LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, February 15, 2022
1:00PM-3:00PM (PST)

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

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
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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.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, FEBRUARY 15, 2022|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/42yeyu6n
**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001
Access code: 2596 006 9518

Planning, Priorities and Allocations Committee Members:			
Frankie Darling Palacios, Co-Chair	Kevin Donnelly, Co-Chair	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	Jesus "Chuy" Orozco	LaShonda Spencer, MD
Damone Thomas	Guadalupe Velasquez, (LOA)	DHSP Staff	
QUORUM:	8		

AGENDA POSTED: February 11, 2022

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.

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

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located 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. – 1:05 P.M.

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

II. PUBLIC COMMENT 1:05 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. – 1:30 P.M.
a. Committee Updates

6. CO-CHAIR REPORT 1:30 P.M. – 1:35 P.M.
a. Co-Chair Nominations/Elections

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:35 P.M. – 2:00 P.M.
a. FY 2021 (PY31) Fiscal Report

V. DISCUSSION 2:00 P.M. – 2:40 P.M.

8. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP
a. Ryan White Part A, MAI, and Prevention Programs

9. COMPREHENSIVE HIV PLAN (CHP) 2:40 P.M. – 2:55 P.M.

VI. NEXT STEPS 2:55 P.M. – 2:58 P.M.

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

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

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

VIII. ADJOURNMENT 3:00 P.M.

13. Adjournment for the Meeting of February 15, 2022.

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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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

January 18, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	P	Anthony M. Mills, MD	A
Frankie Darling Palacios	A	Derek Murray	P
Felipe Gonzalez	A	Jesus "Chuy" Orozco	P
Joseph Green	P	LaShonda Spencer, MD	P
Karl T. Halfman, MS	A	Damone Thomas	P
Michael Green, PhD, MHSA	P	Guadalupe Velasquez	A
William King, MD, JD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Carolyn Echols-Watson, Jose Rangel-Garibay, A.J. King, Consultant, Catherine Lapointe, Lazara Paz-Gonzalez, Facente Consulting/State Consultant and Sonja Wright			
DHSP STAFF			
True Beck, Jane Bowers, Wendy Garland, 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/LinkClick.aspx?fileticket=uZmZWYgsxQs%3d&portalid=22

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Kevin Donnelly, Committee Co-Chair, called the meeting to order at approximately 1:06 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: The Committee approved the November 16, 2021, meeting minutes. 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.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

California State Department of Public Health, Office of AIDS Presentation

C. Barrit noted the California Department of Public Health, Office of AIDS (CDPH) presentation on the meeting agenda. The presentation is on OA'S Strategic Plan Planning Process. It was hoped the presentation would enhance the Committee's planning conversations in the development of the Comprehensive HIV Plan (CHP). The presentation is also in line with the Commission's intent to share and collaborate with State and local partners.

Program Directives

C. Barrit directed the Committee's attention to the Health Resources and Services Administration (HRSA) Quick Reference Handout included in the meeting packet. Members were encouraged to review the materials to assist in preparing Comprehensive Program Directives for the Division on HIV and STD Programs (DHSP).

C. Barrit discussed the preparation of directives. The process includes the review of current directives as well as the refinement and creation of new program directives to enhance the delivery of services. It was noted, DHSP was on the agenda to present data on the Emergency Financial Assistance (EFA) program and Minority AIDS Initiative (MAI) expenditures and demographics which would aid the Committee in developing directives.

C. Barrit highlighted additional directive issues such as some areas for inclusion which could include geographic targeting (i.e., Identifying Service Planning Areas (SPA) of greatest need.), targeting populations, and identifying barriers to care. Directives can be modified throughout the year as additional information is received. They should not duplicate service standards. Any specific items or ideas identified during the process that are related to standards and best practices (SBP) will be brought to the attention of the SBP Committee. Directives should be expressed in plain direct language. Finally, the directives provide direction to DHSP when implementing programs and provides a monitoring tool for the planning body as it relates to the execution of services.

Psychosocial Support Services Allocations

C. Barrit addressed allocation percentages for Psychosocial Support Services. In November 2021, PP&A allocated 1% of funding for Psychosocial Support Services in PY 34. There was concern that the Committee had not allocated funding to these services previously. Staff researched Psychosocial Support Services allocations and found PP&A approved a 2% allocation for Psychosocial Support Services in PY 31 and 32. The recommendations were approved by the Commission in December of 2019.

In September 2020 the Commission approved an allocation modification that did not include funding for Psychosocial Support Services. The modifications reflected DHSP recommendations which were based on PY 30 expenditures.

6. CO-CHAIR REPORT

K. Donnelly thanked Frankie Darling-Palacios for their service as Co-chair.

Jesus "Chuy" Orozco was welcomed to the Committee as the representative from the City of Los Angeles Housing Opportunities for Persons with AIDS (HOPWA) program.

a. Co-Chair Nominations/Elections

Kevin Donnelly accepted his nomination and the Committee elected him by consensus. Dr. William King was nominated but decline the nomination.

K. Donnelly ask for Co-Chair nominations. There were no nominations.

- Co-chair nominations and elections will remain on the agenda until a co-chair is elected.

b. 2022 Workplan

K. Donnelly reviewed the PP&A 2022 Workplan with the Committee. (Workplan in meeting packet) The plan includes nine tasks and were reviewed by K. Donnelly with the Committee. The tasks are as follows.

- Develop the Comprehensive HIV Plan (CHP) 2022-2026,
- Address Areas of Improvement from the Health HIV Planning Council Effectiveness Assessment,
- Strengthen Core Planning Council Responsibilities,
- Develop Strategies for Maximizing Part A and MAI Funding
- Review, discuss and understand financial information from DHSP
- Annual Progress Report (APR)
- Rank Service Categories for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)
- Prevention Planning

J. Green discussed the inclusion of co-chairs visiting Commission entities (committee, taskforces, caucus and workgroups) to inform them of PP&A's tasks as a training tool. It was noted, as part of the Co-Chairs CHP charge, co-chairs visited all Commission entities.

C. Barrit informed PP&A that the Operations committee will launch a training program, in March 2022, that will provide annual mandatory training, refreshers and/or mini trainings on a quarterly basis. Quizzes and incentives to enhance the learning experience have been included. Staff office hours will be

instituted to debrief Committee members on elements discussed in meetings. There will be multiple ways of learning to address the varying ways individuals learn. This addressed J. Green's training issues.

The Committee approved the workplan (7 yeas; 0 noes). K Donnelly noted the plan will be the guiding document for the Committee during 2022.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

Minority AIDS Initiative (MAI) Expenditure and Client Demographics

i. Three years of MAI Expenditures and Demographics by Service Category

Dr. Green noted the MAI report was submitted to the Committee prior to the meeting for review and questions. The floor was opened for questions.

The Committee requested clarification on expenditures and demographics in the report. Wendy Garland reviewed the report with the Committee. (The report is included in the meeting packet.) W. Garland noted the report was prepared to address services provided, quantity of services and client demographics of MAI funded services.

C. Barrit ask for information regarding the pending assessment of mental health services in the County and if the evaluation could shed light on the specific mental health needs of MAI populations. DHSP reported working on a comprehensive review mental health care system capacity in L.A. County. DHSP has not completed the assessment, so analysis of the information is not yet available.

Emergency Financial Assistance (EFA) Expenditure and Client Demographics

ii. EFA Expenditures and Demographics

It was noted the EFA report was provided right before the meeting. Dr. Green reviewed the report with the Committee.

The report displayed demographics and service utilization data from March 2021 through November 2021. (The program was implemented in November 2020.) The annual limit for EFA services is $5,000 annually. Findings indicate White males over 50 were overrepresented in service utilization. Women were slightly overrepresented while Hispanics were underrepresented.

Five hundred (500) applications were received. Because the program is new, DHSP has no historical data to measure previous usage. DHSP has relied on providers to recruit applicants. Expenditures are below the allocated amount. DHSP stated agencies did not have clients in need of EFA services.

The Committee voiced concern about the demographics served and the notion that clients are not in need of services. Young people and women were specifically identified by the Committee.

It was noted, many agencies providing EFA services are located in South Los Angeles and East Valley which include large percentages of people of color. The question was asked what type of outreach activities providers are using to inform people of color about EFA services.

DHSP stated they provided a lot of outreach to agencies regarding the service which included training with Medical Care Coordination (MCC) teams and Benefits Specialists at minimum of twice. Additionally, DHSP continues to reach out to the agencies to answer specific program questions.

The Committee wanted more information on why applicants were not applying for EFA services. It was felt clients are not aware of the service because agencies are not informing clients. A consumer Committee member needed the services but was not made aware of the service until months after requesting a need to the provider.

It was noted clients, particularly women are not on rental agreements. When they apply paperwork can be a barrier because many times their names are not on the agreement. Additionally, paperwork can be a barrier to clients with literacy deficiencies and other disabilities that can impede the completion of required documentation. MCC teams have limited time to assist clients through the entire application process and clients can be intimidated when completing the process without assistance.

- It was recommended DHSP follow up with agencies to determine why the EFA funds have not been fully expended with such a great need for rental assistance. The comment was made that program managers may be aware of the programs, but not line staff. DHSP may need to recommend agencies provide the EFA information to all clients served.

It was noted the EFA demographics were similar to HOPWA utilization data. HOPWA offers a short-term rental and utility assistance program. Multiple housing programs were noted as a possible reason for limited use of EFA funds. Staff providers may be overwhelmed by all the new housing programs each with different application processes. Providers may focus on some programs more than others based on the amount of funding available for client needs. Line staff may tend to direct clients to programs for which they are familiar with the application process.

Housing for Health and Alliance for Housing and Healing administer the application process. They do not provide services directly. EFA referrals and applications are provided by agencies. The program is accessed through a MCC team or Benefit Specialist.

- The Committee recommended some analysis on staff cost of those that assist clients with EFA applications. DHSP noted the contracts do not support salary costs. It was noted the pay and burnout due to the pandemic have led to increasing high turnover rates which is a barrier to service.

- DHSP has agreed to bring back information on some of the issues identified which include outreach and line staff training on the EFA program and application completion.

V. DISCUSSION

8. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. Ryan White Part A, MAI and Prevention Programs

K. Donnelly opened discussion on directives by referencing the previous directives included in the meeting packet. The last approved directives for DHSP were for Program Years (PY) 30, 31, and 32.

- K. Donnelly is requesting all Committees have input to the directives. To that end, K. Donnelly intends to present the directives topic at the Executive Meeting to get input from Committee Co-Chairs.

The Committee was encouraged to review the directives included in the meeting packet.

9. COMPREHENSIVE HIV PLAN (CHP)

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

Lazara Paz-Gonzalez, consultant for OA, provided a PowerPoint presentation on the OA Strategic Plan Planning Process. (The PowerPoint is included in the meeting packet.) The presentation provided insight into State strategies used to prepare the States plan for addressing HIV, HCV, and STI syndemics.

The presentation included general information about

- How the plan is informed (stakeholders, surveys, providers, etc.)
- Plan contents (Vision, values, population priorities)
- Next steps (goals, objectives, community engagement, synthesizing data, etc.)
- Proposed plan (scope of work, advisory committee, community engagement, etc.)
- State's Commitment (collaborate, share, alignment efforts, etc.)

The State will share data and information as appropriate and ensure that there is ongoing communication through the development of the plan. What was presented today will be included in the formal submission to the federal government.

The Committee requested survey results mentioned in the presentation. The Committee has discussed the usage of surveys in the development of the CHP.

- L. Paz-Gonzalez agreed to share raw data and survey questionnaire from surveys used by the State to gather data on social determinants with the Committee. The survey informed the prioritization of strategies. The State wanted to look at social determinants of health as root causes to true need.

L. Paz-Gonzalez provided an e-mail address Lazara@facenteconsulting.com and encouraged members to contact her with any questions.

K. Donnelly noted his attendance at the January 2022 Consumer Caucus meeting in an effort to inform the Caucus on the CHP process and the charge of the Commission in preparing the plan. K. Donnelly received information to inform the plan. As efforts continue, the plan will begin to focus on issues and take shape. A lot of data has been collected. The Committee can use the data to analyze needs and/or gaps in service.

C. Barrit encouraged the Committee to be deliberate and intentional in their efforts to create a plan and assess what is available.

It was recommended the Aging Task Force recommendations and the care framework be included in the directives.

The Committee recommended making the directives very specific targeting geographic populations and effective service models.

Directives are the compliments to service category rankings and percentage allocations approved in the planning process. They can be a very powerful way to address inequities.

- Committee members were encouraged to email any ideas they have for directives before the next meeting.

- The Committee did request housing barrier be addressed in the directives.

VI. NEXT STEPS

10. Task/Assignment Recap

- Committee members were requested to review the utilization data for MAI and send any questions to staff. The questions will be compiled and shared with DHSP for response at the February 2022 meeting.

Additionally, task and assignment are included in the notes above.

11. Agenda Development for the Next Meeting

The following items will be included on the February 15, 2022, agenda

- The Comprehensive Program Directives
- The CHP
- Co-Chair Nominations/Elections

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

13. Adjournment:

The meeting was adjourned at approximately 2:48 PM.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/4/22

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)
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing 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
GARTH	**Gerald**	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
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
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
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
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
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
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
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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**	We Can Stop STDs LA	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)
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	Unaffiliated consumer	No Ryan White or prevention contracts
VEGA	**Rene**	Unaffiliated consumer	No Ryan White or prevention contracts
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

LOS ANGELES COUNTY
COMMISSION ON HIV

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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)**

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 January 11, 2022

1	2	3	4	5	6	7	8	9	10	11
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+8)	COH YR 31 ALLOCATIONS FOR HRSA PART A AND MAI
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 5,326,778	$ -	$ 5,326,778	$ 7,413,108	$ -	$ 7,413,108	$ -	$ -	$ 5,326,778	$ 9,258,477
MEDICAL CASE MGMT (Medical Care Coordination)	$ 8,346,408	$ -	$ 8,346,408	$ 11,198,981	$ -	$ 11,198,981	$ -	$ -	$ 8,346,408	$ 12,174,533
ORAL HEALTH CARE	$ 3,858,564	$ -	$ 3,858,564	$ 6,980,687	$ -	$ 6,980,687	$ -	$ -	$ 3,858,564	$ 5,298,780
MENTAL HEALTH	$ 300,955	$ -	$ 300,955	$ 361,145	$ -	$ 361,145	$ -	$ -	$ 300,955	$ 264,747
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 1,785,389	$ -	$ 1,785,389	$ 2,396,367	$ -	$ 2,396,367	$ -	$ -	$ 1,785,389	$ 2,693,515
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 1,187,415	$ -	$ 1,187,415	$ 1,447,945	$ -	$ 1,447,945	$ -	$ -	$ 1,187,415	$ 1,339,084
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ 310,594	$ 239,270	$ 549,864	$ 519,369	$ 239,270	$ 758,639	$ -	$ -	$ 549,864	$ 302,422
HOUSING-RCFCI, TRCF	$ 98,607	$ -	$ 98,607	$ 194,971	$ -	$ 194,971	$ 2,979,308	$ 3,811,300	$ 3,077,915	$ 403,647 Part A portion
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 2,065,425	$ 2,065,425	$ -	$ 2,733,251	$ 2,733,251	$ -	$ -	$ 2,065,425	$ 2,967,007
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	$ 620,400	$ 827,200	$ 620,400	Part B
MEDICAL TRANSPORTATION	$ 337,565	$ -	$ 337,565	$ 414,122	$ -	$ 414,122	$ -	$ -	$ 337,565	$ 790,405
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 1,745,959	$ -	$ 1,745,959	$ 2,622,221	$ -	$ 2,622,221	$ -	$ -	$ 1,745,959	$ 2,789,438
EMERGENCY FINANCIAL ASSISTANCE	$ 484,147	$ -	$ 484,147	$ 601,678	$ -	$ 601,678	$ -	$ -	$ 484,147	$ -
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 225,593	$ -	$ 225,593	$ 601,582	$ -	$ 601,582	$ -	$ -	$ 225,593	$ -
LEGAL	$ 328,642	$ -	$ 328,642	$ 369,664	$ -	$ 369,664	$ -	$ -	$ 328,642	$ 88,249
SUB-TOTAL DIRECT SERVICES	$ 24,336,616	$ 2,304,695	$ 26,641,311	$ 35,121,840	$ 2,972,521	$ 38,094,361	$ 3,599,708	$ 4,638,500	$ 30,241,019	$ 38,369,155
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 4,637,537	$ 264,891	$ 4,299,341	$ 4,034,450	$ 363,270	$ 4,397,720	$ 212,421	$ 361,500	$ 4,511,762	
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 522,433	$ -	$ 522,433	$ 1,178,277	$ -	$ 1,178,277	$ -	$ -	$ 522,433	
TOTAL EXPENDITURES	$ 29,496,586	$ 2,569,586	$ 31,463,085	$ 40,334,567	$ 3,335,791	$ 43,670,358	$ 3,812,129	$ 5,000,000	$ 35,275,214	
TOTAL GRANT AWARD				**$ 40,344,502**	**$ 3,632,709**	**$ 43,977,211**		**$ 5,000,000**		
VARIANCE				(9,935)	(296,918)			0		
Estimated MAI Carryover from YR 21 to YR 22	**$**	**306,853**								

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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October 9, 2020

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

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

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

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

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

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

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

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

The 2019 HIV Surveillance Report notes following areas of disparities:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

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

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

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

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

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

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

Black/African American Trans Women:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter (COH), Dr. William King (COH), Cynthia Davis (AHF), Luckie Fuller (COH), Jeffrey King (ITMT), Louis Smith III, Stevie Cole, Ivan Daniel III, Carl Highshaw (AMAAD Institute), Charles McWells (LACADA), Dr. Derrick Butler (THE Clinic), David Lee (CDU), Rev Russell Thornhill (MAPP), Terry Smith (APLA), Doris Reed (COH), Carolyn Echols-Watson (COH) and Dawn Mc Clendon (COH).

Endnotes

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

Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32
Status Updates from the Division of HIV and STD Programs (DHSP)

DIRECTIVE	DHSP RESPONSE/STATUS UPDATE
1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.	Solicitations are composed using the latest data, which reflect the geography and other demographics of target populations
2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:	
• Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.	In progress. Some training resources still need to be identified and tested.
• In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/AfricanAmerican population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.	This should be included in the needs assessments conducted as part of the formative work for the development of the comprehensive plan.
• Assess available resources by health districts by order of high prevalence areas.	
• Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.	
• Fund mental health services for Black/African American women that are responsive to their needs and strengths.	Is there a different standard of care for these services for this population?

• Earmark funds for peer support and psychosocial services for Black gay and bisexual men. • It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.	Must be allocated by PP&A. DHSP relies on SBP for guidance.
3. Provide Non-Medical Case Management services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 yrs).	Commission must allocate funds for these programs.
4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.	DHSP has used EHE and HRSA CARES funds to improve capacity to store perishable, nutritious foods, and increase variety and quality of food available consistently.
5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.	The entire housing portfolio needs to be examined in order to determine where DHSP's limited housing resources can have the most impact.
6. Continue to support the expansion of medical transportation services.	In progress
7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to	In progress

reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distributionof eligibility cards as stated by DHSP representatives.	
8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM andtransgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.	Childcare solicitation is nearly complete. EFA program is in place.
9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.	Need more information on what this would look like.
10. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.	Commission should allocate funds accordingly.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21; COH approved on 11/18/21)

STRATEGIES:

1. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for ALL older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, experience aging-related issues earlier in life (before age 50) .

2. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program.

3. Integrate a geriatrician in medical home teams.

4. Establish coordination process for specialty care.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21)

Assessments and Screenings			
Mental Health	Hearing	HIV-specific Routine Tests	Immunizations
Neurocognitive Disorders/Cognitive Function	Osteoporosis/Bone Density	Cardiovascular Disease	Advance Care Planning
Functional Status	Cancers	Smoking-related Complications	
Frailty/Falls and Gait	Muscle Loss & Atrophy	Renal Disease	
Social Support & Levels of Interactions	Nutritional	Coinfections	
Vision	Housing Status	Hormone Deficiency	
Dental	Polypharmacy/Drug Interactions	Peripheral Neuropathologies	

From Golden Compass Program

From Aging Task Force/Commission on HIV

Screenings & Assessment Definitions

- HIV-specific Routine Tests
  - HIV RNA (Viral Load)
  - CD4 T-cell count
- Screening for Frailty
  - Unintentional weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, weak grip strength
- Screening for Cardiovascular Disease
  - Lipid Panel (Dyslipidemia)
  - Hemoglobin A1c (Diabetes Mellitus)
  - Blood Pressure (Hypertension)
  - Weight (Obesity)
- Screening for Smoking-related Complications
  - Lung Cancer - Low-Dose CT Chest
  - Pulmonary Function Testing, Spirometry (COPD)

Screening for Renal Disease

  - Complete Metabolic Panel
  - Urinalysis
  - Urine Microalbumin-Creatinine Ratio (Microalbuminuria)
  - Urine Protein-Creatinine Ratio (HIVAN)
- Screening for Coinfections
  - Injection Drug Use
  - Hepatitis Panel (Hepatitis A, B, C)
  - STI - Gonorrhea, Chlamydia, Syphilis

Screenings & Assessment Definitions (continued)

- Screening for Osteoporosis
  - Vitamin D Level
  - DXA Scan (dual-energy X-ray absorptiometry)
  - FRAX score (fracture risk assessment tool)
- Screening for Male and Female Hormone Deficiency
  - Menopause, decreased libido, erectile dysfunction, reduced bone mass (or low-trauma fractures), hot flashes, or sweats; testing should also be considered in persons with less specific symptoms, such as fatigue and depression.
- Screening for Mental Health Comorbidities
  - Depression – Patient Health Questionnaire (PHQ)
  - Anxiety – Generalized anxiety disorder (GAD), Panic Disorder, PTSD
  - Substance Use Disorder - Opioids, Alcohol, Stimulants (cocaine & methamphetamine), benzodiazepines
  - Referral to LCSW or MFT
  - Referral to Psychiatry
- Screening for Peripheral Neuropathologies
  - Vitamin B12
  - Referral to Neurology
  - Electrodiagnostic testing
- Screening for Sexual Health

Other Suggestions from ATF/COH Discussions

- Screen patients for comprehensive benefits analysis and financial security
- Assess patients if they need and have access to caregiving support and related services
- Assess service needs for occupational and physical therapy (OT/PT) and palliative care
- Review home-based case management service standards for alignment with OT and PT assessments
- Establish a coordinated referral process among DHSP-contracted and partner agencies
- Collaborate with the AIDS Education Training Centers to develop training for HIV specialist and geriatricians.

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AGING TASK FORCE RECOMMENDATIONS
(Final 12/10/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

**This is a living document and the recommendations will be refined as key papers such the State of California Master Plan on Aging and APLA's HIV and Aging Townhall Forums are finalized. **

Ongoing Research and Needs Assessment:

- Encourage the Division of HIV and STD Programs (DHSP) to collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:
    - Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
    - Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.
    - Conduct studies on the prevention and care needs of older adults.
    - Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status.

- Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
- Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.
- Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.
- Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.

Workforce and Community Education and Awareness:

- Educate the Commission on HIV, Department of Public Health, HIV workforce and community at large on ageism, stigma, and build a common understanding of definitions of older adults, elders, aging process and long-term survivors.
- Address ageism on the Commission on HIV and the community at large through trainings and by convening panels composed of Ryan White and prevention services clients and subject experts.
- Openly discuss and examine as part and parcel of HIV planning and implementation, the impediments to HIV prevention and care among aging populations posed by the historically embedded discrimination and bigotry institutionalized in mainstream US culture and society, as well as embedded in subcultural (ethnic, racial, social, religious, etc.) cultures and institutions that often goes unacknowledged: that is the interconnected/overlapping linkages between ageism (or what is expressed in ageism) and societal heteronormativity/homophobia (internalized and cultural), sexism, misogyny, racism, xenophobia, ableism, and all forms of discrimination and bigotry targeting "The Other."
- Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.
- Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.
- Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.
- Expand opportunities for employment among those over 50 who are able and willing to work.
- Provide training on the use of technology in managing and navigating their care among older adults.

- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.
- Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist patients affected by cognitive decline in navigating their care.
- Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.
- Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.
- Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.
- Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50 accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older
- Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.

- Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.

General Recommendations:

- Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.