RW, all services must relate to HIV diagnosis, care, and support. Cost must adhere to established HIV clinical practice standards consistent with HHS treatment guidelines. All providers must be appropriately licensed and in compliance with state and local regulations.

RW CORE MEDICAL SERVICES	RW SUPPORT SERVICES
AIDS Drug Assistance Program Treatments (ADAP) A State administered program authorized under RW Part B to provide medications to low-income clients living with HIV who have no or limited health coverage.	**Child Care Services** • Licensed or registered childcare provider to deliver intermittent care • Informal childcare provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

<table>
<tr><td></td><td>Direct cash payments to clients are not permitted.</td></tr>
<tr><td>AIDS Pharmaceutical Assistance (Local)
Supplemental means of providing ongoing medication assistance when RW ADAP has a waiting list, restricted formulary, restricted financial eligibility criteria.

Funds are not to be used for emergency or short-term financial assistance.</td><td>Emergency Financial Assistance (EFA)
• Limited one-time or short-term payments for urgent need of essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another allowable cost needed to improve health outcomes.

EFA must occur as a direct payment to an agency or through a voucher program.

Continuous provision of an allowable service to a client must not be funded through EFA.</td></tr>
<tr><td>Early Intervention Services (EIS)
• Targeted HIV testing.
• Referral, access, linkage to HIV care and treatment services.
• Outreach Services and Health Education/ Risk Reduction related to HIV diagnosis

HIV testing paid by EIS cannot supplant testing efforts paid by other sources.</td><td>Food Bank/Home Delivered Meals
• Provision of food items, hot meals, or a voucher program to purchase food.
• Personal hygiene products
• Household cleaning supplies
• Water filtration/purification systems in communities where issues of water safety exist

Unallowable costs are household appliances, pet food and other non-essential products.</td></tr>
<tr><td>Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals –
• Pays health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
• Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients *; and/or</td><td>Health Education/Risk Reduction (HERR)
• Provision of education to clients living with HIV about HIV transmission and how to reduce the risk of transmission.
This includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.
Topics covered may include:
• Education on risk reduction strategies to reduce transmission such as preexposure</td></tr>
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<tr><td>

- Paying cost sharing on behalf of the client.

*A specific formulary is needed to determine client eligibility.
</td><td>

prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

HERR services **cannot** be delivered anonymously.
</td></tr>
<tr><td>

Home and Community-Based Health Services
- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Inpatient hospitals, nursing homes and other long-term care facilities are **not** considered an integrated setting for the purpose of providing home and community-based health services.
</td><td>

Housing
- Transitional, short-term, or emergency housing assistance.
- Development of an individualized housing plan (updated annually) linkage to permanent housing.
- Housing may provide core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).
- Housing referral services, including assessment, search, placement, and housing advocacy services, as well as fees associated with these activities.

Housing activities **cannot** be in the form of direct cash payments to clients

Mortgage payments or rental deposits are **not** allowable costs. (although mortgage and rental deposits maybe allowable under HOPWA)
</td></tr>
<tr><td>

Home Health Care
- Administration of prescribed therapeutics (e.g., intravenous, and aerosolized Treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies
</td><td>

Linguistic Services
- Interpretation and translation activities, both oral and written provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client.
- Services are to be provided when such services are necessary to facilitate
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This is limited to the homebound. Home settings do not include nursing facilities/in-patient mental health/substance abuse treatment facilities.	communication between the provider and client and/or support delivery of eligible services.
Hospice Services • Mental health counseling • Nursing care • Palliative therapeutics • Physician services • Room and board The service does **not** extend to skilled nursing facilities or nursing homes.	**Medical Transportation** • Contracts with providers of transportation services • Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject) • Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle • Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)Voucher or token systems Costs **not** allowed include ▪ Direct cash payments or cash reimbursement to clients. ▪ Direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle. ▪ Any other costs associated with a privately owned vehicle such as lease, loan payments, insurance, license, or registration fees.
Medical Case Management, including Treatment Adherence Services • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Timely and coordinated access to medically appropriate levels of health and support services and continuity of care	**Non-medical Case Management Services** • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Timely and coordinated access to medically appropriate levels of health and support services and continuity of care

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- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- Benefits counseling

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- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

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Medical Nutrition Therapy

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

All services must be pursuant to a medical providers referral and based on a nutritional plan developed by a registered dietitian or other licensed nutritional professional.

</td>
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Other Professional Services (Legal Services, Permanency Planning)

- Legal services involving legal matters related to or arising from HIV including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to eligible RW services
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- Permanency planning to help clients/ families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney

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<tr><td></td><td>Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.
Criminal defense and class-action suits unless related to access to service eligibility to RW funding are excluded from these services.</td></tr>
<tr><td>Mental Health Services
Outpatient psychological and psychiatric
Screening, assessment, diagnosis, treatment, and counseling services</td><td>Outreach Services
Identification of people who do not know their HIV status and/or
Linkage or re-engagement of PLWH who know their status into RW services RW services, including provision of information about health care coverage options.
Refer HIV negative people referred to risk reduction activities.
Outreach Services must not include out-reach activities that exclusively promote HIV prevention education

Outreach services cannot be delivered anonymously, as information is needed to facilitate any necessary follow-up care.</td></tr>
<tr><td>Oral Health Care
Outpatient diagnosis
Prevention
Therapy</td><td>Psychosocial Support Services
Bereavement counseling
Caregiver/respite support (HRSA RWHAP Part D)
Child abuse and neglect counseling
HIV support groups
Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
Pastoral care/counseling services</td></tr>
</table>

	Funds may **not** be used to provide nutritional supplements. Funds may **not** be used for social/ recreational activities or to pay for a client's gym membership.
Outpatient/Ambulatory Health Services • Medical history taking • Physical examination • Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing • Treatment and management of physical and behavioral health conditions • Behavioral risk assessment, subsequent counseling, and referral • Preventive care and screening • Pediatric developmental assessment • Prescription and management of medication therapy • Treatment adherence • Education and counseling on health and prevention issues • Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology	**Referral for Health Care and Support Services** • Referrals to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).
Substance Abuse Outpatient Care ○ Screening ○ Assessment ○ Diagnosis, and/or **Treatment of substance use disorder, including:** ○ Pretreatment/recovery readiness programs ○ Harm reduction ○ Behavioral health counseling associated with substance use disorder ○ Outpatient drug-free treatment and counseling ○ Medication assisted therapy	**Rehabilitation Services** • Physical, occupational, speech, and vocational therapy Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are **not** allowable

○ Neuro-psychiatric pharmaceuticals ○ Relapse prevention	
	Respite Care • Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/ Ambulatory Health Services or satellite facilities. • Support informal, home-based Respite Care Direct cash payments to clients are **not** permitted. Funds may **not** be used for off premise social/recreational activities or to pay for a client's gym membership
	Substance Abuse Services (residential) • Pretreatment/recovery readiness programs • Harm reduction • Behavioral health counseling associated with substance use disorder • Medication assisted therapy • Neuro-psychiatric pharmaceuticals • Relapse prevention • Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital) • Acupuncture therapy may be an allowable cost with some restrictions Funds may **not** be used for inpatient detoxification in a hospital setting with some exceptions

Information Source: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received…will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under…an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

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[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

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[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

> Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
> Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services.*

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients in the absence of any other resources.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
  - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
  - Referral services to improve HIV care and treatment services at key points of entry
  - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
  - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
  - Counseling individuals with respect to HIV
  - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
    - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
    - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
  - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
  - Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:
- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:
- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals
Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

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[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:
- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services
Description:
Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:
- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services

Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care

Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

See also Psychosocial Support Services

Substance Abuse Services (residential)

Description:

Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:

Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

The Ryan White Program and Minority AIDS Initiative Subpopulations of Focus in Los Angeles County

BACKGROUND

The goal of the Ryan White HIV/AIDS Program (RWP) Minority AIDS Initiative (MAI) is to improve access to HIV care and reduce disparities in health outcomes for people living with diagnosed HIV (PLWDH) through supplemental funding across all parts of the RWP. This will be achieved by providing services designed to address the unique barriers and challenges faced by individuals disproportionately impacted by HIV within the eligible metropolitan and transitional areas (EMA/TGA).

As a Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives supplemental MAI funding to increase access to core medical and related support services and reduce disparities in health outcomes among persons of color living with or at increased risk for HIV. The amount of the award is based on the number of PWLDH who are people of color within a jurisdiction. MAI funds represent approximately 8.3% of the $43.9 million combined MAI ($3.6 million) and Part A ($40.3 million) award for FY 2021.

The 2022-2024 MAI plan for HIV services in LAC is based on the principles of identifying and addressing unmet need, with the goals of improving and broadening access for underserved and disenfranchised communities of color who are not in care and improving retention and viral suppression among those in care.

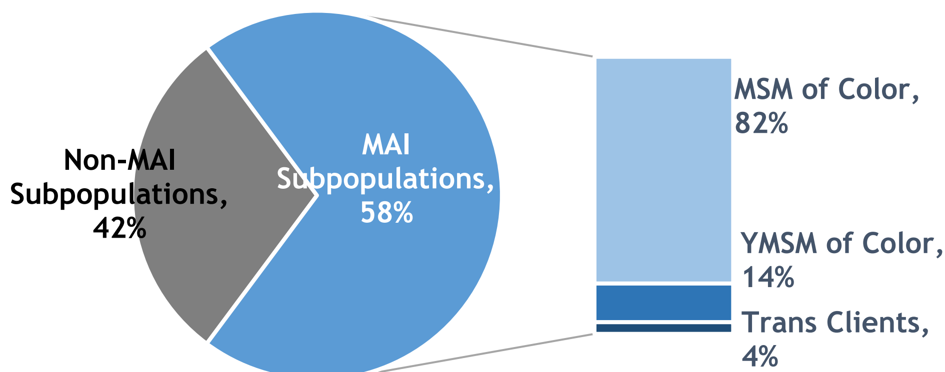
MINORITY AIDS INITIATIVE SUBPOPULATIONS OF FOCUS

HRSA requires that each EMA/TGA identify MAI subpopulations of focus based on local epidemiologic and programmatic data. For LAC, there are **three MAI subpopulations**:

1. Cisgender men of color aged 30 or older who have sex with men (**MSM of color**)
2. Cisgender men of color aged 18-29 years who have sex with men (**YMSM of color**), and
3. Transgender persons of color (**Trans clients**)

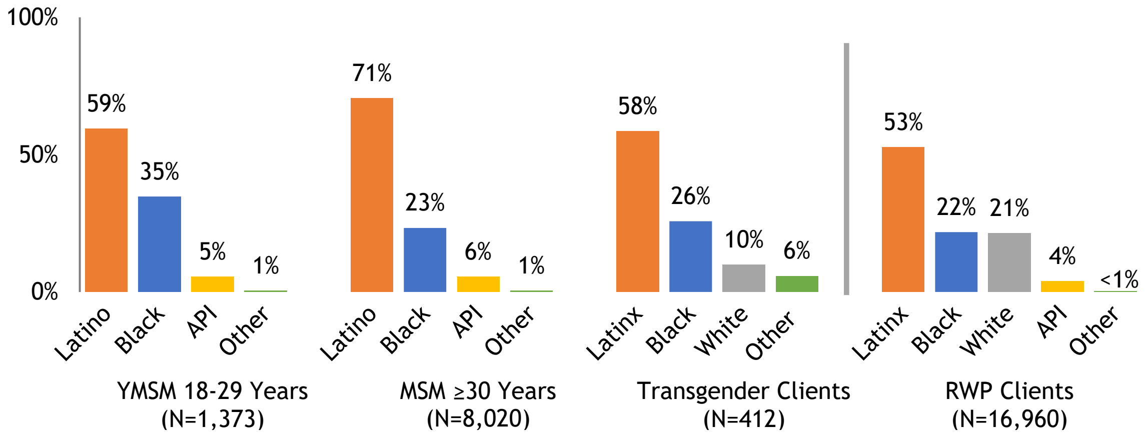
As shown in Figure 1, **MAI subpopulations represented 58% of clients** receiving at least one RWP service in Year 30. Largest MAI subpopulation was MSM of color followed by YMSM of color and transgender clients. **Non-MAI populations are RWP clients who do not meet the definition for the MAI subpopulations including cisgender women, heterosexual cisgender men**, **white MSM, and people who use injection drugs.**

Figure 1: Clients ≥ 13 and older living with diagnosed HIV utilizing Ryan White Program (RWP) services by MAI Subpopulation, Year 30 (March 1, 2020-February 28, 2021), LAC (N=16,960)



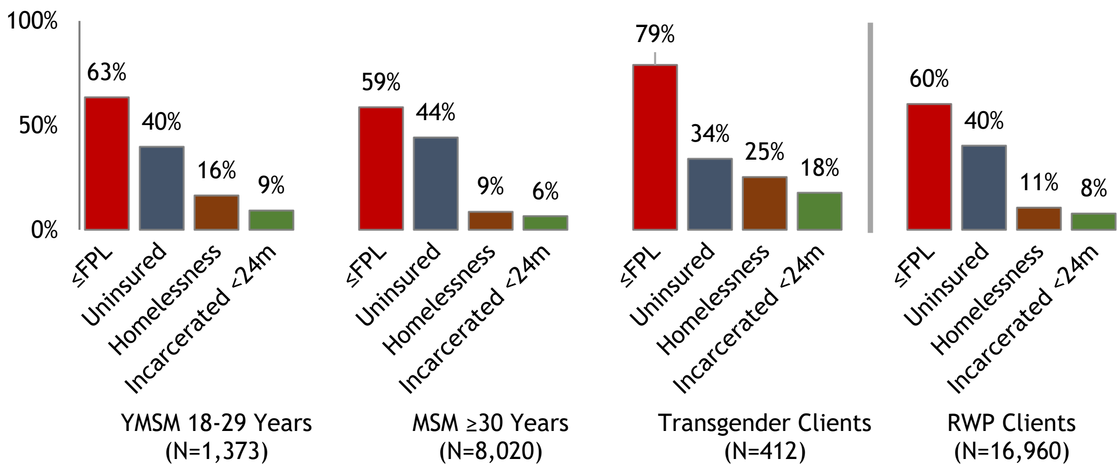
A comparison of the MAI subpopulations with all RWP clients by race/ethnicity is presented below to show the composition of each (Figure 2). Social determinants, such as poverty, health insurance coverage, housing status and experience with the justice system can all influence how, and whether, PLWDH access and utilize HIV care and support services. Understanding how these determinants impact the MAI subpopulations is important to effective service planning and delivery. Key determinants for all RWP clients compared to MAI subpopulations are presented in Figure 3.

Figure 2: Minority AIDS Initiative Subpopulations by Race/Ethnicity compared to Ryan White Clients aged ≥ 13 years, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,2]



In Year 30, persons of color represented 4 out of 5 RWP clients. Latinx were the largest percentage of RWP clients and within each MAI subpopulation followed by Blacks.

Figure 3: Key social determinants of health among Ryan White Program clients aged ≥ 13 years diagnosed compared to Minority AIDS Initiative Subpopulations, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,2]

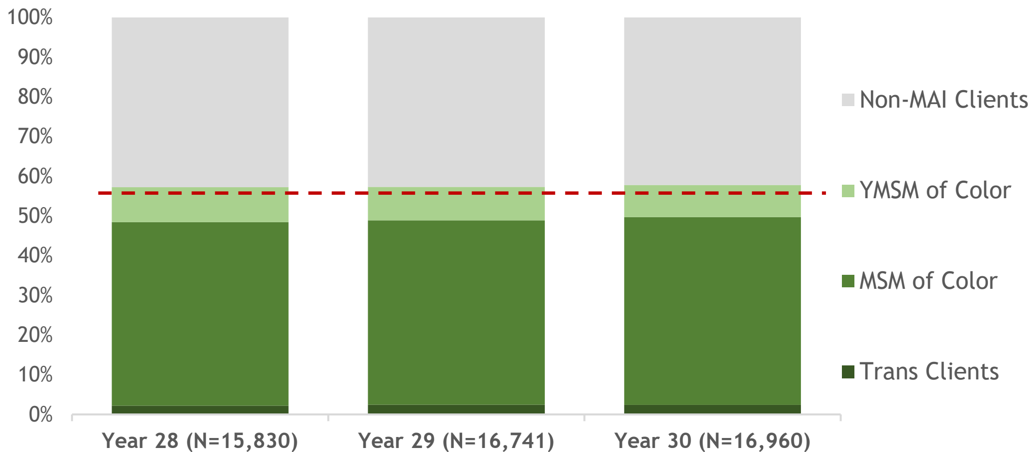


Poverty and lack of insurance was high among RWP clients and all MAI subpopulations. The highest levels of poverty, recent incarceration and homelessness were among transgender clients followed by YMSM.

[1]Other race/ethnicity includes American Indians, Alaskan Natives and persons of multiple race/ethnicities.
[2]Total percentage may exceed 100% due to rounding

Figure 4 presents trends in the percentage of MAI subpopulations receiving RWP services each year. The green shaded area represents the MAI subpopulations.

Figure 4: Ryan White Clients aged ≥ 13 years by Minority AIDS Initiative Subpopulation, LAC, Years 26-30 (March 1, 2016-February 28, 2021)[1]



MAI subpopulations have represented more than half of RWP clients over the past five years and have been slowly increasing.

MINORITY AIDS INITIATIVE SERVICES

MAI services are different from Part A services. **Part A services are intended to meet the needs of all low-income PLWDH while MAI services should be targeted to meet the specific needs of the MAI subpopulations to promote better health through distinct service interventions.** The 2022-2024 MAI Plan identifies key services crucial for LAC's comprehensive HIV care delivery system and will continue to support two services funded under MAI:

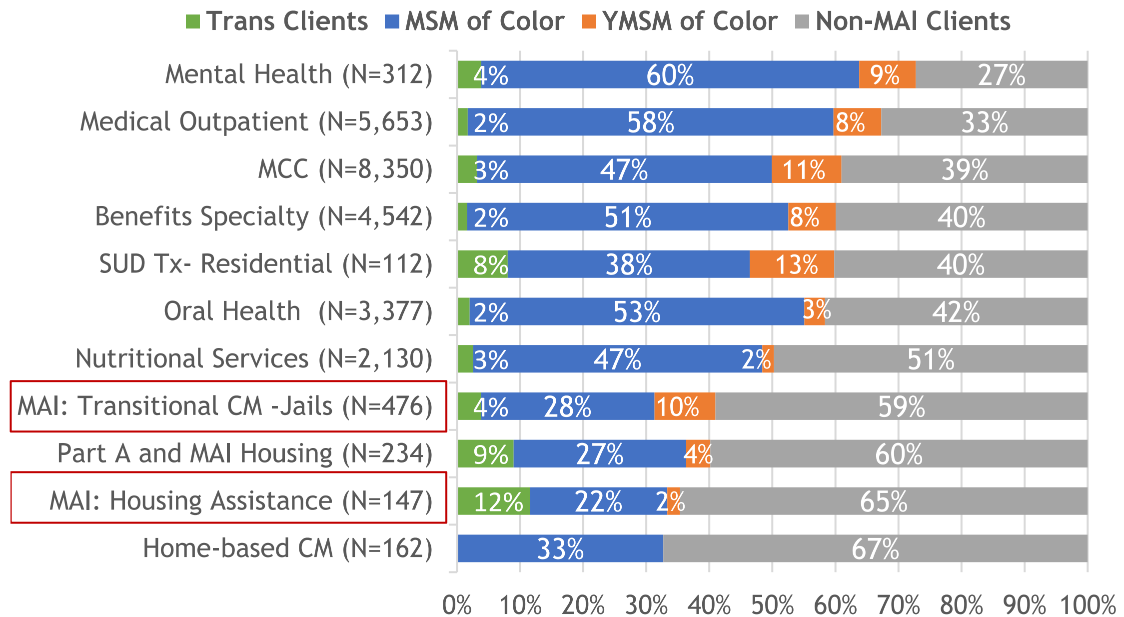
1. **Transitional Case Management – Jails**: This form of non-medical case management services provides additional support to PLWDH upon release from jail. Case managers assist these clients to secure medication, housing, follow-up care, and referrals to support programs. In addition, case managers facilitate navigation and linkage within the RWP to needed services including the MCC program, HIV medical home, nutritional support, transportation and housing.

2. **Housing Assistance:** This form of housing services provides rental subsidies and permanent supportive housing with case management services for PLWDH and and housing services for PLWDH who are also living with a diagnosed mental health disorder. This MAI service is intended to directly connect clients with permanent housing services in contrast to Part A housing services which provide residential care facilities for the chronically ill (RCFCI) and transitional residential care facilities (TRCF) as a transition to permanent housing.

SERVICE UTILIZATION AMONG MAI SUBPOPULATIONS

Use RWP services in for MAI subpopulations compared to non-MAI clients in Year 30 is presented below in Figure 5. These include the services for which data are reported in HIV Casewatch. Those services supported with MAI funding are indicated with a red box. The services are ordered by those used by the largest percent of MAI subpopulations.

Figure 5: Utilization of Ryan White Program Services among clients aged ≥ 13 years by Minority AIDS Initiative Subpopulation, LAC, Year 30 (March 1, 2020-February 28, 2021)[1]



The top three services most utilized by the MAI subpopulations in Year 30 were Mental Health, Medical Outpatient and MCC.

By number, less than half of clients utilizing Transitional CM or Housing Assistance were MAI subpopulations, however Housing Assistance was used by largest percentage of transgender clients. This is important as transgender clients were also disproportionately impacted by homelessness.

Low percentages of clients transgender and YMSM of color utilizing Transitional CM services do not correspond to higher levels of recent incarceration for these populations but may reflect the impact of COVID-19 on service continuity in Year 30 as contracted providers had restricted access to the jails.

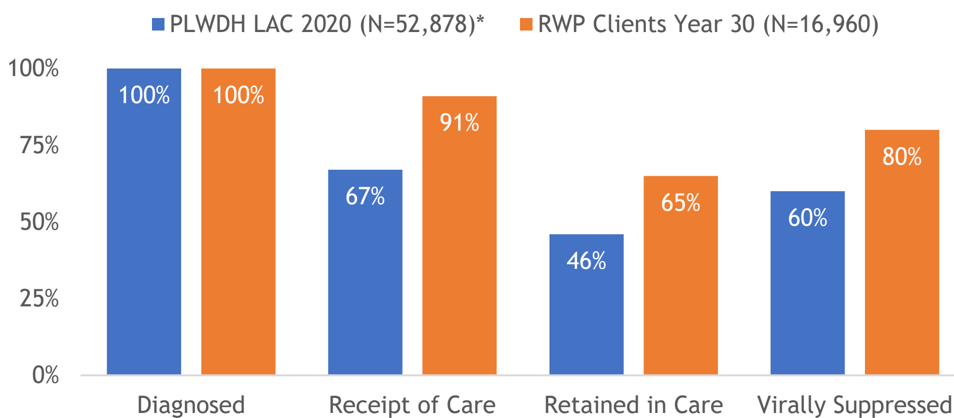
Number of clients using the service doesn't necessarily correlate with expenditures and does not reflect how clients are utilizing the service. Further analysis is needed to determine whether MAI subpopulations are receiving more or fewer service units per client (visits, hours, procedures) compared to non-MAI subpopulations.

HIV CARE INDICATORS FOR MINORITY AIDS INITIATIVE SUBPOPULATIONS

Entering and staying in HIV care is necessary to ensure that adherence to HIV treatment occurs and that viral suppression is achieved. HIV laboratory data (viral load [VL], CD4 or genotype tests) reported by providers to DHSP is used to estimated the HIV care continuum (HCC) indicators: receipt of care (≥ 1 laboratory test in the past 12 months), retention in care (≥2 laboratory test >90 days apart in the past 12 months), and viral suppression (VL<200 copies/mL at most recent test in the past 12 months).

The HCC indicators presented in Figure 6 show how RWP clients compare to PLWDH in LAC with respect to engagement in care, retention in care, and viral suppression in 2020. RWP clients represent a subset of PLWDH who received at least one RWP service in the past 12 months.

Figure 6: HIV Care Continuum for PLWDH age ≥ 13 in LAC compared to Ryan White Program Clients, LAC[1]



[1]LAC surveillance data is for Jan-Dec 2020 and RWP data is Mar 2020-Feb 2021)
*Source: Los Angeles County HIV Surveillance Program

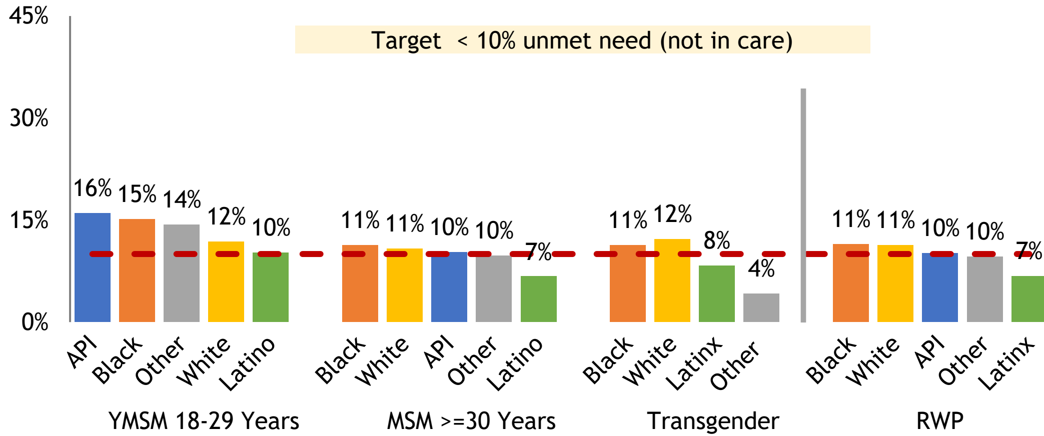
In 2020, approximately 1 out of 3 PLWDH were also RWP clients.

With higher percentages of PLWDH engaged in care, retained in care and virally suppressed RWP clients had better HCC outcomes than PLWDH in LAC.

The next figures show how MAI subpopulations compare by race/ethnicity with non-MAI subpopulations for unmet need for medical care (not in care) and unsuppressed viral load. Within each subpopulation a white comparison group is included in addition presenting the overall RWP population. The primary indicator of progress is viral suppression among RWP clients across racial/ethnic groups. It is important to note that non-MAI target populations include BIPOC who are not among the target populations.

Examining and identifying disparities allows us to determine whether changes to services needed to help PLWDH stay in care, get back in care, and ensure they are taking their medication as prescribed.

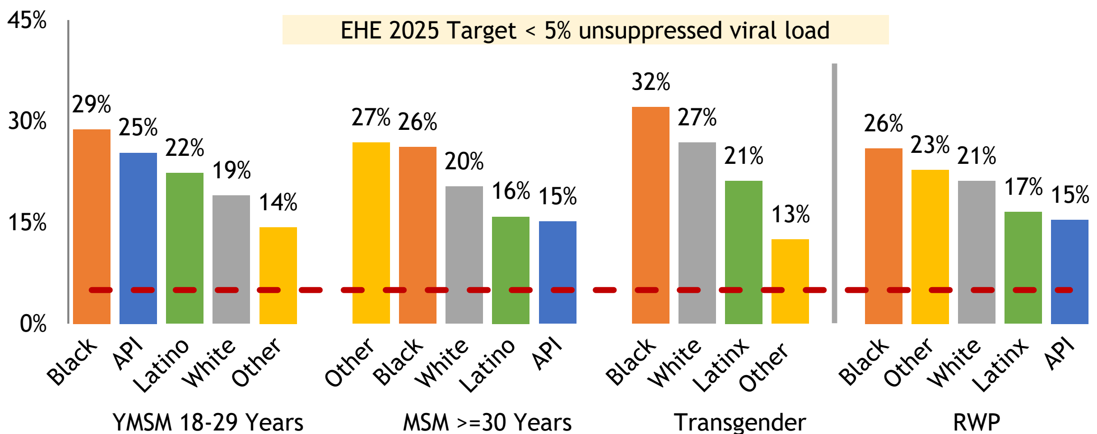
Figure 7: RWP Clients aged ≥ 13 years living with diagnosed HIV with unmet need (not in HIV medical care) compared to MAI Subpopulations by race/ethnicity, Year 30 (March 1, 2020-February 28, 2021), LAC[1,2]



Compared to other MAI subpopulations and RWP overall, unmet need was highest among YMSM.

Only Latinx across all subpopulations and transgender clients of other racial/ethnic groups met the target for unmet need.

Figure 8: Unsuppressed viral load among RWP Clients aged ≥ 13 years diagnosed compared to MAI Subpopulations, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,3]



None of the subpopulations or racial/ethnic groups met the EHE 2025 target for unsuppressed viral load. Within each subpopulation there is wide variation in unsuppressed viral load and was higher among Black clients across all subpopulation groups.

Interventions that promote receipt of and retention in care and ART adherence such as rapid linkage and MCC need to be strengthened to consider the key social determinants of health experienced by MAI subpopulations in order to reduce HCC disparities.

[1]Other race/ethnicity includes American Indians, Alaskan Natives and persons of multiple race/ethnicities. For transgender clients this API are also included. [2]Unmet need (not in care): numerator includes Year 30 clients with no CD4/VL/Genotype test reported in the 12-month period; denominator includes clients receiving ≥ 1 RWP service in the 12-month period in Year 30. [3]Not virally suppressed: numerator includes clients with VL >200 copies/mL at last test or no VL test reported within the 12-month period; denominator includes clients receiving ≥ 1 RWP service in the 12-month period.

SUMMARY - RWP EXPENDITURE REPORT

As of April 8, 2021

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 31 AND PART B YR 31 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by September 16, 2021

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	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+7)	COH YR 31 ALLOCATIONS FOR HRSA PART A AND MAI
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 2,746,238	$ -	$ 2,746,238	$ 7,809,027	$ -	$ -	$ -	$ 2,746,238	$ 9,258,477
MEDICAL CASE MGMT (Medical Care Coordination)	$ 3,403,912	$ -	$ 3,403,912	$ 11,320,627	$ -	$ -	$ -	$ 3,403,912	$ 12,174,533
ORAL HEALTH CARE	$ 1,674,469	$ -	$ 1,674,469	$ 6,235,914	$ -	$ -	$ -	$ 1,674,469	$ 5,298,780
MENTAL HEALTH	$ 143,779	$ -	$ 143,779	$ 351,989	$ -	$ -	$ -	$ 143,779	$ 264,747
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 791,461	$ -	$ 791,461	$ 2,198,539	$ -	$ -	$ -	$ 791,461	$ 2,693,515
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 589,101	$ -	$ 589,101	$ 1,388,232	$ -	$ -	$ -	$ 589,101	$ 1,339,084
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 261,988	$ 261,988	$ -	$ 736,899	$ -	$ -	$ 261,988	$ 302,422
HOUSING-RCFCI, TRCF	$ 98,607	$ -	$ 98,607	$ 109,068	$ -	$ 1,662,734	$ 4,395,841	$ 1,761,341	$ 403,647 Part A portion
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 952,382	$ 952,382	$ -	$ 2,857,146	$ -	$ -	$ 952,382	$ 2,967,007
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ 356,400	$ 855,360	$ 356,400	Part B
MEDICAL TRANSPORTATION	$ 184,036	$ -	$ 184,036	$ 429,711	$ -	$ -	$ -	$ 184,036	$ 790,405
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 631,055	$ -	$ 631,055	$ 2,469,944	$ -	$ -	$ -	$ 631,055	$ 2,789,438
LEGAL	$ -	$ -	$ -	$ 240,282	$ -	$ -	$ -	$ -	$ 88,249
SUB-TOTAL DIRECT SERVICES	$ 10,262,658	$ 1,214,370	$ 11,477,028	$ 32,553,333	$ 3,594,045	$ 2,019,134	$ 5,251,201	$ 13,496,162	$ 38,369,155
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 2,893,664	$ 165,861	$ 3,059,525	$ 4,034,450	$ 363,270	$ 129,659	$ 361,518	$ 3,189,184	
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 280,188	$ -	$ 280,188	$ 1,082,954	$ -	$ -	$ -	$ 280,188	
TOTAL EXPENDITURES	$ 13,436,510	$ 1,380,231	$ 14,816,741	$ 37,670,737	$ 3,957,315	$ 2,148,793	$ 5,612,719	$ 16,965,534	
TOTAL GRANT AWARD				**$ 40,344,502**	**$ 3,632,709**		**$ 5,000,000**		
VARIANCE				(2,673,765)	324,606		612,719		
Estimated MAI Carryover from YR 21 to YR 22	**$**	**1,736,440**							

Note: Amount in ( ) means that the amount of estimated expenditures is less than the grant award

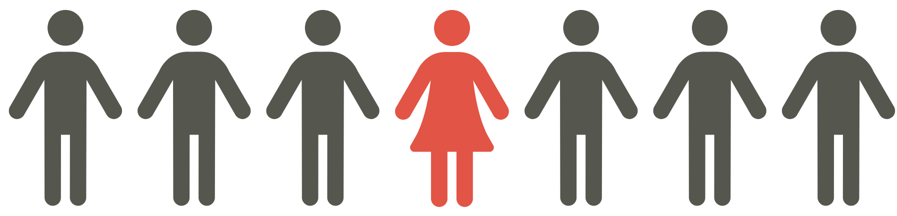
COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YR 31 AND PART B YR 31 EXPENDITURES BY RWP SERVICE CATEGORIES
Expenditures reported by October 6, 2021

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	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURE S MAI	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURE S PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+7)	COH YR 31 ALLOCATIONS FOR HRSA PART A AND MAI
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 2,921,558	$ -	$ 2,921,558	$ 7,615,881	$ -	$ -	$ -	$ 2,921,558	$ 9,258,477
MEDICAL CASE MGMT (Medical Care Coordination)	$ 4,228,468	$ -	$ 4,228,468	$ 11,346,075	$ -	$ -	$ -	$ 4,228,468	$ 12,174,533
ORAL HEALTH CARE	$ 2,103,040	$ -	$ 2,103,040	$ 6,352,833	$ -	$ -	$ -	$ 2,103,040	$ 5,298,780
MENTAL HEALTH	$ 150,356	$ -	$ 150,356	$ 351,216	$ -	$ -	$ -	$ 150,356	$ 264,747
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 843,935	$ -	$ 843,935	$ 2,174,343	$ -	$ -	$ -	$ 843,935	$ 2,693,515
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 639,550	$ -	$ 639,550	$ 1,383,853	$ -	$ -	$ -	$ 639,550	$ 1,339,084
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 312,529	$ 312,529	$ -	$ 741,223	$ -	$ -	$ 312,529	$ 302,422
HOUSING-RCFCI, TRCF	$ 98,607	$ -	$ 98,607	$ 109,068	$ -	$ 1,825,692	$ 4,381,660	$ 1,924,299	$ 403,647 Part A portion
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,312,190	$ 1,312,190	$ -	$ 2,624,380	$ -	$ -	$ 1,312,190	$ 2,967,007
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ 356,400	$ 855,360	$ 356,400	Part B
MEDICAL TRANSPORTATION	$ 197,725	$ -	$ 197,725	$ 413,546	$ -	$ -	$ -	$ 197,725	$ 790,405
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 700,700	$ -	$ 700,700	$ 2,444,597	$ -	$ -	$ -	$ 700,700	$ 2,789,438
LEGAL	$ -	$ -	$ -	$ 240,282	$ -	$ -	$ -	$ -	$ 88,249
SUB-TOTAL DIRECT SERVICES	$ 11,883,939	$ 1,624,719	$ 13,508,658	$ 32,431,694	$ 3,365,603	$ 2,182,092	$ 5,237,020	$ 15,690,750	$ 38,369,155
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 2,893,664	$ 165,861	$ 3,059,525	$ 4,034,450	$ 363,270	$ 129,659	$ 361,518	$ 3,189,184	
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 280,188	$ -	$ 280,188	$ 1,082,954	$ -	$ -	$ -	$ 280,188	
TOTAL EXPENDITURES	$ 15,057,791	$ 1,790,580	$ 16,848,371	$ 37,549,098	$ 3,728,873	$ 2,311,751	$ 5,598,538	$ 19,160,122	
TOTAL GRANT AWARD				**$ 40,344,502**	**$ 3,632,709**		**$ 5,000,000**		
VARIANCE				(2,795,404)	96,164		598,538		
Estimated MAI Carryover from YR 21 to YR 22	**$**	**2,100,702**							

Note: Amount in ( ) means that the amount of estimated expenditures is less than the grant award

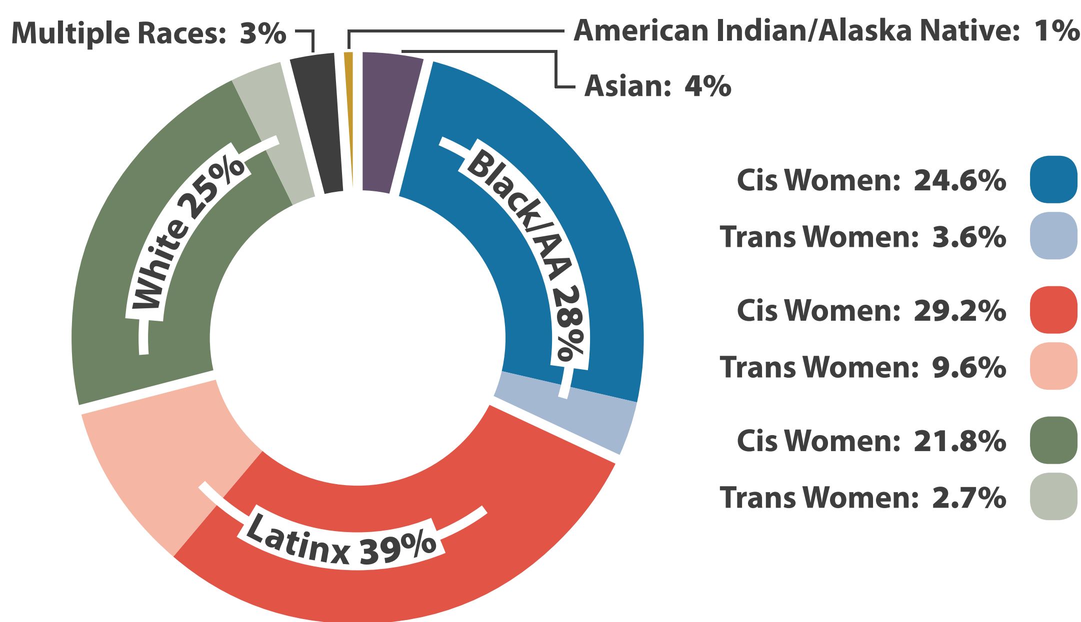
HIV & WOMEN

There were 4,396 new HIV diagnoses in California in 2019. Of those, 15% were among women (12% among cisgender women and 3% among trans women).

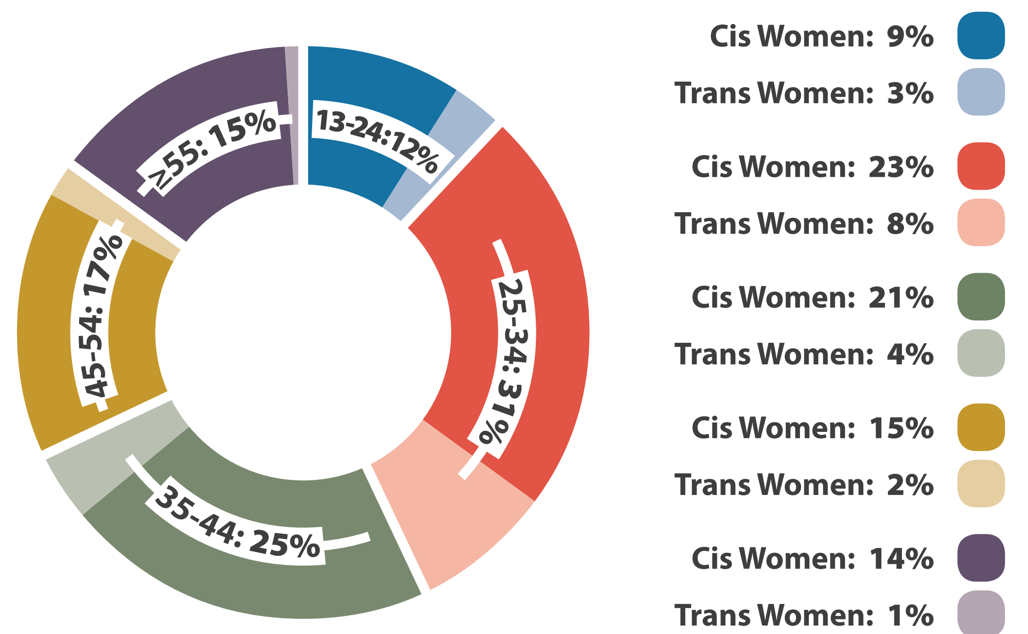


ONE in seven new HIV diagnoses are among WOMEN

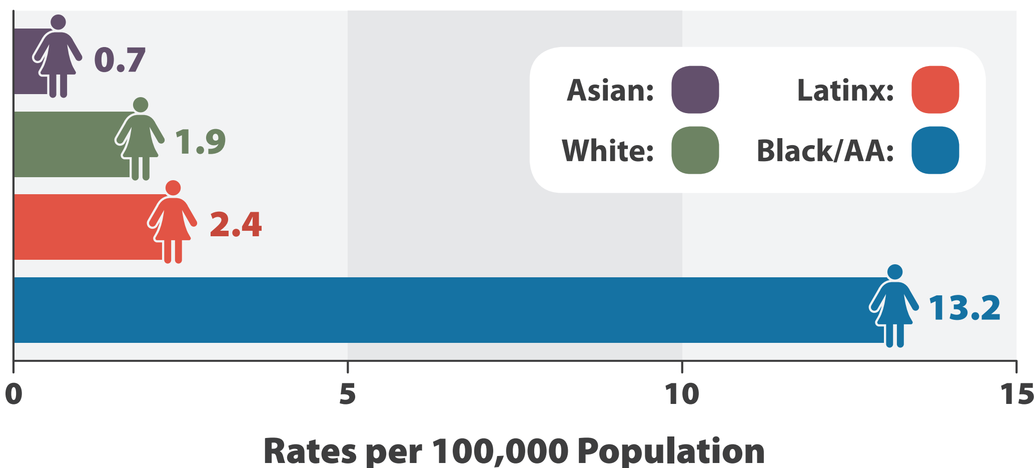
Black/African American & Latinx Women are Disproportionately Affected by HIV



Women Aged 25 to 34 had the Largest Proportion of New Diagnoses

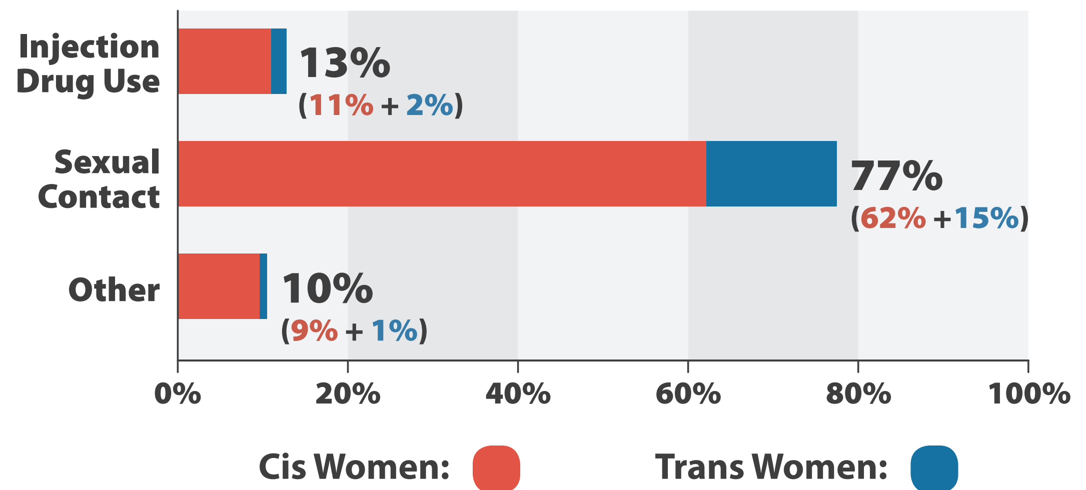


Black/African American Cisgender Women Have the Highest Rate of New HIV Diagnoses



Rates among newly diagnosed Black/African American cis women are 6.9 times higher than White cis women, and among Latinx cis women, 1.3 times higher than White cis women. Although rates for transgender individuals are unknown, National HIV prevalence among transgender individuals is estimated at 9.2%, with transgender women among the groups most affected by HIV.[1]

Most New HIV Diagnoses Among Women are Attributed to Sexual Contact



Risk categories are in order of highest transmission risk (Injection Drug Use, Sexual Contact, and Other). Individuals with multiple risk factors are reported in the category most likely to result in HIV transmission. "Other" includes perinatal exposure and risk factors not reported or identified.

Source of Figures: California Department of Public Health, Office of AIDS, California HIV Surveillance Data

[1] Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA, *Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017*. Am J Public Healthexternal 2018 Nov 29:e1-e8. doi: 10.2105/AJPH.2018.304727.

PrEP Can Reduce Your Chance of Getting HIV

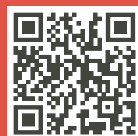
Pre-Exposure Prophylaxis (PrEP) is a pill that reduces the risk of getting HIV from sex by about 99% when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by at least 74% when taken daily.[2]

PrEP is safe to take during pregnancy and breastfeeding, and can help protect you and your baby from getting HIV.

There are no known drug conflicts between PrEP and hormone therapy, and no reason why the drugs cannot be taken at the same time.

PrEP is covered by most insurance plans as well as Medicaid programs. There are also programs that provide PrEP for free or at a reduced cost.

[2] PrEP Effectiveness (https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html)


pleaseprepme.org/california

getyourprep.com
(855) 447.8410

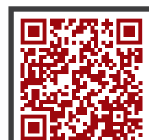
HIV Prevention

Partner Status
Know your partner's HIV status.

Condom Use
Helps prevent the sexual transmission of HIV and other STIs.

Clean Syringes
Use clean syringes and injecting equipment when you inject.

Services Near You



HIV Testing

The only way to know your status is to GET TESTED.

Find an HIV testing site near you.

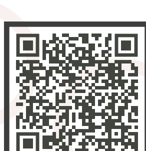
locator.hiv.gov

Order FREE in-home HIV test kits.

takemehome.org

undetectable = untransmittable

- People living with HIV are leading lives that are normal in quality and length. With effective treatment, they are NOT infectious.
- Effective treatment reduces HIV transmission to ZERO.
- There is currently no cure for HIV, but there is treatment.
- If you are HIV positive, **get in care**, **stay in care**, and **live well**.



For More Information: cdph.ca.gov/programs/cid/doa/pages/hiv-women-additional-resources.aspx

09/2021

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Service Category Rankings Worksheet
Program Year (PY) 33 and 34

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

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

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

Footnote:
1 – Service rankings approved 9/09/2021

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PY 33 AND 34 MULTI-YEAR WORKSHEET

	FY 2022 RW Allocations (PY 32) [1]					FY 2023 RW Allocations (PY 33)			FY 2024 RW Allocation (PY 34)		
PY 32 Priority #	Core/ Support Services	Service Category	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI %
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%	0.00%	0.00%		0.00%	0.00%	
2	S	Non-MedicalCase Management - BSS/TCM/CM for new positives/RW clients	2.44%	12.61%	3.30%	0.00%	0.00%		0.00%	0.00%	
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%	0.00%	0.00%		0.00%	0.00%	
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%	0.00%	0.00%		0.00%	0.00%	
7	C	Mental Health Services	4.07%	0.00%	3.72%	0.00%	0.00%		0.00%	0.00%	
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
10	C	Early Intervention Services	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
11	S	Medical Transportation	2.17%	0.00%	1.99%	0.00%	0.00%		0.00%	0.00%	
12	S	Nutrition Support Food Bank/Home-delivered Meals	8.95%	0.00%	8.19%	0.00%	0.00%		0.00%	0.00%	
13	C	Oral Health Services	17.60%	0.00%	16.13%	0.00%	0.00%		0.00%	0.00%	
14	S	Child Care Services	0.95%	0.00%	0.87%	0.00%	0.00%		0.00%	0.00%	
15	S	Other Professional Services - Legal Services	1.00%	0.00%	0.92%	0.00%	0.00%		0.00%	0.00%	
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
18	C	Home Based Case Management	6.78%	0.00%	6.21%	0.00%	0.00%		0.00%	0.00%	
19	C	Home Health Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
20	S	Referral	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
22	S	Language	0.65%	0.00%	0.60%	0.00%	0.00%		0.00%	0.00%	
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
24	S	Rehabilitation	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
25	S	Respite Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
26	C	Local Pharmacy Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
27	C	Hospice	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
		Overall Total	**100.0%**	**100.00%**	**100%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**

Footnotes:

1 - Service Category Rankings and Allocation Percentages Approved by the Commission on 09/09/2021

Development of LA County Integrated HIV Prevention and Care Plan, 2022-2026

LA County Commission on HIV
Planning, Priorities & Allocations Committee Meeting

10.19.2021
AJ King, Next-Level Consulting, Inc.

Agenda

- Integrated Plan Guidance
- Required Sections
- Proposed Timeline
- Discussion: *How best to engage stakeholders*

Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022- 2026

Division of HIV/AIDS Prevention

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

HIV/AIDS Bureau

Health Resources and Services Administration

June 2021

- Second iteration of Integrated Plan Guidance (first in 2015)
- Necessitates engagement from wide range of stakeholders including people at risk for and living with HIV
- Aligned with national goals but reflective of local vision, values and needs
- May submit portions of EHE plans as long as the submission addresses broader needs of jurisdiction and applies to the entire HRSA & CDC HIV funding portfolio.

Requirement	Requirement Details
Section I: Executive Summary	a. Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.). b. List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement.
***Section II: Community Engagement and Planning Process**	Purpose: To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements. a. Entities involved in process b. Role of the RWHAP Part A Planning Council c. Role of Planning Bodies and Other Entities d. Collaboration with RWHAP Parts e. Engagement of people with HIV f. Priorities that arose out of planning and CE g. Updates to other plans used

*This requirement may include submission of portions of other submitted plans including the EHE plan

Requirement	Requirement Details
***Section III: Contributing Data Sets and Assessments**	1. Data Sharing and Use 2. Epidemiologic Snapshot 3. HIV Prevention, Care and Treatment Resource Inventory: a. Strengths and gaps; b. Approaches and Partnerships 4. Needs Assessment: a. Priorities; b. Actions Taken; c. Approach
***Section IV: Situational Analysis**	Purpose: To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies The situational analysis should include an analysis in each of the following areas: Diagnose; Treat; Prevent; Respond a. Priority Populations - Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.

*This requirement may include submission of portions of other submitted plans including the EHE plan

Requirement	Requirement Details
***Section V: 2022-2026 Goals and Objectives**	Purpose: To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding. 1. Goals and Objectives - how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. a. Updates to Other Strategic Plans Used to Meet Requirements
***Section VI: Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up**	Purpose: To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: 1. Implementation; 2. Monitoring; 3. Evaluation; 4. Improvement; 5. Reporting and Dissemination
Section VII: Letters of Concurrence	Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the jurisdiction.

*This requirement may include submission of portions of other submitted plans including the EHE plan

Deliverables	Timeline												
	2021	2022											
	11/1 – 4/1	4/1	5/2	6/1	7/1	7/7	7/15	8/1	8/15	9/15	10/3	11/1	11/30
Pre-Planning and Planning	X												
Submit draft of Section III: Contributing Data Sets and Assessments		X											
Submit draft of Section IV: Situational Analysis			X										
Submit draft of Section V: 2022-2026 Goals and Objectives				X									
Submit draft of Section VI: Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up; and Other Sections: Executive Summary (Section I), Community Engagement and Planning Process (Section II), Data Sharing and Use					X								
DHSP & Medical Director review draft						X							
Draft to Executive Committee/COH for review							X						
All comments due to prepare for public comment period								X					
Open 30 day public comment period									X				
Public comment period closes									X				
Revise draft and share with Executive Committee for final revisions										X			
Comments due from Executive Committee											X		
DHSP Director reviews final document											X		
Revise with final edits												X	
Submit Final Plan													X

Deliverables	Timeline												
	2021	2022											
	11/1 – 4/1	4/1	5/2	6/1	7/1	7/7	7/15	8/1	8/15	9/15	10/3	11/1	11/30
Pre-Planning and Planning	X												
Submit draft of Section III: Contributing Data Sets and Assessments		X											
Submit draft of Section IV: Situational Analysis			X										
Submit draft of Section V: 2022-2026 Goals and Objectives				X									
Submit draft of Section VI: Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up; and Other Sections: Executive Summary (Section I), Community Engagement and Planning Process (Section II), Data Sharing and Use					X								
DHSP & Medical Director review draft						X							
Draft to Executive Committee/COH for review							X						
All comments due to prepare for public comment period								X					
Open 30 day public comment period									X				
Public comment period closes									X				
Revise draft and share with Executive Committee for final revisions										X			
Comments due from Executive Committee											X		
DHSP Director reviews final document											X		
Revise with final edits												X	
Submit Final Plan													X

Deliverables	2021				
	11/1 – 4/1	4/1	5/2	6/1	7/1
Pre-Planning and Planning	X				
Submit draft of Section III: Contributing Data Sets and Assessments		X			
Submit draft of Section IV: Situational Analysis			X		
Submit draft of Section V: 2022-2026 Goals and Objectives				X	
Submit draft of Section VI: Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up; and Other Sections: Executive Summary (Section I), Community Engagement and Planning Process (Section II), Data Sharing and Use					X

Examples of Stakeholders to Consider for Community Engagement

- Existing community advisory boards
- Community members that represent the demographics of the local epidemic
- STD clinics and program
- City, county, tribal, and other state public health department partners
- Clinics & school-based healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners and private payors
- Correctional facilities, juvenile justice, local law enforcement
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions

Examples of Community Engagement Activities

- Focus groups or interviews
- Town hall meetings
- Topic-focused community discussions
- Community advisory group or ad hoc committees or panels
- Collaboration building meetings with new partners
- Public planning body(s) meetings or increased membership
- Meetings between state and local health departments
- Social media events

Thank you!

ajking@next-levelconsulting.org

Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022- 2026

Division of HIV/AIDS Prevention

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

HIV/AIDS Bureau

Health Resources and Services Administration

June 2021

Executive Summary

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed this guidance to support the submission of the Integrated HIV Prevention and Care Plan (hereafter referred to as Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026 (hereafter referred to as Integrated Plan Guidance). This guidance builds upon the previous guidance issued in 2015 when the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV AIDS Bureau (HAB) published its first Integrated HIV Prevention and Care Guidance, including the SCSN for CY 2017-2021. This guidance allowed funded health departments and planning groups to submit one integrated HIV plan to lead the implementation of both HIV prevention and care services. As in 2015, the Integrated Plan Guidance for CY 2022-2026 meets all programmatic and legislative requirements associated with both CDC and HRSA funding. It reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. The Integrated Plan Guidance necessitates engagement from a wide range of stakeholders including people at risk for HIV and people with HIV. The Integrated Plan Guidance intends to accelerate progress towards meeting national goals while allowing each jurisdiction to design a HIV services delivery system that reflect local vision, values, and needs.

CDC and HRSA funded recipients will notice several key changes in the Integrated Plan Guidance for CY 2022-2026 from the Integrated Plan Guidance for CY 2017-2021. These changes reflect feedback from recipients and people with HIV as well as priorities detailed in the HIV National Strategic Plan published January 2021 and the implementation strategies outlined in the Ending the HIV Epidemic in the U.S. (EHE) initiative. Specifically, recipients who have already conducted extensive planning processes as part of the development of their EHE awards and in conjunction with CDC's *Strategic Partnerships and Planning to Support the Ending the HIV Epidemic in the United States(PS19-1906*) program or through other jurisdictional efforts (e.g., Getting to Zero plans, Fast Track Cities, Cluster and Outbreak Detection and Response plans) may submit portions of those plans to satisfy this Integrated Plan Guidance as long as the Integrated Plan submission addresses the broader needs of the geographic jurisdiction and applies to the entire HRSA and CDC HIV funding portfolio. To that end, the Integrated Plan Guidance for CY 2022-2026 includes the *CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* (See *Appendix 1*). This checklist details submission requirements and allows each jurisdiction to determine which elements may require new content and which elements were developed as part of another jurisdictional plan.

Additionally, jurisdictions should submit plans that follow the goals and priorities as described in the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025* and in the updated HIV strategy that will be released later this year, and use data to devise strategies that reduce new HIV infections by 90% by 2030. Proposed strategies should include the implementation of activities that will diagnose all people with HIV as early as possible, treat all people with HIV rapidly and effectively to reach sustained viral suppression, prevent new HIV transmissions by using proven

interventions, and respond quickly to potential outbreaks to get needed prevention and treatment services to people who need them.

Section I: Introduction

In the United States, we have the tools to end the HIV epidemic. During 2015–2019, the annual number and rate of diagnoses of HIV infection decreased in both the United States and six dependent areas. Although numbers and rates decreased overall, diagnoses of HIV infection increased in some subgroups and decreased in others. The work of dedicated individuals across HIV prevention and care delivery systems have contributed to the number of HIV diagnoses decreasing nine percent among adults and adolescents between 2015 and 2019[1], and viral suppression rates for clients in the Ryan White HIV/AIDS Program (RWHAP) increased from 69.5 percent in 2010 to 88.1 percent in 2019[2]. However, health disparities persist among gay, bisexual and other men who have sex with men, particularly Black, Latino, and American Indian/Alaska Native men; Black women; transgender women; youth aged 13-24 years; and people who inject drugs[3]. To reach the national goals of reducing new HIV infections by 75 percent by 2025 and by 90 percent by 2030, our systems of HIV prevention and care must work together in unprecedented ways to address health inequities that remain. This includes providing equal access to all available tools so that no population or geographic area is left behind and efforts to end the HIV epidemic are accelerated.

The Integrated Plan Guidance for CY 2022-2026 is the second five-year planning guidance, developed by CDC and HRSA. This Integrated Plan Guidance builds on the first iteration of the Integrated Plan Guidance by allowing each jurisdiction to develop new goals and objectives that align public and private sectors to leverage strengths from the last five years and to add or revise services to address local health inequities that may remain. The Integrated Plan Guidance speaks to the need for aggressive actions necessary to achieve the HIV National Strategic Plan 2025 goals and targeted efforts to end the HIV epidemic by the year 2030.

Specifically, the Integrated Plan Guidance was designed to:

1. Coordinate HIV prevention and care activities by assessing resources and service delivery gaps and needs across HIV prevention and care systems to ensure the allocation of resources based on data;

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[1] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2019*; vol.32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021.

[2] Health Resources and Services Administration. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019*. https://hab.hrsa.gov/data/data-reports. Published December 2020.

[3] Black is defined as African American or Black and Latino is defined as Latino or Hispanic (U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025. (Pp 9) Washington, DC , https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

2. Address requirements for planning, community engagement and coordination established by the RWHAP legislation as well as programmatic planning and community engagement requirements established by both HRSA and CDC through guidance;

3. Improve health outcomes along the HIV care continuum by using data to prioritize those populations where systems of care are not adequately addressing high HIV morbidity and/or lower than average viral suppression rates;

4. Promote a status neutral approach[4], where testing serves as an entry point to services regardless of a positive or negative result, to improve HIV prevention and care outcomes;

5. Reduce recipient burden by allowing recipients to submit portions of other significant planning documents (e.g., EHE Plans, Fast Track Cities, Getting to Zero, or Cluster and Outbreak Detection and Response plans) to meet Integrated Plan requirements and by aligning submission requirements and dates across HIV prevention and care funding; and,

6. Advance health equity and racial justice by ensuring that government programs promote equitable delivery of services and engage people with lived experience in service delivery system design and implementation.

Relationship to other National Plans and Initiatives

HRSA and CDC recognize that many jurisdictions have established and implemented extended planning processes as part of other local initiatives including but not limited to EHE funding, Fast Track Cities, locally funded Getting to Zero initiatives, or Cluster and Outbreak Detection and Response Plans. To minimize burden and align planning processes, the jurisdiction may submit portions of these plans to satisfy the Integrated Plan Guidance requirements. It is important to note that all submitted plans must address the national HIV goal of reducing the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030. Jurisdictions should review the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025* or subsequent updates to the current national plan by visiting www.hiv.gov and subscribing to receive updates.

National Framework for Ending the HIV Epidemic

It is important to think about this Integrated Plan Guidance within the framework of national objectives and strategic plans that detail the principles, priorities, and actions that direct the national public health response and provide a blueprint for collective action across the federal government and other sectors (see *Appendix 5*). HRSA and CDC support the implementation of these strategies.

[4] A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated in the same way. Source: Julie E Myers, Sarah L Braunstein, Qiang Xia, Kathleen Scanlin, Zoe Edelstein, Graham Harriman, Benjamin Tsoi, Adriana Andaluz, Estella Yu, Demetre Daskalakis, Redefining Prevention and Care: A Status-Neutral Approach to HIV, Open Forum Infectious Diseases, Volume 5, Issue 6, June 2018, ofy097, https://doi.org/10.1093/ofid/ofy097

In January 2021, the U.S. Department of Health and Human Services (HHS) released the *HIV National Strategic Plan: A Roadmap to End the Epidemic 2021- 2025* which creates a collective vision for HIV service delivery across the nation. Each jurisdiction should create Integrated Plans that address four goals[5]:

- Prevent new HIV infections
- Improve HIV-related health outcomes for people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders

To achieve these goals, the HIV National Strategic Plan identifies key priority populations, focus areas, and strategies. All plans submitted in response to the Integrated Plan Guidance should incorporate the national goals and strategies detailed in the HIV National Strategic Plan. This should include activities that:

- Leverage public and private community resources toward meeting the goals;
- Address health inequities for priority populations including inequities related to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral health issues including but not limited to substance use disorders;
- Create strategic partnerships across a broad spectrum of service systems as a means to lessen the impact of social and structural determinants of health such as systemic racism, poverty, unstable housing and homelessness, stigma, and/or under- or un-employment;
- Implement innovative program models that integrate HIV prevention and care with other services and other service organizations as a means to address comorbid conditions and to promote a status neutral approach to care; and,
- Coordinates HIV prevention and care systems around key focus areas to strengthen the local response.

For more information on the HIV National Strategic Plan, visit: https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf.

In 2019, HHS announced the EHE initiative in the United States coordinated around four strategies – diagnose, treat, prevent, and respond – that leverage highly successful programs, resources, and infrastructure. The EHE initiative aligns with the HIV National Strategic plan goal of 90 percent reduction in new HIV diagnoses in the United States by 2030, decreasing the number of new HIV infections to fewer than 3,000 per year. The EHE initiative focuses resources, expertise and technology in jurisdictions hardest hit by the HIV epidemic. For more information on the EHE initiative, visit: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview .

[5] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 2-3) Washington, DC. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

The Integrated Plan Guidance utilizes the HIV care continuum model and the status neutral approach. The HIV care continuum depicts the stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to reach viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner, thus providing an additional strategy to prevent new HIV infections. Strategies to address racism and discrimination that threatens HIV public health goals within HIV prevention care, and treatment systems are needed to increase the number of people with HIV that reach and maintain viral suppression.

The adoption of a status neutral approach can improve HIV prevention and care service delivery and outcomes. Persons with positive test results should be linked to HIV care, treatment, and other social support services; and, persons testing negative should be linked, as needed, to biomedical HIV prevention services, such as PrEP, and other social support services.

The HIV care continuum allow recipients and planning groups to measure progress and to direct HIV resources most effectively. HRSA and CDC encourage jurisdictions to use the HIV care continuum to identify populations for whom the service system may not adequately prevent exposure to HIV or may not support improved HIV health outcomes. Additionally, all jurisdictions should include performance measures in their Integrated Plan submission including the core performance measures that measure progress along the HIV care continuum for all priority groups. Please see *Appendix 4* for links to suggested CDC and HRSA data sources, performance measures, and indicators.

Section II: Planning Requirements and Submission Guidelines

HIV Planning Requirements

All CDC DHAP and HRSA HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a system-wide plan for the delivery of HIV prevention and care services and the establishment of an HIV planning group, planning council, or advisory group, also known as a planning body. By design, the HIV planning body must engage people with different interests, responsibilities, and involvement with HIV to inform and support the development and implementation of an Integrated Plan submission that guides the delivery of HIV prevention and care services.

For the development of the Integrated Plan, jurisdictions should include and use their existing local prevention and care HIV planning bodies, as consistent with CDC and HRSA planning group requirements, and engage traditional stakeholders and community members (e.g., AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics and local education agencies (LEAs)) to get input. In addition, recipients should broaden their existing group of partners and stakeholders to include other federal, state, and local HIV programs, local organizations, and community groups not previously engaged for the purposes of improving data sources, leveraging services, and assisting with key portions of the plan, such as the HIV prevention and care inventories.

When developing the Integrated Plan submission, the planning body should collaborate with the recipient to analyze data for program action and decisions, prioritize resources to those jurisdictions at highest risk for HIV transmission and acquisition, and address health equity by improving both individual and population based HIV health outcomes in those jurisdictions. Through strategic collaborations among stakeholders, HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention and care service delivery needs and priorities. Please refer to CDC's most recent HIV Planning Guidance (HPG) and the RWHAP Part A and Part B Manual for more details about HIV planning processes.

Integrated Plan Development

Integrated planning is a vehicle for jurisdictions to identify HIV prevention and care needs, existing resources, barriers, and gaps and outline local strategies to address them. The Integrated Plan submission should articulate existing and needed collaborations among people with HIV, service providers, funded program implementers, and other stakeholders, including but not limited to other programs funded by the federal government, such as the Housing Opportunity for Persons with AIDS (HOPWA) program and providers from other service systems such as substance use prevention and treatment providers. The Integrated Plan submission should reflect current approaches and use the most recent data available. To ensure coordinated implementation of their Integrated Plan submission, each jurisdiction should include information on the persons or agencies responsible for developing the plan, implementing the plan, coordinating activities and funding streams, and monitoring the plan.

To submit the Integrated Plan, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission. As part of the Integrated Plan submission, jurisdictions will need to outline the communities and stakeholders represented in the planning and concurrence process (e.g., community members, people with HIV, providers, governmental entities). Please see *Appendix 6* for a sample letter of concurrence.

The Integrated Plan submission should include all funding sources, service delivery, and system integration (entire system of HIV prevention and care). It should include the following sections:

1. Executive Summary
2. Community Engagement and description of Jurisdictional Planning Process
3. Contributing Data Sets and Assessments, including:
    a. Epidemiologic Snapshot
    b. HIV Prevention, Care and Treatment Resource Inventory
    c. Needs Assessment
4. Situational Analysis Overview, including priority populations/groups
5. CY 2022-2026 Goals and Objectives to be organized by the goals in the HIV National Strategic Plan and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See *Appendix 2* for examples.

In addition to these sections, please use the checklist attached, as *Appendix 1,* to ensure the jurisdiction submits all of the documents needed to meet submission requirements,

including existing materials and newly developed materials needed for each required section.

Submission

While there is not a standard template for the Integrated Plan submission, the plan submitted must include all the components outlined in this guidance and include a completed *CY2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be broad enough to ensure that all HIV prevention and care funding work together to reduce new HIV infections by 90% by 2030. The new written plan should not redevelop existing products such as epidemiologic profiles, if these products are current and up-to-date. Existing versions of these documents may be updated or modified if needed for the current integrated planning process.

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan.

- The Integrated Plan should include information on who is responsible for developing the Integrated Plan within the jurisdiction (i.e., RWHAP Part A planning councils/body(ies), RWHAP Part B advisory groups, and CDC HIV planning bodies).

- The Integrated Plan should define and provide the goal(s), which allows the jurisdiction to articulate its approach for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the goals of the HIV National Strategic Plan.

All funded jurisdictions (funded by both CDC DHAP and HRSA HAB) must submit an Integrated Plan responsive to this guidance. State and/or local jurisdictions (municipalities) have the option to submit to CDC and HRSA:

1. Integrated state/city prevention and care plan,
2. Integrated state-only prevention and care plan, and/or
3. Integrated city-only prevention and care plan.

NOTE: All submissions should integrate prevention and care as a mechanism to better coordinate a response to HIV among all partners and stakeholders.[6] Per legislative and programmatic requirements, regardless of the option used, CDC and HRSA expect coordination among funded entities and community stakeholders in the development of Integrated Plan and its submission.

The Integrated Plan submission may include several jurisdictions (e.g., the state, the RWHAP Part A jurisdiction(s) in that state, CDC directly funded cities in that state), but each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of the Integrated Plan. For jurisdictions submitting city-only or state-only Integrated Plans, the city Integrated Plan should complement the state Integrated Plan, including the SCSN. Additionally, both the

[6] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 45-47) Washington, DC. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

city-only and state-only Integrated Plans should describe how the jurisdictions will coordinate actions to prevent duplication and should depict and address the HIV epidemic within its jurisdiction.

The jurisdiction's Integrated Plan submission is due to CDC DHAP and HRSA HAB ***no later than 11:59 PM ET on December 9, 2022***. Submissions should be no longer than 100 pages not including the completed checklist and no smaller than 11pt font. The submission package must contain a completed Integrated Plan that includes the sections detailed above; a *CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* detailing where CDC and HRSA may find each of the required elements; and a signed letter from the HIV planning group/body indicating concurrence, concurrence with reservations, or non-concurrence with the plan. Further details on how to submit your jurisdiction's Integrated Plan are forthcoming.

Monitoring

The Integrated Plan provides an overarching vehicle to coordinate approaches for addressing HIV at the state and local levels. Monitoring the Integrated Plan will assist recipients and planning bodies with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information, and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction.

Jurisdictions must identify how they will provide regular updates to the planning bodies and stakeholders on the progress of plan implementation, solicit feedback, and use the feedback from stakeholders for plan improvements. Each jurisdiction also will need to use surveillance and program data to assess and improve health outcomes, health equity, and the quality of the HIV service delivery systems, including strategic long-range planning.

The Integrated Plan is a "living document" and must be reviewed and updated at least annually or as needed. The process for annual review should include the identification of relevant data and data systems, analysis of data on performance measures, the inclusion of planning bodies in the ongoing evaluation of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process.

To ensure progress on Integrated Plan activities and the Integrated Plan's alignment with funding strategies, CDC and HRSA will engage in monitoring activities both independently and jointly. Recipients will use established reporting requirements (i.e., applications, annual progress reports) to document progress on achieving the objectives presented in the Integrated Plan. These reporting updates should include the jurisdiction's plan to monitor and evaluate implementation of the goals, strategies, and objectives included in the Integrated Plan. Additionally, CDC and HRSA project officers will continue to monitor progress during regularly scheduled calls and will conduct periodic joint monitoring calls with recipients.

CDC DHAP and HRSA HAB remain committed to our ongoing partnership and the provision of technical assistance (TA) services. For TA services around integrated planning, please contact your respective project officers.

Appendix 1

CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section I: **Executive Summary of Integrated Plan and SCSN**	*Purpose:* To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission Tips for meeting this requirement 1. Be sure to write the summary with enough detail to ensure the reader understands how you have met Integrated Plan requirements. 2. If you are using a combination of new and existing materials, be sure to describe how submitted materials relate to each other.		
1. Executive Summary of Integrated Plan and SCSN	Provide an overall description of the Integrated Plan, including the SCSN, and the extent to which previous/other plans/SCSNs inform this plan/SCSN, or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below.	*New material required*	

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Approach	Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.).	*New material required*	
b. Documents submitted to meet requirements	List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement.	*New material required*	
Section II: Community Engagement and Planning Process	*Purpose:* To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. Review of the HIV National Strategic Plan and the updated HIV strategy, when released. 2. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. 3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The community engagement process should reflect the local demographics. 5. The planning process should include key stakeholders and broad-based communities that include but are not limited to: people with HIV, funded-service providers, and stakeholders, especially new stakeholders, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of stakeholders to be included. 6. Explain how the jurisdiction will build collaborations among systems of prevention and care relevant to HIV in the jurisdictions (e.g., behavioral health and housing services). 7. Include community engagement related to "Respond" and support of cluster detection activities.		
1. Jurisdiction Planning Process	Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans such as the EHE plan. Please be sure to address the items below in your description		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Entities involved in process	List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. See *Appendix 3* for list of required and suggested stakeholders		
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state-only plans)	Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.		
c. Role of Planning Bodies and Other Entities	Describe the role of CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
d. Collaboration with RWHAP Parts – SCSN requirement	Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system.		
e. Engagement of people with HIV – SCSN requirement	Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan.		
f. Priorities	List key priorities that arose out of the planning and community engagement process.		
g. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. How the jurisdiction uses annual needs assessment data to adjust priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders. 3. Any changes to the plan as a result of updates assessments and community input. 4. Any changes made to the planning process as a result of evaluating the planning process.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section III: Contributing Data Sets and Assessments	*Purpose:* To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps in the service delivery system. This section fulfills several legislative requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. *Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county*. 2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements. 3. Include both narrative and graphic depictions of the HIV-related health disparities in the area including information about HIV outbreaks and clusters.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction. 5. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.		
1. Data Sharing and Use	Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose.		
2. Epidemiologic Snapshot	Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 years). The snapshot should highlight key descriptors of people diagnosed with HIV and at-risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at-risk for exposure to HIV. This snapshot should also describe any HIV clusters identified and outline key characteristics of clusters and cases		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	linked to these clusters. Priority populations for prevention and care should be highlighted and align with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction showing burden of HIV in the jurisdiction.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
3. HIV Prevention, Care and Treatment Resource Inventory	Create an HIV Prevention, Care and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive: • Organizations and agencies providing HIV care and prevention services in the jurisdiction. • HRSA (must include all RWHAP parts) and CDC funding sources. • Leveraged public and private funding sources, such as those through HRSA's Community Health Center Program, HUD's HOPWA program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding. • Describe the jurisdiction's strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services. • Services and activities provided by these organizations in the jurisdiction and if applicable, which priority population the agency serves. • Describe how services will maximize the quality of health and support services available to people at-risk for or with HIV.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Strengths and Gaps	Please describe strengths and gaps in the HIV prevention, care and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts.		
b. Approaches and partnerships	Please describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
4. Needs Assessment	Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data including: 1. Services people need to access HIV testing, as well as the following status neutral services needed after testing: a. Services people at-risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs 2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression – Needs 3. Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility		
a. Priorities	List the key priorities arising from the needs assessment process.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
b. Actions Taken	List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.		
c. Approach	Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in *Appendix 3*.		
Section IV: Situational Analysis	Purpose: To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III. Tips 1. New or existing material may be used; however, existing material will need to be updated if used. 2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN. 3. Jurisdictions may submit the Situational Analysis submitted as part of their EHE Plan to fulfill this requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system.* If using EHE plans to fulfill this		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	requirement, be sure to include updates as noted below.		
1. Situational Analysis	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	Please note jurisdictions may submit other plans to satisfy this requirement, if applicable to the entire HIV prevention and care service system across the jurisdiction.		
a. Priority Populations	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.		
Section V: **2022-2026 Goals and Objectives**	*Purpose:* To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding. Tips for meeting this requirement: 2. *Recipients may submit plans (e.g., EHE, Getting to Zero, Cluster and Outbreak Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area.* 3. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. 4. The plan should include goals that address both HIV prevention and care needs and health equity.		
1. Goals and Objectives Description	List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. There should be at least 3 goals and objectives for each of these four areas. See *Appendix 2* for suggested format for Goals and Objectives. *Please note jurisdictions may submit other plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and care service delivery system and geographic area.*		
a. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.		

<table>
<tr>
<td>Section VI:
2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up</td>
<td><u>Purpose:</u> To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases:
1. Implementation
2. Monitoring
3. Evaluation
4. Improvement
5. Reporting and Dissemination

Tips for meeting this requirement
1. This requirement may require the recipient to create some new material or expand upon existing materials.
2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process.
3. If you are submitting portions of a different jurisdictional plan to meet this requirement, you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases.</td>
<td></td>
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</tr>
<tr>
<td>1. 2022-2026 Integrated Planning Implementation Approach</td>
<td>1. Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met</td>
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</table>

a. Implementation	2. Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdictions Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams including but not limited to HAB and CDC funding.		
b. Monitoring	3. Describe the process to be used for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. *Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.*		
c. Evaluation	4. Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.		

d. Improvement	5. Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.		
e. Reporting and Dissemination	6. Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan.		
f. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities. 2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes. 3. Revisions made based on work completed.		
Section VII: **Letters of Concurrence**	Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. See *Appendix 6* for a sample Letter of Concurrence.		
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)			
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)			

3. RWHAP Part B Planning Body Chair or Representative			
4. Integrated Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.		
5. EHE Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.		

Appendix 2

Examples of Goal Structure

Note: There is not a required format for submission of Integrated HIV Prevention and Care goals. This format is provided as an example.

Diagnose (EXAMPLE)

Goal 1: To diagnose XX people with HIV in 5 years.

Key Activities and Strategies:
1) Increase routine testing in XX ERs, acute care settings, etc.
2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venue to reach demographic XX

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, sexual health clinics, women's health services/prenatal services providers, hospitals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, RWHAP, Bureau of Primary Health Care (Health Centers), State and/or Local Funding, Medicaid, etc.

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): # of newly identified persons with HIV

Monitoring Data Source: EMR data, surveillance data

Expected Impact on the HIV Care Continuum: Increase the number of people who know their HIV diagnosis by XX% and linked to medical care within 90 days by XX%

Treat (EXAMPLE)

Goal 1: To engage XX people with HIV in ongoing HIV care and treatment in 5 years.

Key Activities and Strategies:
1) Increase linkage to care activities in XX populations
2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venues to reach demographic XX

Key Partners: FQHCs, medical care providers, hospitals, community-based organizations, school-based clinics, various professional health care associations, etc.

Potential Funding Resources: RWHAP, State Local Funding, SAMHSA, HOPWA, Medicaid expenditures, Bureau of Primary Health Care (Health Centers), Administration for Children and Families, and other public and private funding sources

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): Linkage to HIV care within 30 days of less for # of newly identified persons with HIV; Linkage to HIV care within 30 days or less for # of persons with HIV identified as not in care

Monitoring Data Source: Surveillance, RWHAP, CDC testing linkage data

Expected Impact on the HIV Care Continuum: Increase the number of people receiving ART by XX% and improve viral suppression rates in targeted populations by XX%

Prevent (EXAMPLE)

Goal 1: To increase access to PrEP by X% for priority populations in 5 years.

Key Activities and Strategies:
1) Increase number of providers trained to prescribe PrEP
2) Increase PrEP prescriptions among priority populations

Key Partners: Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care (Health Centers), State and/or Local Funding, Minority AIDS Initiative (MAI), SAMHSA, HOPWA, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, and other public and private funding sources, etc.

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): # of providers trained; # of prescriptions for PrEP

Monitoring Data Source: Local databases, medical records data, pharmacy records

Expected Impact on Status Neutral Approach: Increase by XX number the people prescribed PrEP, Increase by XX number the people linked to PrEP services, Increase by XX% in the number of syringe services programs available

Respond (EXAMPLE)

Goal: To increase capacity and implementation of activities for detecting and responding to HIV clusters and outbreaks in 5 years.

Key Activities and Strategies:
1) Increase involvement of health department staff, community members, and community organizations in response planning, implementation, and evaluation
2) Increase flexible funding mechanisms capable of supporting HIV cluster response efforts

Key Partners: Community members, community-based organizations, HIV care providers, FQHCs, correctional facilities, hospitals, social services providers, people with HIV, health departments, public health professionals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, STD Funding, RWHAP, SAMHSA, HUD/HOPWA, Medicaid, Bureau of Primary Health Care (Health Centers), viral hepatitis funding, opioid/substance use funding, State and/or Local Funding

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): Establishment of strengthened cluster and outbreak detection and response plans; protocols for flexible funding mechanisms; number of clusters detected; number and description of cluster responses and lessons learned; incorporation of strategies from Diagnose, Treat, and Prevent pillars into responses to clusters.

Monitoring Data Source: Local protocols and reports

Expected Impact on Status Neutral Approach: Increase the number of people in networks affected by rapid transmission who know their HIV diagnosis, are linked to medical care, and are virally suppressed, or who are engaged in appropriate prevention services (e.g., PrEP, syringe services programs)

Appendix 3

Examples of Key Stakeholders and Community Members

Community engagement is a key expectation of the Integrated Planning Guidance. Community engagement involves the collaboration of key stakeholders and broad-based communities who work together to identify strategies to increase coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. Each community should select stakeholders including persons with HIV who reflect the local demographics of the epidemic with lived experience and can best help align resources and set goals that promote equitable HIV prevention and health outcomes for priority populations. This should include not only traditional stakeholders but engagement with new partners and non-traditional organizations. While the Integrated Plan submission should be done in collaboration with identified Integrated Planning body(s), community engagement may also include assessment processes (e.g., focus groups, population-specific advisory boards) that take place outside of or in conjunction with the Integrated HIV Care and Prevention body(s) and to inform the Integrated Plan submission.

Please Note: Persons or groups with a "*" must be included in the planning process to meet HRSA and/or CDC's legislative or programmatic requirements.

Key Stakeholders to Consider for Planning Group Membership

- Health department staff*
- Community- based organizations serving populations affected by HIV as well as HIV services providers*
- People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C*
- Populations at risk or with HIV representing priority populations
- Behavioral or social scientists
- Epidemiologists
- HIV clinical care providers including (RWHAP Part C and D)*
- STD clinics and programs
- Non-elected community leaders including faith community members and business/labor representatives*
- Community health care center representatives including FQHCs*
- Substance use treatment providers*
- Hospital planning agencies and health care planning agencies*
- Intervention specialists
- Jurisdictions with CDC- funded local education agencies/academic institutions (strongly encouraged to participate).
- Mental health providers*
- Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*
- Representatives from state or local law enforcement and/or correctional facilities
- Social services providers including housing and homeless services representatives*

- Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners

Examples of Key Stakeholders to Consider for Community Engagement

- Existing community advisory boards
- Community members resulting from new outreach efforts
- Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.)
- Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC
- STD clinics and programs
- Other key informants
- City, county, tribal, and other state public health department partners
- Local, regional clinics, and school-based healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners and private payors
- Correctional facilities, juvenile justice, local law enforcement and related service providers
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions
- Other key informants

Examples of Community Engagement Activities

- Focus groups or interviews
- Town hall meetings
- Topic-focused community discussions
- Community advisory group or ad hoc committees or panels
- Collaboration building meetings with new partners
- Public planning body(s) meetings or increased membership
- Meetings between state and local health departments
- Social media events

Appendix 4

Suggested Data Sources

Suggested Data Sources:

- Behavioral surveillance data, including databases such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)
- HIV surveillance data, including clinical data (e.g., CD4 and viral load results) and HIV cluster detection and response data. HIV Surveillance Report, Supplemental Reports, and Data Tables: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html
- STI surveillance data
- HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees; CDC HIV testing data)
- NCHHSTP AtlasPlus (HIV, STD, Hepatitis, TB, and Social Determinants): https://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=ss_AtlasPlusUpdate001
- Medical Monitoring Project: https://www.cdc.gov/hiv/statistics/systems/mmp/index.html
- Ryan White HIV/AIDS Program data (Ryan White HIV/AIDS Program Services Report; ADAP Data Report): https://hab.hrsa.gov/data/data-reports
- AHEAD: America's HIV Epidemic Analysis Dashboard: https://ahead.hiv.gov/
- HOPWA EHE Planning Tool: https://ahead.hiv.gov/resources
- Other relevant demographic data (i.e., Hepatitis B or C surveillance, tuberculosis surveillance, and substance use data)
- Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)
- Vital statistics data (e.g., state office of vital statistics, National Death Index, Social Security Death Master File)
- Other Federal Data Sources (e.g., Medicaid Data, HOPWA Data, VA Data)
- Local Data Sources (e.g., Department of Corrections, Behavioral Health services data including information on substance use and mental health services)
- Other Relevant Program Data: (e.g. Community Health Center program data).

Note: An update to the Integrated Guidance for Developing Epidemiologic Profiles is forthcoming in late 2021.

References for CDC DHAP and HRSA HAB Performance Measures:

- HRSA HAB Performance Measure Portfolio: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio
- Core Indicators for Monitoring the Ending the HIV Epidemic: https://ahead.hiv.gov/

Appendix 5

Federal Strategic Plans and Resources

Federal Strategic Planning Documents

- Healthy People 2030: Sets data-driven national objectives to improve health and well-being over the next decade.
- HIV National Strategic Plan: A Roadmap to End the HIV Epidemic (2021– 2025): Roadmap for ending the HIV epidemic in the United States, with a 10-year goal of reducing new HIV infections by 90% by 2030.
- Sexually Transmitted Infections National Strategic Plan for the United States (2021– 2025): Groundbreaking, first ever five-year plan that aims to reverse the recent dramatic rise in STIs in the United States
- Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025: Provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030.
- HHS Ending the HIV Epidemic (EHE): A Plan for America Initiative: EHE aims to reduce the number of new HIV infections in the United States by at least 90% to fewer than 3,000 per year.

Federal HIV Funding Resources

This non-exhaustive list provides web sites to assist with identifying federal HIV funding resources in U.S. jurisdictions.

General

- USA Spending
- Federal HIV Budget

Health Resources and Services Administration (HRSA)

- HRSA HIV/AIDS Programs – Grantee Allocations & Expenditures
- HRSA Bureau of Primary Health Care Health Center Recipients Locator
- HRSA Federal Office of Rural Health Policy, Rural Assistance Center, Rural HIV and AIDS Funding & Opportunities

Centers for Disease Control and Prevention (CDC)

- CDC Division of HIV/AIDS Prevention (DHAP) Funding and Budget
- Notice of Funding Opportunity (NOFO) PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States Component B: Accelerating State and Local HIV Planning to End the HIV Epidemic
- Ending the Epidemic (EHE): Scaling Up HIV Prevention Services in STD Specialty Clinics
- CDC DIS Workforce Development Funding

U.S. Department of Housing and Urban Development (HUD)

- HUD Community Planning and Development Program Listing
- HUD Community Planning and Development – Cross-Program Funding Matrix and Dashboard Reports

Substance Abuse and Mental Health Services Administration (SAMHSA)

- SAMHSA's Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities
- SAMHSA Grant Awards by State
- SAMHSA's Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders

HHS, Office on Minority Health (OMH)

- HHS Office of Minority Health Active Grant Award Locator

National Institutes of Health

- Centers for AIDS Research (CFAR) program

CDC/HRSA Project Officer

Appendix 6

Sample Letter of Concurrence or Concurrence with Reservations between Planning Body and State or Local Health Department or Funded Agency

Dear (Name):

The [insert name of Planning Body, e.g. planning council, advisory council, HIV planning group, planning body] [insert ***concurs or concurs with reservations***] with the following submission by the [insert name of State/Local Health Department/ Funded Agency] in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body (e.g. planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [insert ***concurs or concurs with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

[Insert the process used by the planning body to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process.]

The signature(s) below confirms the [insert ***concurrence or concurrence with reservations***] of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Date:

Planning Body Chair(s)

Sent on behalf of Dr. Ramos, Chief, Office of AIDS

Part A Jurisdictions:

The California Department of Public Health (CDPH), Office of AIDS (OA) is developing the new strategic plan that will fulfill the HRSA and CDC requirements to create a plan to replace the 2016 – 2021 Comprehensive HIV Surveillance, Prevention, and Care Integrated Plan. It will be submitted prior to the December 9, 2022 deadline. The 2022 – 2026 integrated plan will address all of California and will define strategies to achieve the prescribed goal of a 90 percent reduction in new HIV infections by 2030. We have contracted with Facente Consulting to coordinate and assist in writing the new plan.

We want to invite you to use this new statewide plan to satisfy your Part A requirements for an updated plan as is the intent of the HRSA/CDC Guidance. The 2016 – 2021 guidance is intended that funded health departments and planning groups submit one integrated HIV plan to lead the implementation of both HIV prevention and care services. Submitting one plan reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. The Integrated Plan Guidance necessitates engagement from a wide range of stakeholders including people at risk for HIV and people with HIV. If you choose to sign on to this new statewide plan, you could include an addendum for specific local strategies and objectives.

Here is a summary of the process CDPH OA is using to develop the new integrated plan.

The plan is addressing the syndemic of HIV, STDs, and HCV as requested by the large Ending the Epidemics stakeholder group.

- The plan is focused on key social determinants of health that are driving the syndemic
- The plan is being developed in two stages:
  - Year One: Development of Mission, Vision, Values, Core Strategies and Goals.
  - Year Two: Creating a "blueprint" defining activities to achieve the strategies and goals.
- In year one, there has been a core team consisting of staff from the Office of AIDS, the STD Control Branch, and community stakeholders representing the Ending the Epidemics Coalition and community leaders. The core team has representative from northern and southern California, community-based organizations, and priority populations.
  - A series of listening sessions were conducted that brought community subject matter experts addressing racial equity, health access, economic justice, housing first, and behavioral health.

- Values being refined and finalized include: Justice, dignity, collaboration, bold leadership, harm reduction, and structural response.

A draft of the year one portion of the strategic plan is being completed and will be submitted for approval in November.

Based on that input, a final document including the mission, vision, values, core strategies and goals will be completed by the end of the year.

Year Two will be the time to develop a blueprint defining activities to achieve the strategies and goals. This will include:

- Reconfiguring the core team guiding the development of the blueprint. Representatives from each Part A Planning Council will be invited to be part of the core team, significant community engagement in the first half of the year,
- drafting of the plan,
- circulating for community review and final input,
- Completion of the 2022 – 2026 Integrated HIV Prevention and Care plan and submission to HRSA and the CDC by the December 9, 2022 deadline.

We see significant benefits in having one plan for all of California, inclusive of all Part A jurisdictions, and hope you will join us in developing the plan and using it to fulfill the HRSA and CDC requirements as they intend. You will soon receive the draft for the first portion of the plan for your review and feedback. If you have questions about the process and the plan, please feel free to send them to Kevin.Sitter@cdph.ca.gov , who will direct questions to the appropriate people. If you choose to join in using this new statewide plan or are choosing to write your own plan, please let Kevin know so we can ensure your participation in year two as the critical activities necessary to achieve the goals are defined and developed.