LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Virtual Meeting

Tuesday, February 16, 2021

1:00PM-3:00PM (PST)

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

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**Link is for non-Committee members only*

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PUBLIC COMMENTS

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, FEBRUARY 16, 2021|1:00 PM – 3:00 PM

To Join by Computer: http://tiny.cc/8f6ctz
**Link is for non-committee members only*

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

Access code: 145 965 6486

Planning, Priorities and Allocations Committee Members:			
Raquel Cataldo, Co-Chair	Frankie Darling Palacios, Co-Chair	Luckie Alexander	Everardo Alvizo, MSW
Al Ballesteros,	Kevin Donnelly	Felipe Gonzalez	Joseph Green
Karl T. Halfman	(Alt .Damontae Hack)	Diamante Johnson (Alt. Kayla Walker-Heltzel)	William King, MD, JD
Miguel Martinez, MPH, MSW	Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD
Maribel Ulloa	Guadalupe Velasquez	DHSP Staff	
QUORUM:	10		

AGENDA POSTED February 12, 2021

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

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

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

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

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.
If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

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

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

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

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

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

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

III. COMMITTEE NEW BUSINESS 1:06 P.M. – 1:08 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 2:00 P.M. – 2:10 P.M.

5. EXECUTIVE DIRECTOR'S/STAFF REPORT

a. New Committee Members
b. Committee Updates

6. CO-CHAIR REPORT 2:10 P.M. – 2:20 P.M.

a. Draft 2021 Committee Work Plan

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT** 2:20 P.M. – 2:30 P.M.

a. Fiscal Update
b. Contracts and Procurement Update
c. Emergency Financial Assistance (EFA) Update

8. **PREVENTION PLANNING WORGROUP UPDATE** 2:30 P.M. – 2:55 P.M.

9. **VI. NEXT STEPS** 2:55 P.M. – 2:58 P.M.

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

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

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

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

a . Adjournment for the Meeting of February 16, 2021.

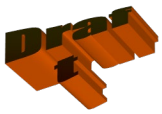
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

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



December 15, 2020

PP&A MEMBERS PRESENT	PP&A MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/CONSULTANTS
Al Ballesteros, MBA, *Acting Co-Chair*	Anthony Mills, MD	Luckie Alexander	Cheryl Barrit, MPIA
	Derek Murray	Geneviéve Clavreul, RN, PhD	Carolyn Echols-Watson, MPA
Raquel Cataldo, *Co-Chair*	LaShonda Spencer, MD	Pamela Coffey	Dawn McClendon
Everardo Alvizo, MSW		Kevin Donnelly	Jane Nachazel
Frankie Darling Palacios	**PP&A MEMBERS ABSENT**	Bernard Schaefers	Sonja Wright, MS, Lac
Joseph Green	Diamante Johnson	Peter Soto	
Michael Green, PhD, MHSA	Kayla Walker-Heltzel	Kevin Stalter	**DHSP/DPH STAFF**
Karl Halfman, MS	Maribel Ulloa		Jane Bowers, MPH
William King, MD, JD			Pamela Ogata, MPH
Miguel Martinez, MPH, MSW			Victor Scott

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Planning, Priorities & Allocations Committee Virtual Meeting, *12/15/2020*
2) **Agenda**: Planning, Priorities & Allocations Committee Meeting Agenda, *12/15/2020*
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *11/17/2020*
4) **Table**: Ending the HIV Epidemic (EHE) Awards – Financial Resources Inventory, *12/15/2020*
5) **Executive Summary**: Ending the HIV Epidemic in Los Angeles County, Executive Summary, *12/1/2020*
6) **PowerPoint**: Integrated Prevention and Care Planning Proposed Short-Term Action Steps, *12/15/2020*
7) **Recommendations**: Integrating Prevention in Multiyear Planning and Commission on HIV Functions, Ideas and Recommendations, *12/2020*
8) **List**: Paradigms/Operating Values
9) **Newsletter**: What's at Stake in the Courtroom?: Health Care Litigation Round-Up, *11/3/2020*

CALL TO ORDER - INTRODUCTIONS - CONFLICT OF INTEREST: Ms. Cataldo called the meeting to order at 1:04 pm.

I. ADMINISTRATIVE MATTERS

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

2. **APPROVAL OF MEETING MINUTES**
MOTION 2: Approve the 11/17/2020 Planning, Priorities and Allocations (PP&A) Committee Meeting Minutes, as presented **(*Passed by Consensus*)**.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION:

- Mr. Stalter noted the Standards and Best Practices (SBP) Committee released the Emergency Financial Assistance (EFA) Standards of Care (SOC) around September 2020, but few people were aware of it despite severe need.
- He urged DHSP mail EFA information to all Ryan White clients much like the California Office of AIDS (OA) mails notices.
- ➲ Refer item to Dr. Green under DHSP report. Ms. Barrit added she and DHSP staff had been trouble-shooting launch issues.

III. COMMITTEE NEW BUSINESS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA: There were no items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- Ms. Barrit noted reviewing accomplishments at this time of year to inform the Commission's Annual Report to the Board of Supervisors (Board). She commended the Co-Chairs for their leadership, compassion, and patience as well as the entire Committee for conducting the Commission's Priority Setting and Resource Allocation (PSRA) process virtually. PSRA is already a difficult process so it is highly commendable to accomplish it virtually on top of today's professional and personal challenges. The Co-Chairs worked hard to foster meaningful consumer engagement and training.
- Commission staff was working with DHSP to finalize the Ending the HIV Epidemic (EHE) Plan due to the federal government at the end of December 2020. Highlights were presented at the last meeting, the Plan was distributed for review after the meeting, and the Executive Summary was in this packet to help inform the prevention planning conversation.
- Staff and the Commission Co-Chairs were also developing the Letter of Concurrence required with EHE Plan submission.
- Per request, an EHE financial resources inventory was in the packet. Ms. Echols-Watson compiled the living document.
- Ms. Barrit was speaking with DHSP staff, especially Wendy Garland, MPH, regarding follow-up on the EHE modeling study on which she presented at the last full Commission meeting. The value of modeling for local and national work and the density of the material warrant a follow-up presentation on the collaboration among DHSP, the University of California at Los Angeles (UCLA), and the Comprehensive Housing Information and Referrals for People Living With HIV/AIDS/Los Angeles (CHIRP/LA). Meanwhile, Ms. Barrit was now reviewing additional materials provided by Ms. Garland.
- ➲ Ms. Barrit previously emailed a reminder to all Commissioners to submit their suggestions for the top three to five Commission accomplishments for the Annual Report to the Board. The suggestion deadline is 12/31/2020. The Commission will see a draft version of the Report before it is submitted.

a. Committee, Caucus, Task Force Updates

- Ms. Barrit will transmit Aging Task Force recommendations to DHSP after this meeting with any additional input.
- The Black African American Community (BAAC) Task Force has started preparations for the National Black HIV/AIDS Awareness Day (NBHAAD) on 2/7/2021. Other groups such as aging and youth were developing 2021 panels as well.
- The Women's Caucus was also developing another Lunch and Learn series for 2021 on health and quality of life.

6. CO-CHAIR REPORT

a. Committee Co-Chair Nominations/Elections

- Ms. Barrit noted that Committee Members are eligible to run for Co-Chair after 12 months on the Committee.
- Mr. Ballesteros will continue on PP&A and will provide his assistance, as requested.
- ➲ Ms. Cataldo nominated Frankie Darling-Palacios who accepted based on a February start and Ms. Cataldo was renominated. Elections will be at the next meeting.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Fiscal Update

- Dr. Green reported no updated projections since the Commission meeting. DHSP still projected fully expending Ryan White grants within the grant terms.
- ➲ Updated financials should be available to share by January 2020.

b. Contracts and Procurement Update

- Dr. Green reported one work order solicitation was active which was for community engagement. The submission deadline has either recently closed or will close soon. It was hoped the new vender will be identified in January and will be able to start the fully executed work order in February 2020.
- Regarding EFA, DHSP has provided extensive training on the SOC to Medical Care Coordination (MCC) teams and was monitoring uptake of services. Using MCC teams as an entry point was largely chosen to ensure linkage to medical care.
- DHSP does not have the capacity to contact clients directly. Contracted providers are expected to notify clients of information though some do so better than others. That does not apply, however, to those in other networks.
- The service itself does not have an outreach component, but DHSP can troubleshoot how to promote availability.
- DHSP will meet with providers on 12/16/2020 to get a sense from them on what uptake has been to date.
- EFA primarily supports utility and very short-term rental assistance. Other eligible costs such as some food and nutrition support are listed in the SOC. Funds can never go directly to a client which can be a limiting factor for eligible assistance, e.g., it cannot be used to pay for a driver's license renewal due to lack of a mechanism to pay for it.
- A significant amount of money was allocated to this multi-year investment. The annual client cap is $5,000 so a realistic plan is developed to keep the client housed. Paperwork is minimal, e.g., a statement from the landlord showing how many months the client is behind, the dollar amount, a copy of a lease with the client's name, and an HIV diagnosis. It was noted by several people that anyone eligible for other financial assistance is already eligible by self-attestation.
- Mr. Stalter said many people like himself are two months rent behind and only need a bridge until the COVID-19 vaccine can support the economy re-opening. He felt it reasonable for EFA support to keep such clients housed.
- Regarding communication, people like himself in the Kaiser network are not as likely to be informed. Dr. Green recognized that access through MCC can be a barrier. DHSP was working on the issue. Current providers are the Alliance for Housing and Healing and Housing for Health (HFH) with the Department of Health Services (DHS).
- On another matter, Mr. Stalter asked how the grant was being spent down when so many appointments were being cancelled. Dr. Green replied that care providers were doing an excellent job of billing at close to the same rate as pre-COVID. Prevention providers were not doing as well so DHSP was asking to be able to carryover some of those funds.

➲ Commissioners may filter clients in need of EFA through the Commission office for DHSP. Staff will track comments.
➲ Dr. Green will follow up on the process for accessing EFA services outside of MCC.
➲ DHSP will request the AIDS Drug Assistance Program (ADAP) provide a contact list for DHSP to advise clients of EFA. DHSP will also consider ads on Scruff and Grindr, and an updated flyer with a contact phone number.

MOTION 2: **(*Darling-Palacios/Spencer*)** Remove as many barriers as possible for clients or PLWH in Los Angeles County (LAC) to access EFA services in order to receive help during this time. Forward this recommendation to both the Commission and DHSP acknowledging that there is a potential for fraud but that providers are very competent at screening clients **(*Passed by Consensus*)**.

V. DISCUSSION

8. PREVENTION PLANNING

a. Work Group Update

- Ms. Barrit thanked Miguel Martinez, Luckie Alexander, Maribel Ulloa, Michael Green, Pamela Ogata, and Carolyn Echols-Watson for their work on these recommendations.

i. Structure and Membership

- Miguel Martinez and Luckie Alexander reviewed the PowerPoint in the packet which followed prevention planning from the pre-integration period under the then Prevention Planning Committee to the present.
- It was recommended to keep Workgroup reports and prevention planning as a standing PP&A agenda item.

➲ Develop Workgroup timeline.

ii. Review Ending the HIV Epidemic (EHE) Plan – Prevention Pillars

- Review of the EHE Plan, DHSP service and investment presentations, and PSRA analysis should be from December 2020 to February 2021. Review and prioritization of data requests should occur from January to March 2021.

iii. Prevention-focused Community Forums among Priority Populations

- Forums from March to May 2021 will offer input to help inform the PSRA process. These may be at atypical times.
- May to June 2021 will offer the opportunity for review and to prepare for a data summit in July or August.
- All Center for Disease Control and Prevention (CDC) grants are on a calendar year.

➲ Agendize both a Workgroup report for the Commission as well as a prevention 101 presentation.

9. OPERATING PARADIGMS AND VALUES REVIEW

- Ms. Barrit noted PP&A has created Paradigms and Operating Values for years to assist in PSRA and drive decision-making discussions with key values and concepts. They are reviewed annually and chosen from a set of a couple dozen.
- Current Paradigms are: Compassion and Equity. Operating Values are: Efficiency, Quality, Advocacy, and Representation.
- Mr. Martinez suggested reversing the order of the Paradigms to Equity and Compassion.
- Luckie Alexander asked how Equity applies when data is lacking for a disproportionately impacted population. Mr. Martinez said it especially pertained to Social Determinants of Health (SDH). Mr. Ballesteros added that PP&A has traditionally requested more data in such cases and, if not available, considered lived experience while requesting a needs assessment.
- ➲ Agendize review of the full list of Paradigms and Operating Values to ensure more complete input from all the Members.

VI. NEXT STEPS

10. TASK/ASSIGNMENTS RECAP: There were no additional items.

11. AGENDA DEVELOPMENT FOR NEXT MEETING: There were no additional items.

VII. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:

- Mr. Ballesteros recognized PP&A achieved a much-needed service with EFA despite this hard year. Ms. Cataldo noted we can achieve much if we unite together in compassion.
- Happy Holidays were wished to all!

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 2:40 pm.

LOS ANGELES COUNTY COMMISSION ON HIV

2021 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
DRAFT 02/16/2021

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Raquel Cataldo and Frankie Darling Palacios
Committee Approval Date:	Revision Dates:

Committee Responsibilities: The PP&A Committee is charged with the following responsibilities: (1)

A. Conducting continuous, ongoing needs assessment activities and related collection and review as the basis for decision-making including gathering expressed need data from consumers on a regular basis and reporting regularly to the Commission on consumer service needs, gaps and priorities;
B. Overseeing development and updating of the comprehensive HIV plan and monitoring of the plan;
C. Recommending to the Commission annual priority rankings among service categories and types of activities and determining resource allocations for Part A, Part B, prevention, and other HIV and STD funding;
D. Ensuring that the priorities and implementation efforts are consistent with needs, the continuum of HIV services, and the service delivery system;
E. Monitoring the use of funds to ensure they are consistent with the Commission's allocations;
F. Recommending revised allocations for Commission approval, as necessary;
G. Coordinating planning, funding, and service delivery to ensure funds are used to fill gaps and do not duplicate services provided by other funding sources and/or health care delivery systems;
H. Developing strategies to identify, document, and address "unmet need" and to identify people living with HIV who are unaware of their status, make HIV testing available, and bring them into care;
I. Collaborating with DHSP to ensure the effective integration and implementation of the continuum of HIV services;
J. Reviewing monthly fiscal reporting data for HIV and STD expenditures by funding source, service category, service utilization and/or type of activity;
K. Monitoring, reporting and making recommendations about unspent funds;
L. Identifying, accessing, and expanding other financial resources to meet Los Angeles County's HIV service needs; and
M. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

Purpose of Work Plan: To focus and prioritize key activities for COH 2021

Prioritization Criteria: Select activities that 1) represent the core functions of the COH; 2) advance goals of the local Ending the HIV Epidemic (EHE) Plan; 3) align with COH staff and member capacities and time commitment; 4) ongoing COVID public health emergency response and recovery priorities.

LOS ANGELES COUNTY COMMISSION ON HIV

2021 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
DRAFT 02/16/2021

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Committee Member Training	Conduct Priority Setting and Resource Allocation (PSRA) Process trainings	Ongoing	Collaborate with the Consumer Caucus for ongoing customized training.
2	Develop Strategies for Maximizing Part A Funding	Monitor and assess the effectiveness of approved allocations and service priority plan. Use data provided by resources such as Department of HIV and STD Programs (DHSP), Ending the HIV Epidemic (EHE) Plan, listening sessions, Transgender, Women and Consumer Caucuses; Black African American Community (BAAC) and Aging Taskforce (TF) recommend-ations. Use the data to establish increasingly effective service strategies.	On-going	
3	Conduct Integrated Prevention and Care Multi-Year Planning	Monitor, review, assess and approve multi-year service and resource allocation plans for coherence.	04/2021	

LOS ANGELES COUNTY COMMISSION ON HIV

2021 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
DRAFT 02/16/2021

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
4	Update program Directives for Maximizing Ryan White Part A and Minority AIDS Initiative (MAI) Funds for PY 31 & 32	Monitor, review, and update Ryan White (RW), Prevention and Minority AIDS Initiative (MAI) directives to DHSP based on current program outcomes.	06-2021	
5	Organize and present financial information	Review and monitor fiscal reports on all HIV funding supporting LAC HIV Care and Prevention services.	Ongoing	Provided by DHSP monthly.
6	Data review	Review epidemiology, program-matic, service utilization for vulnerable populations and prevention data. Prevention data to include HIV testing, PrEP, and PEP.	06/2021	Substance Abuse Prevention and Control (SAPC) presented on Needle Exchange, Wellbeing Center and Meth TF.
7	Unmet Needs	Review and analyze available data on unmet needs annually	07/2021	DHSP presents this data
8	Annual Progress Report (APR)	Review progress report prepared for Health Resources and Services Administration (HRSA) by DHSP	08/2021	
9	Rank Service Categories for PY 33 (FY 2023-24)	Rank (HRSA) Ryan White services numerically and obtain Commission approval to provide service rankings to DHSP for program implementa-tion.	08-2021	Part of integrated prevention and care multi-year planning.
10	Allocations for PY 33 (FY 23-24)	Determine financial resource allocation percentages for HRSA ranked services and obtain Commission approval to provide to DHSP for program implementation.	08/2021	Part of integration prevention and care multi-year planning.

LOS ANGELES COUNTY COMMISSION ON HIV

2021 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
DRAFT 02/16/2021

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
11	Los Angeles County Ending of the HIV Epidemic (EHE) Plan	Monitor LAC efforts to meet EHE plan goals.	09/2021	
12	Prevention Planning	Develop integrated prevention and care planning strategies. Participate in the CDC prevention application process by recommending strategies for inclusion in the CDC prevention plan.	08/2021	The committee established a Prevention Planning Workgroup to prepare short- and long-term prevention activities for recommendation to DHSP; DHSP to provide prevention data

Footnote:
(1) – Taken from Policy/Procedure #60.1000: Commission Bylaws; Adopted July 11, 2013; Page 17 and 18; Section 2 Planning, Priorities and Allocations (P&A) Committee Responsibilities

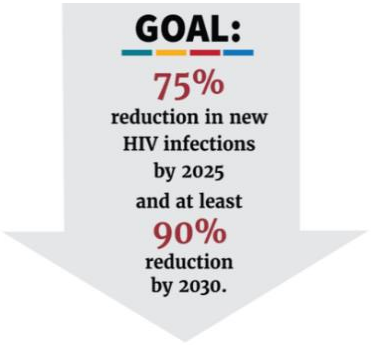
County of Los Angeles - Department of Public Health
Division of HIV and STD Programs

Ending the HIV Epidemic in Los Angeles County
Executive Summary

December 1, 2020

What is Ending the HIV Epidemic?

Ending the HIV Epidemic: A Plan for America (EHE) is a national initiative which focuses on four key pillars of interventions designed to help us reach the goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years (by 2025) and by 90 percent in ten years (by 2030).[i] The four EHE Pillars are: (1) **Diagnose** people living with HIV as early as possible, (2) **Treat** people living with HIV rapidly and effectively to achieve viral suppression, (3) **Prevent** new HIV transmissions using proven interventions, and (4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them. A network of federal partners, including the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Indian Health Service (HIS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Region IX Prevention through Active Community Engagement (PACE) Program, have collaborated to fund and support 57 EHE Phase I priority jurisdictions across the United States to develop and implement strategies that will move us towards an AIDS-free generation. Los Angeles County is one of the 57 priority jurisdictions.



What does HIV look like in Los Angeles County?

In Los Angeles County (LA County) there are approximately 58,000 people living with HIV (PLWH), the majority of these persons are male (90%), a smaller fraction are female (9%) and a smaller number (but highly disproportionate compared to their share of the LA County population) are transgender (either male to female or female to male). The majority of PLWH in LA County are treating their HIV with highly active antiretroviral therapy (ART) and effectively managing HIV as evidenced by their achievement of sustained viral suppression – a level of HIV in the bloodstream that is so low that it is undetectable. While some people living with HIV can achieve viral suppression through the routine and consistent access to their health care delivery system, many other persons living with HIV depend on access to a broader menu of medical and support services to achieve viral suppression. These services include but are not limited to medical care coordination services that improve health system navigation, housing support, mental health, oral health food and nutrition services, substance use treatment, and transportation services.

In Los Angeles County, there are nearly 1,700 new HIV infections each year and separately there are more than 6,000 undiagnosed people living with HIV. For people living with HIV, adherence to ART and achieving viral suppression is critical to promoting health and to ensuring that HIV is not sexually transmitted to others.[ii] For persons who have HIV but are not yet diagnosed (e.g. unaware of their HIV infection) or for persons who have been diagnosed but are experiencing challenges with both adherence to ART and maintaining viral load suppression, the scale up of existing effective interventions and the adoption of new interventions are necessary to achieve our Ending the HIV Epidemic goals. It has been well established that broad scale testing that allows persons with HIV to be diagnosed as close to the period of infection as possible and promptly linking newly HIV diagnosed persons to care and treatment services will not only improve overall individual health outcomes but will also have broad public health benefits. The support and access of new biomedical HIV prevention tools like PrEP (pre-exposure prophylaxis or a daily pill that prevents HIV transmission) for HIV-negative persons at elevated risk for HIV continues to be uneven across Los Angeles County.

Ending the HIV Epidemic in Los Angeles County
Executive Summary
December 1, 2020

The underutilization of these low-cost or no-cost prevention tools in the most impacted areas of our County will require a renewed commitment of education, awareness and mobilization if we are to realize the full potential of this science, and end the HIV epidemic, once and for all.

At the end of 2018, approximately 0.6% of the 10.3 million LA County residents were living with HIV. The group with the plurality of PLWH are Latinx cisgender men who have sex with men (~40%), followed by White cisgender men who have sex with men (26%), followed by Black/African-American cisgender men who have sex with men (23%).[iii] The balance of males with HIV are injection drug users of multiple racial/ethnic groups as well as cisgender American Indian/Alaskan Native, Asian or Pacific Islander men who have sex with men.

Separately, Latinx and Black/African American cisgender heterosexual females each represent approximately 40% of the cases among females while White cisgender heterosexual females represent nearly 19% of female cases. Approximately 1% of female cases are among cisgender heterosexual females who identify as American Indian/Alaskan Native, Asian or Pacific Islander.

Transgender persons continue to be the most disproportionately impacted gender group compared to their share of the LA County population with HIV positivity rates exceeding 30%. The disproportionate impact is evident across all racial/ethnic groups.

Black/African American males, female and transgender persons and American Indian/Alaskan Native males are disproportionately impacted with HIV compared to their share of the LA County population.

How will we end the HIV epidemic in Los Angeles County?

Ending the HIV epidemic locally requires the significant scale up and expanded reach of proven and new interventions that work towards overarching goals and are undergirded by overarching strategies.

Overarching Goal: Reduce new HIV transmissions and acquisitions in the United States by 75% in five years and by 90% in ten years.

Overarching Strategy: Ensure that Los Angeles County Ending the HIV Epidemic pillars of interventions address and eliminate health inequities, address and dismantle racial inequities that are at the root of HIV and related syndemics, focus on the communities most impacted by HIV, and adopts a client-centered, people first approach.

Priority Populations: Based on the most recent LA County epidemiologic profile and other key local data, the priority populations include: Black/African-American men who have sex with men (MSM), Latinx MSM, women of color, people who inject drugs, transgender persons, and persons under 30 years of age.

Ending the HIV Epidemic in Los Angeles County
Executive Summary
December 1, 2020

Diagnose people living with HIV as early as possible.

Why is early diagnosis important? An HIV diagnosis as close to the period of infection as possible is a crucial first step to achieving good HIV-related health outcomes and reducing the likelihood of HIV transmission to others. In LA County in 2019, 1,660 people aged 13 years or older were newly diagnosed with HIV. While HIV diagnoses rates have declined in general and across all most racial and gender groups, Black/African American cisgender men and cisgender women continue to have the highest rates of new diagnoses (number per 100,000 residents.) In 2017, 6,400 people in LA County were unaware of their HIV-positive status and the greatest disparities in awareness were among young people living with HIV (PLWH). In 2017, only 48% of PLWH aged 13-24 years and 66% of PLWH aged 25-34 years were aware of their HIV status, falling short of the 95% local and national target. Disparities in status awareness also persist among persons who inject drugs (PWID), with over one-third of PWID with HIV unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

What will be measured as part of this pillar of EHE?

- Increase the percentage of people living with HIV (PLWH) who are aware of their HIV status to 95%
- Reduce annual number of HIV diagnoses

What strategies will be implemented?

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other settings (such as emergency departments and community health centers) in high prevalence communities. Identify additional opportunities in healthcare and non-healthcare settings where HIV testing can be included, including as part of the delivery of STD screening, substance use treatment, and syringe service program services, among others.

Strategy 1B: Develop locally tailored HIV testing programs to reach persons in non-healthcare settings including home and/or self-testing.

Strategy 1C: Increase the rate of annual HIV re-screening among persons at elevated risk for HIV in both healthcare and non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening and increase ways of maintaining communication with clients.

Pillar 2: Treat people rapidly and effectively to achieve viral suppression.

Why is this important? People diagnosed with HIV should be linked to medical care within days of diagnosis to ensure optimal treatment for the individual and reduce transmission to others. In LA County, HIV testing providers are responsible for linking people who are newly diagnosed with HIV to a specialty care provider. In many instances, due to a combination of factors, including denial of the diagnosis, competing life demands, health care access barriers, necessary but cumbersome financial screening requirements, among others, access to HIV is delayed or halted. In response to these barriers, we must insist on the universal availability of rapid initiation of antiretroviral therapy (ART), an intervention that has been shown to shorten the time to viral suppression. Our current approach to linkage to care must be restructured to promote and incentivize the prompt linkage to care of newly diagnosed persons and coupled with building the capacity among HIV specialty providers to receive same day referrals.
In 2018, 75% of people aged 13 and older newly diagnosed with HIV in LA County were linked to care within one month of diagnosis. The lowest levels of prompt linkage to care were noted among cisgender

women, Black/African-American persons, young persons aged 13-19, persons over age 60, and individuals whose mode of HIV transmission was heterosexual sex or injection drug use, persons who were unhoused at the time of HIV diagnosis, and those who report injection drug use as the transmission risk.

What will we measure to determine if we are making progress in this area?

- The proportion of people diagnosed with HIV who are linked to HIV care within 1 month of diagnosis to 95%
- The proportion of diagnosed people living with HIV (PLWH) who are virally suppressed to 95%

What strategies will be implemented?

Strategy 2A: Ensure rapid linkage to HIV care and ART initiation for all persons newly diagnosed with HIV by developing a network of specialty care providers who offer same day appointments with rapid ART disbursement.

Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not eligible for Ryan White Program-supported services, persons with mental illness and persons with substance use disorders.

Strategy 2C: Expand promotion of Ryan White Program services to increase awareness, access to and utilization of available medical care and support services for PLWH.

Strategy 2D: Develop and implement an emergency financial assistance program that supports PLWH experiencing financial hardship to allow for better treatment adherence or engagement in medical care and/or supportive services.

Strategy 2E: Improve the delivery of HIV services and client satisfaction rates by supporting strategies to address workforce burnout, improve staff capacity to better meet the needs of PLWH, and expand the availability of staff training tied to trauma informed care, stigma reduction, implicit bias, and medical mistrust.

Strategy 2F: Develop and fund a housing service portfolio that provide rental subsidies to prevent homelessness among PLWH.

Strategy 2G: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH. Implement and evaluate a pilot program to determine continued use of financial incentives and potential for expansion to disproportionately impacted populations.

Pillar 3: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs.

Why is this important? PrEP will be a cornerstone to our efforts to end the HIV epidemic because it reduces the risk of getting HIV through sex by about 99% and reduces the risk of getting HIV among people who share and inject drugs by at least 74%, when the medication is taken as prescribed.[iv] In 2018, an estimated 72,700 Los Angeles County residents had an indication for PrEP and approximately 25,500 had

been prescribed PrEP; despite widely available PrEP resources and providers, fewer than a third of people with an indication for PrEP report taking it. Interventions to address suboptimal PrEP coverage, particularly among Black/African American men who have sex with men (MSM) and cisgender women of color, are critically needed.

Historical LA County HIV transmission data reveals that injection drug use (IDU) is a consistent, but less common risk factor for HIV transmission, accounting for less than 5% of HIV cases annually. However, across the United States and the west coast, IDU-based HIV outbreaks have occurred, even in areas where syringe support programs are available. The rise of conditions and co-morbidities that contribute to drug use and are associated with HIV risk, such as economic inequality, homelessness, untreated mental illness, and opioid and methamphetamine use, are becoming more pervasive in LA County. These trends increase our local susceptibility to an HIV outbreak among persons who inject drugs and demands that we expand the reach of syringe service programs. Of the six agencies funded by the LA County Substance Abuse and Prevention Control (SAPC) Program to deliver syringe service programs, only three are funded to deliver HIV, STD, and hepatitis C (HCV) testing, revealing a critical service gap.

What will we do as a sign of progress in this area?

- Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% from a 2017 baseline of 21.5%.
- Increase the number of syringe service programs by 50%.

What strategies will be implemented?

Strategy 3A: Accelerate efforts to increase PrEP use (particularly for populations with the highest rates of new HIV diagnoses and lowest PrEP coverage rates) by adopting new strategies at LA County funded PrEP Centers of Excellence tied to client retention, PrEP navigation, community education related to cost, effectiveness and availability, supporting alternatives to daily PrEP and expanding PrEP support groups.

Strategy 3B: Increase availability, use, and access to comprehensive syringe services programs in collaboration with LA County Substance Abuse and Prevention Control (SAPC) Program and other partners and identify opportunities to improve the delivery of linkage to care services for client accessing syringe service programs to HIV prevention and other services. As part of service expansion efforts, explore alternate models of prevention service delivery (e.g., syringe exchange vouchers for use at pharmacies in exchange for clean syringes and home HIV test kits.)

Pillar 4: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Why is this important? In 2018, LA County adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention.) Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their status but are not virally suppressed. LA County staff perform molecular cluster analysis of available

surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams.

All persons newly diagnosed with HIV should receive a partner services interview to help them engage in HIV care and ensure that any sex or needle-sharing partner is tested for HIV and linked to PrEP or Syringe Service Programs as a strategy to prevent the forward transmission of HIV. Current data suggests that only two-thirds of persons newly diagnosed with HIV infection in LAC receive an offer of Partner Services around the time of their new diagnosis.

What will we accomplish as a sign of progress in this area?

- Develop and maintain capacity for cluster and outbreak detection and response.
- Increase the number of people newly diagnosed with HIV that are interviewed for partner services within 7 days of diagnosis to at least 85%.

What strategies will be implemented?

Strategy 4A: Refine processes, data systems, and policies for robust, real-time cluster detection, time-space analysis within DHSP to help identify hot-spot locations and sub-populations where rapid investigation and response is needed.

Strategy 4B: Refine current processes to increase capacity of Partner Services to ensure people newly diagnosed are interviewed and close partners are identified and offered services in a timely and effective manner.

Ending the HIV Epidemic in Los Angeles County Next Steps

In this unprecedented era of COVID-19, it is imperative now more than ever that the strategies and activities tied to the Ending the HIV Epidemic (EHE) Plan be adopted by a broad cross-section of organizations and that we all work in a concerted fashion towards the goals of the EHE plan.

The full EHE Plan for Los Angeles County can be accessed here. The proposed strategies are complementary to the existing LAC HIV service portfolio and strives to further expand existing prevention and care services available to persons living with HIV or at elevated risk for HIV in our County. The proposed strategies and activities will be implemented starting in 2021 and further expanded over the course of the next five years.

[i] https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

[ii] https://getprotectedla.com/uu/what-is-uu/

[iii] https://www.cdc.gov/healthyyouth/terminology/sexual-and-gender-identity-terms.htm

[iv] https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html

COVID-19: Considerations for People with HIV

Version: December 22, 2020

This document on COVID-19 considerations for people with HIV (PWH) is intended as a resource for clinicians and public health officials. The information is based on evolving best practices developed during the coronavirus pandemic and the available published data on COVID-19. *See the IDSA Real-Time Learning Network's HIV and COVID-19 literature review*. This document will be updated as new data and information become available.

This information is not intended to supersede existing clinical practice guidelines, nor should it be construed as a care directive. For HIV treatment, refer to the HHS *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV* and the HHS HIV/AIDS Guidelines Panel's Interim Guidance for COVID-19 and Persons with HIV. Email HIVMA with suggestions or questions and visit the IDSA RTLN. for additional resources.

Vaccines

The Centers for Disease Control and Prevention recommend that because people with HIV may be at higher risk for serious illness, they can receive the Pfizer-BioNTech and Moderna COVID-19 vaccines if they have no contraindications. They should be counseled that we do not yet know whether the level of protection for people with HIV is as strong as it is for those without HIV. Like everyone else, they should continue to protect themselves and others by wearing face coverings, practicing physical distancing and avoiding crowds because we also do not yet know whether the vaccines prevent infection entirely or just prevent infection from turning into severe disease.

Currently, in most states health care workers and individuals living in nursing homes or long-term care facilities are eligible to receive the two mRNA vaccines that have been given emergency use authorization by the U.S. Food and Drug Administration. During the next phase, essential workers and persons 75 and older will be prioritized for vaccination. People with HIV who fall into any of these groups should be eligible to receive the vaccines barring any contraindications.

Patients with HIV Hospitalized with COVID-19

- PWH on antiretroviral treatment have a normal life expectancy. Therefore, **HIV status should not be a factor in medical decision-making regarding the triaging of potentially lifesaving interventions or enrollment into clinical trials**. Since HIV is eminently treatable, *whether HIV is currently controlled or not* should also not be factor in triaging clinical care interventions, or resources for COVID-19.
- Care and treatment for COVID-19 in PWH should follow the same protocols advised for patients without HIV. See the IDSA Guidelines on the Treatment and Management of Patients with COVID-19 and the NIH COVID-19 Treatment Guidelines.

- Emerging data on COVID-19 in people with HIV suggest that they may be at higher risk for severe disease and worse outcomes. However, it is not yet known if this is due to immunodeficiencies; high rates of comorbid conditions, such as cardiovascular disease, hypertension, obesity and diabetes; or the social determinants of health, including poverty and poor health care access.
- Until more data are available **heightened awareness for severe disease should be considered for persons with HIV**, particularly those who have other comorbidities associated with worse COVID-19 outcomes or CD4+ T cells <200/ml and viral loads > 1000/ml (see Interim Guidance).
- **Consultation with an HIV or infectious diseases (ID) specialist** is strongly recommended for people with HIV who are hospitalized for the treatment of COVID-19.
- If HIV or ID expertise is not available locally, the national Clinician Consultation Center maintains an HIV management warmline Monday to Friday from 9 am ET to 8 pm ET. HIV treatment consultation is available by leaving a voicemail message at **(800) 933-3413 or submitting a** case online **(registration required).** The service responds to voicemail messages as soon as possible with the average response time being 30 to 60 minutes during their business hours. Cases submitted online are responded to within one business day.
- For providers caring for pregnant women with HIV who are also admitted with COVID-19, the Perinatal HIV/AIDS Hotline -- **(888) 448-8765** -- provides 24 hour/7 day week consultation services.
- **Antiretroviral therapy should be continued during hospitalization for COVID-19 without interruption** and changes in therapy are generally not recommended.
- For patients who have not initiated antiretroviral therapy or have been off therapy for > 2 weeks prior to hospitalization, consult with an HIV or ID specialist about a safe plan for initiating antiretroviral therapy as soon as is clinically feasible.
- If a patient is on a COVID-19 clinical trial with a drug active against HIV, an HIV or ID specialist should be consulted to ensure their HIV therapy remains appropriate and that a complete antiretroviral regimen is maintained. In addition, if a patient admitted for COVID-19 is in an HIV-related clinical trial, their ID/HIV providers should be contacted.
- Medications used for treatment of COVID-19 may interact with some HIV medications. **The Liverpool Drug Interaction Group is maintaining prescribing resources for experimental COVID-19 treatments including drug interaction information**.
- For patients who are not able to swallow medications, consult an HIV or ID specialist. Also refer to a resource like this one from the Toronto General Hospital on *Oral Antiretroviral/HCV DAA Administration: Information On Crushing And Liquid Drug Formulations*.

Diagnostic Testing

Follow the IDSA *Guidelines on the Diagnosis of COVID-19* when prioritizing diagnostic testing for COVID-19. As recommended in the guidelines for the general population, people with HIV who are symptomatic should be prioritized for diagnostic testing or who have been exposed to COVID-19 depending on the availability of testing. We have insufficient data in people living with HIV at this time to suggest what laboratory parameters comprise increased immunologic risk for severe COVID-19 disease.

Clinical Trials

People with HIV who are virally suppressed should not be excluded from COVID-19 clinical trials, including trials of therapeutics, prophylaxis, and vaccines. It is important to evaluate the response of people with HIV to COVID-19 therapies and prevention interventions, including vaccines, to ensure interventions approved by the U.S. Food and Drug Administration include an indication for people with HIV.

Issues for Ambulatory HIV Care Management

Social and Physical Distancing

All patients should be educated on the importance of following the CDC guidelines to promote physical distancing and to wear face coverings in public to reduce spread of the virus. Clinic and clinical protocols should be adjusted to support physical distancing through telehealth and home delivery of medication when possible.

HIV Treatment

Changes in antiretroviral therapy to prevent or treat COVID-19 are generally not recommended, except in the context of a clinical trial, a documented failing HIV regimen, and in consultation with an ID or HIV specialist. Please refer to the HHS Interim Guidance for COVID-19 and Persons with HIV.

HIV Viral Load Monitoring

Laboratory monitoring for HIV remains important and should follow current guidelines when possible (see *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV* and the HHS HIV/AIDS Guidelines Panels Interim Guidance for COVID-19 and Persons with HIV). However, it is important to recognize that some of the same resources (personnel, machines, reagents) that are used for HIV RNA testing are also used for COVID-19 testing which might result in limited viral load testing capacity. In these cases, HIV viral load testing **should be prioritized for those who are on a new regimen, have had recent blips, who are pregnant, or who otherwise do not have a history of stable suppression over time**.

Routine Office Visits

For stable patients, or patients with non-urgent appointments, schedule a telephone or telehealth encounter if that is an option. Check with your patients to see if they have COVID-19 questions. For patients with non-respiratory urgent concerns, consider keeping the appointment or offering a telehealth or telephone visit. The American Society of Addiction Medicine has guidance on maintaining access to buprenorphine by leveraging telehealth.

HRSA's HIV/AIDS Bureau is encouraging the use of telehealth in Ryan White clinical settings to support social distancing and refers to PCN #16-02 in support of the policy. The Center for Connected Health Policy is a resource for updates on state telehealth policies. ACGME is maintaining a web page with guidance for residents and fellows, including for participation in telehealth visits. For protocols for telehealth and in person appointments, please see the Practice Resources/Telehealth section of the IDSA Resource Center. Also see IDSA's *Medicare Telehealth: What You Need to Know*.

Prescription Drug Refills

Patients should maintain at least a supplemental 30-day supply of their medications to prevent the possibility of treatment interruptions. A number of health insurers and state AIDS Drug Assistance

Programs are allowing early medication refills and lifting quantity limits in addition to making other changes to their coverage policies. Many health insurers require patients to have a new prescription to obtain a 90-day supply and/or switch to mail order. Please check with your patients to see if they need a new prescription.

Ryan White HIV/AIDS Program

The HIV/AIDS Bureau maintains an online Frequently Asked Questions resource that is regularly updated with questions raised by Ryan White Program grantees.