LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Virtual Meeting

Tuesday, November 15, 2022

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

Agenda and 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:

https://tinyurl.com/35ad35fj

**Link is for non-Committee members only*

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PUBLIC COMMENTS

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

PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE

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

To Join by Computer:

https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m72ca3dd9971d3cb50aebb237e917f7fb

**Link is for non-committee members only*

To Join by Phone: 1-213-306-3065 US Toll

Access code: 2593 727 8158

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA, Co-Chair	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	Michael Green, PhD
QUORUM:	7		

AGENDA POSTED: November 8, 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.

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 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 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 PM – 1:02 PM

I. ADMINISTRATIVE MATTERS 1:02 PM – 1:04 PM

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

II. PUBLIC COMMENT 1:04 PM – 1:14 PM

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 1:14 PM – 1:19 PM

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 1:19 PM – 1:25 PM

6. CO-CHAIR REPORT 1:25 PM – 1:40 PM

a. Co-chair Nominations/Elections
b. Committee Workplan Update
c. Prevention Planning Workgroup (PPW) | Updates
d. Holiday Meeting Schedule (December 20, 2022)
e. Comprehensive HIV Plan 2022-2026 | Updates
f. STI Crisis

7. CITY OF LOS ANGELES HOUSING OPPORTUNITIES FOR PEOPLE LIVING WITH AIDS (HOPWA) REPORT 1:40 PM - 2:00 PM

a. Housing Services | Updates
   i. Service Utilization, Costs and Gaps
   ii. Available Housing Inventory for PLWH
   iii. Waiting Lists

8. DIVISION OF HIV AND STD PROGRAMS (DHSP) 2:00 PM - 2:10 PM

a. Ryan White Program Expenditures

V. DISCUSSION

9. DHSP Response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34. 2:10 PM – 2:30 PM

10. Gaps in services allowable for reimbursement under Ryan White Program 2:30 PM – 2:45 PM

VI. NEXT STEPS 2:45 PM – 2:50 PM

10. Task/Assignments Recap

12. Agenda Development for the Next Meeting

a. Committee Co-chair elections for 2023
b. Continue Discussion of Reallocations of Ryan White Funds

VII. ANNOUNCEMENTS 2:50 PM – 2:55 PM

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

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the Meeting of November 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

COMMISSION MEMBER “CONFLICTS-OF-INTEREST”

Updated 8/31/22

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
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CAO	**Michael**	Golden Heart Medical	No Ryan White or prevention contracts
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	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
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
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
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
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 Affiliation)	No Ryan White or prevention contracts
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	No Affiliation	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

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

September 27, 2022

COMMITTEE MEMBERS **P = Present | A = Absent |EA = Excused Absence**			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	P
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	EA
Joseph Green	P	Derek Murray	P
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	EA
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Lizette Martinez, Sonja Wright, AJ King			
DHSP STAFF			
Pamela Ogata, Victor Scott, Sona Oksuzyan			

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

Meeting agenda and materials can be found on the Commission's website. Click HERE.

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST
Kevin Donnelly, Co-Chair, called the meeting to order at approximately 1:05 PM, welcomed attendees, and led introductions.

I. ADMINISTRATIVE MATTERS

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

2. **Approval of Meeting Minutes**

MOTION #2: Approval of Meeting Minutes ***(✓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

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 committee new business items.*

IV. REPORTS

5. **Execute Director/Staff Report**
   Cheryl Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the Board of Supervisors had their first in-person meeting on September 27th. The Commission on HIV (COH) will vote for in-person vs continuing virtual meetings during October's full-body (COH) meeting. If resume in person meetings, safety protocols will be in place.

   a. **Staffing Update -** C. Barrit introduced new Commission staff, Lizette Martinez, who will be lead staff for the Planning, Priorities and Allocations Committee and Prevention Planning Workgroup.

6. **Co-Chair Report**
   a. **Committee Workplan Review -** K. Donnelly provided an overview of the revisions to the PP&A 2022 Workplan, which can be found in the meeting packet. K. Donnelly identified the reallocations of RWP Part A and MAI funds as high priority item.
   b. **Prevention Planning Workgroup (PPW) | Updates –** Miguel Martinez thanked COH members who completed the Prevention Knowledge, Attitudes, and Beliefs (KAB) survey. PPW will be reviewing the results of the survey during their next meeting on September 28th and will identify key opportunities around prevention planning efforts within the COH.
   c. **Sexually Transmitted Infections (STI) Letter to the Board of Supervisors**
      - COH sent Thank You letter to BOS regarding BOS response for funding to address STIs in LA county. See meeting packet for details.
      - Al Ballesteros inquired if the letter including language for additional funding. C. Barrit commented that the Public Policy Committee is writing a letter to articulate the need for more funding based on data from DHSP. Lee Kochems recommended the letter be broad and should also be sent to the State.

- Katja Nelson stated the BOS should be well aware of lack of adequate funding for STI prevention and treatment within the County.
- Dr. Michael Green informed the PP&A Committee that the County will be receiving an additional $3 million/year from the State for STI prevention/treatment. Funding is guaranteed for 5 years but the state budget is only approved for 3 years. Award is expected in late February/early March.
- A. Ballesteros inquired if there is a way to encourage private sectors, community clinics, and health departments to lean on Medi-Cal and employer-based insurance to pay for services. He also inquired if the Medicare and Medicaid systems allow for STI service providers to access funding for clients. Dr. M. Green responded that DHSP is not aware of uncompensated costs within the private sector. He also noted clients seeking care are not being turned away from clinics. A. Ballesteros commented more attention may be needed on prevention versus treatment efforts.
- Felipe Gonzalez commented that efforts should be focused on education and prevention. He recommended informing the BOS that it is more expensive to treat STIs than to prevent them through education.

d. **Letter of Assurance FY 2023 Non-Competing Continuation Progress Report –** C. Barrit provided an overview of the Letter of Assurance for FY 2023 and informed the PP&A Committee that it was submitted to the Health Resources and Services Administration (HRSA) on October 3rd. HRSA requires a non-competing continuation progress report describing annual planning process, member involvement, service category rankings, training, and resource allocations.

7. **Division of HIV and STD Programs (DHSP)**

a. **Fiscal and Program Updates –** Victor Scott provided an overview of RWP Part A, Minority AIDS Initiative (MAI) and Part B expenditures for PY 32. Part A award for PY 32 is $42,142,230; MAI award for PY 32 is $3,780,205; MAI carry over from PY 31 to PY 32 is $1,747,329. Current estimates show an approximate $4 million surplus that needs to be reallocated and spent. Must spend MAI carryover from PY 31 plus 10% administrative fees first. Can shift MAI expenditures to Part A to carry over to PY 33 but not the 10% administrative costs.

i. **Ryan White Program (RWP) Service Utilization Report**

- Dr. Sona Oksuzyan presented RWP Year 31 Care Utilization Summary. See meeting packet for presentation slides.
- Data report includes data from HIV Casewatch, Linkage Re-engagement Program (LRP), eHARS and DHSP Expenditure Reports
- In PY 31, 21,877 RWP clients received at least one core or supportive RWP service
- 2 in every 5 people living with diagnosed HIV (PLWDH) in LA County used RWP services
- Overall, RWP recipients have better health outcomes than non-recipients
- Latinx and Black clients continue to represent the largest percentage of RWP clients.
- The majority of RWP clients continue to be cisgender men.
- From Year 27 to Year 31, the proportion of RWP clients aged 60 years and older has continued to increase.

ii. **Net County Cost (NCC) Funds Used to Support HIV Services –** See packet for NCC funds used to support HIV services.

8. **City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report**
   a. **Housing Services | Updates**
      i. **Service Utilization, Costs and Gaps**
      ii. **Available Housing Inventory for PLWH**
      iii. **Waiting Lists**

   No HOPWA Report was provided. Staff will reach out again to Chuy Orozco, HOPWA Representative, to have data available for the October meeting.

V. DISCUSSION

9. **Strategies for Reallocations of Ryan White Funds**
   - C. Barrit shared Funding Allocations by Program Directives document and highlighted which service category each directive would fall under. See meeting packet for materials.
   - DHSP has begun looking at ways to maximize funding to spend out surplus and carry over
   - Dr. M. Green announced DHSP will be providing response to the program directives during next month's PP&A Committee meeting.
   - A. Ballesteros suggested looking at ways to address gaps in care for AOM providers and potential to use RWP funds to augment areas that Medi-Cal does not cover. Dr. M. Green agreed it would be a good exercise and will coordinate a meeting with AOM service providers to gather information.
10. **Comprehensive HIV Plan 2022-2026**
    - AJ King provided an overview of the draft Comprehensive HIV Plan 2022-2026. C. Barrit reminded PP&A Committee a draft was sent to the group for review and feedback is due to AJ King by October 3rd.
    - AJ King suggested to narrow target population of people over 50 to people living with HIV over 50.
    - Derek Murray suggested adding language and data that RWP client have better outcomes than the general population of people living with HIV.

VI. NEXT STEPS

11. **Task/Assignments Recap**
    - AJ King will revise the Comprehensive Plan based on PP&A committee/staff feedback and resend for review by full-body COH and public comment.
    - C. Barrit will update Funding Allocations by Program Directives document to add new ideas.
    - DHSP to schedule a meeting with AOM service providers to identify gaps in Medi-Cal funds where RWP funds can be utilized.
    - The PP&A Committee will continue working on the reallocation of $5-6 million of RWP funds.

12. **Agenda Development for the Next Meeting**
    a. **DHSP response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34.**

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

14. Adjournment for the Meeting of September 27, 2022.

The meeting was adjourned by K. Donnelly at 4:10pm

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

October 18, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	A
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	A
Joseph Green	P	Derek Murray	P
Michael Green, PhD, MHSA	EA	Jesus "Chuy" Orozco	A
Karl T. Halfman, MS	EA	LaShonda Spencer, MD	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Lizette Martinez, Sonja Wright, AJ King			
DHSP STAFF			
Pamela Ogata, Victor Scott, Wendy Garland			

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*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website. Click HERE.

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST
Kevin Donnelly, Co-Chair, called the meeting to order at approximately 1:05 PM, welcomed attendees, and led introductions. Kevin noted last minute changes to the agenda.

I. ADMINISTRATIVE MATTERS

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

2. **Approval of Meeting Minutes**

MOTION #2: Approval of Meeting Minutes **(Quorum was not reached; no vote was held.)**

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

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 committee new business items.

IV. REPORTS

5. Execute Director/Staff Report

- Cheryl Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the Commission voted to continue virtual meetings for the month of November during the October full-body Commission on HIV (COH) monthly meeting. The (COH) Annual Meeting will be Nov. 10th from 9am-4pm and will also be virtual. See https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/6e5e4d51-19a4-4d21-97f3-8ffca2bb1e5c/COH%20Annual%20Meeting%202022_FINAL.pdf for meeting details.
- C. Barrit also reminded the committee that co-chair nominations will take place during the November PP&A meeting and elections will be held in December's PP&A meeting.
- Derek Murray inquired about continuing to vote on COH virtual meetings each month until the Governor's public health emergency order ends in February. C. Barrit confirmed monthly voting will continue until the emergency order is lifted and is seeking further clarification with County Counsel regarding virtual meetings beyond the end of the public health emergency order.

6. Co-Chair Report

a. **Committee Workplan Update -** K. Donnelly provided an overview of the revised PP&A 2022 Workplan, which can be found in the meeting packet.

b. **Prevention Planning Workgroup (PPW) | Updates –** Miguel Martinez reported the PPW finalized their workplan and identified 4 key priorities to focus efforts. K. Donnelly stated only 1-2 items focusing on harm reduction and increasing HIV/STD testing strategies would be priority this year and the group will revisit other items at the beginning of the year to make a full, year-long workplan. Felipe Gonzalez agreed with the priority areas and stressed the need to focus on prevention.

c. **Division of HIV and STD Programs (DHSP) Ryan White Program Utilization Report Frequency –** Lizette Martinez reviewed draft utilization report infographics summary. K. Donnelly confirmed the Ryan White Program Utilization Report is only needed once per year. Any other reports will be requested on an as needed basis. Wendy Garland stated DHSP is looking at ways to incorporate some RWP utilization along with expenditure reports to assist in planning and reallocation efforts.

7. **Division of HIV and STD Programs (DHSP) Response to COH Program directives**

P. Ogata provided responses to COH Program Directives; responses provided for directives 1-4. P. Ogata stated that a final document listing DHSP's responses to the directives will be provided to PP&A after Dr. Green's review.

1. Directive #1: Across all prevention programs and services, use a status-neutral approach in service delivery models and create a connected network of services that promote access to PrEP, ongoing preventive care, mental health, substance use, and housing services. A status-neutral approach considers the steps that can lead to an undetectable viral load and steps for effective HIV prevention (such as using condoms and PrEP). The status- neutral approach uses high-quality, culturally affirming care and empowers PLWH to get treatment and stay engaged in care. Similarly, high-quality preventive services for people who are at risk of HIV exposure help keep them HIV-negative. A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated the same way, with dignity and respect, and with the same access to high-quality care and services.

   DHSP Response:

   - DHSP's EHE Outreach and Education team developed HIV Testing palm cards that are status neutral. One side of the palm card has resources for persons diagnosed with HIV, and the other side of the card contains resources for persons who are HIV negative.
   - DHSP recently released a new RFP (through Heluna Health) to fund mini projects that will improve linkage to care, diagnoses, or engagement in care. The RFP recommends the use of a status-neutral approach and is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
   - All DHSP prevention contracts are status-neutral
   - Under vulnerable population contracts, at least four provide housing vouchers and three provide mental health services
   - Persons at risk for HIV should have access to substance use prevention and treatment if they have any private health insurance or through Medi-Cal
   - Identification of a funding source for housing services for persons at risk of HIV has been a challenge. DHSP will advocate with CDC and HRSA to allow more flexibility with funding in order to support the status neutral approach

- P. Ogata noted that new RFPs use blended CDC and HRSA Ending the HIV Epidemic (EHE) funding.

2. Directive #2: Across all funding sources for prevention and care, 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. To determine populations and geographic areas most affected by HIV, request DHSP to provide data on the following:

a. HIV and STD surveillance
b. Continuum of care
c. PrEP continuum
d. Data on low service utilization in areas with high rates of HIV
e. Viral suppression and retention rates by service sites
f. and other relevant prevention and care data

Priority populations are those groups defined in the Los Angeles County Ending the HIV Epidemic plan. "Based on the epidemiologic profile, situational analysis, and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include Black/African American

DHSP Response:

- DHSP has developed HIV and STD dashboards which present current data and trends. Health district and SPA results are available. The dashboards can be accessed at http://publichealth.lacounty.gov/dhsp/Dashboard.htm
- DHSP has and will continue to provide responses to COH data requests. HIV and STD surveillance, RWP Utilization, NHBS, HIV testing, and MMP data were presented during 2021 and 2022. Data were also provided and included in the Comprehensive Prevention Plan.
- DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.

3. Directive #3: Integrate telehealth across all prevention and care services, as appropriate.

DHSP Response:

- DHSP augmented some biomedical contracts to purchase telehealth software
- RWP AOM, MCC, MH, Transitional Case Management (TCM) and Home-Based Case Management (HBCM) services have had the capacity to deliver services via telehealth since March 2020, and will continue using telehealth (phone)
- Prevention programs used Zoom, Facebook and phone and will continue to use these telehealth modalities and a hybrid approach.
- DHSP will continue to monitor and evaluate telehealth usage in the RWP
- New services such as the Spanish language mental health services will require both on-site and telehealth options

- K. Donnelly inquired if DHSP foresees any impediments to expanding the aforementioned prevention and care services. P. Ogata noted that she unaware of impediments but will consult with Paulina Zamudio.

4. Directive 4: Continue the implementation of 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:

a. Directive 4a: 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, monitoring, and evaluation.

   DHSP Response:
   - DHSP developed a training that addresses issues of cultural humility and implicit bias last year. Three hundred people have been trained so far and this work is ongoing.

- K. Donnelly stated that he will ask the Black Caucus to weigh in on DHSP responses to the directives once a final document is received.

b. Directive 4b: 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. Integrate needs assessment objectives and timelines in the 2022-2026 Comprehensive HIV Plan.

   DHSP Response:
   - DHSP has collaborated with Ranya to obtain perspectives and feedback from the Black/African American community to develop a social marketing strategy
   - Black/African American Taskforce will conduct key informant interviews with service providers including workforce development needs
   - Conducting LACHNA is extremely labor intensive and time-consuming activity. The NHBS data can be used for prevention planning and the Medical Monitoring Project (MMP) can be used to understand HIV care needs.
   - A more targeted needs assessments should be completed by COH and AJ as part of the CHP development

c. Directive 4c: Assess available resources by health districts by order of high prevalence areas.

   DHSP Response:
   - DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.
   - DHSP will help improve the response of local HIV efforts to address epidemic among Blacks and African Americans by enlisting new providers and working with other county departments to help make the county contracting process easier to

navigate and more inclusive.

- K. Donnelly noted that there appears to be a lack of data sharing across independent health jurisdictions (i.e., Cities of Long Beach and Pasadena). W. Garland stated that Long Beach and Pasadena do submit surveillance data to Los Angeles County but also submits other data directly to the CDC. She noted that there may be challenges due to delay in reporting from providers.

d. Directive 4d: Conduct a study to identify out-of-care individuals, and populations who do not access local services and why they do not.

DHSP Response:

- DHSP staff are currently analyzing data from the Linkage and Re-Engagement Program (LRP) as well as other Data-to-Care activities to identify out of care individuals and better understand their service needs.

- P. Ogata stated that data collection is an ongoing DHSP activity.

e. Directive 4e: Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in person. Develop a network of Black mental health providers to promote equity and reduce stigma and medical mistrust.

DHSP Response:

- Under the HRSA EHE grant, DHSP has secured a contractor who has conducted a Mental Health Needs Assessment. This assessment includes three levels of inquiry: systems, providers, and clients/consumers. Fifteen keyholder interviews were conducted, and surveys were collected from 35 providers and 29 consumers.
- The consultant presented preliminary findings at the October COH meeting and the final report will be available before the end of 2022.
- Based on the results of the Needs Assessment, DHSP will determine next steps to increase availability of mental health services for Black/African American women.
- Three RFPs for Black/African American or Latino MSM, Black/African American cisgender women, and Black/African American transgender were recently released (October 2022)
- To fully accomplish this goal, reform in the educational and reimbursement systems are needed which is outside DHSP's scope.

- P. Ogata noted that 3 out of the 5 RFPs mentioned are for the African American community. A. Ballesteros inquired if there gaps in AOM services (and other RW services) and coverage not picked up the Medi-Cal that RW could potentially pick-up? Theoretically, DHSP could go back to the earlier period of the current program year to recoup those costs. What areas are not covered by insurance?
- A. Ballesteros noted that he has been reaching out to other providers and has compiled a list of ideas. For instance, he indicated that providers feel that there is a disconnect between AOM and MCC services and identifying service gaps could help improve care while also maximizing grant funds. He noted that it is his understanding that P. Zamudio is also asking providers the same question. A. Ballesteros indicated that he will send his list to P. Ogata and

COH staff.

8. **City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report**
   a. **Housing Services | Updates**
      i. **Service Utilization, Costs and Gaps**
      ii. **Available Housing Inventory for PLWH**
      iii. **Waiting Lists**

   No HOPWA Report was provided. Staff will reach out again to Chuy Orozco, HOPWA Representative, to have data available for the November meeting.

V. <u>DISCUSSION</u>

9. **Comprehensive HIV Plan Update**

- AJ King provided an update on the Comprehensive HIV Plan. Revisions are being made and the 2nd draft of the plan will be available for review by all committee members and available for public comment at the beginning of November.
- AJ King suggested changing one priority population from everyone age 50+ to people who are living with HIV age 50 and older. M. Martinez agreed with the proposed change.
- AJ King also suggesting adding quality of life (QoL) indicators outlined in the National AIDS Strategy and begin to incorporate into objectives. W. Garland voiced concerns over how data on quality-of-life indicators would be tracked and collected and the data manipulation needed to reflect the Ryan White Program (RWP) population. AJ King reiterated the focus would be to assess how the COH can address those indicators for RWP clients. White House Office of National AIDS Policy (ONAP) Director, Harold Phillips, stated at the PACHA meeting that the QoL indicators were derived from the Medical Monitoring Project.
- F. Gonzalez asked if quality of life indicators included unemployment and training. AJ King confirmed the indicators do include a measure focused on employment/unemployment.
- Al Ballesteros commented a contributing issue to unemployment is the Federal government's lack of a process or program to transition clients off Supplemental Security Income (SSI) benefits and into the workforce. Benefits are often tied to housing and other resources. The potential loss of benefits is a major issue for older adults living with HIV and are afraid to lose their housing.
- Alasdair Burton commented this is an issue for the general population as well and resource is needed to help both the HIV population and general population navigate transitioning off SSI and other benefits.

Pamela Ogata asked if the PP&A Committee will be meeting in December. K. Donnelly suggested discussing the December PP&A meeting during the November meeting.

VI. <u>NEXT STEPS</u>

8. **Task/Assignments Recap**

- Nominations/Elections
- Continue discussion of DHSP response to COH program directives
- City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report

- Discussion on gaps in care and cost recuperation allowable using RWP funds
- DHSP expenditure updates

9. Agenda Development for the Next Meeting

a. DHSP response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34.

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

11. Adjournment for the Meeting of October 18, 2022.

The meeting was adjourned by K. Donnelly at 2:57pm

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

COMMITTEE CO-CHAIR

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, Committee Co-Chairs must meet the following demands of their office, representation and leadership:

COMMITTEE LEADERSHIP:

① Serves as Co-Chair of a standing Commission Committee, and leads those monthly meetings
② Leads Committee decision-making processes, as needed
③ Meets monthly with Executive Director, or his/her designee, to prepare the Committee meeting agendas, course of action and assists Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate
④ Assigns and delegates work to Subcommittees, task forces and work groups
⑤ Serves as a member of the Commission's **Executive Committee**

MEETING MANAGEMENT:

① Serves as the Presiding Officer at the Committee meetings
② In consultation with other Co-Chair and senior Commission staff member(s), leads the Committee meetings,
   - conducting business in accordance with Commission actions/interests
   - recognizing speakers, stakeholders and the public for comment at the appropriate times
   - controlling decorum during discussion and debate and at all times in the meeting;
   - imposing meeting rules, requirements and limitations
   - calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed
   - determining consensus, objections, votes, and announcing roll call vote results
   - ensuring fluid and smooth meeting logistics and progress
   - finding resolution when other alternatives are not apparent
   - ruling on issues requiring settlement and/or conclusion

③ Ability to put aside personal advocacy interests, when needed, in deference to role as the Committee's Presiding Officer.

REPRESENTATION:

In consultation with the Executive Director, Committee Co-Chairs:

① May ONLY serve as Committee spokesperson at various events/gatherings, in the public, with public officials and to the media if approved by the Commission Co-Chairs and Executive Director
② Take action on behalf of the Committee, when necessary

- ③ Generates, signs and submits official documentation and communication on behalf of the Committee
- ③ Present Committee findings, reports and other information to the full Commission, Executive Committee, and, as appropriate, other entities
- ⑤ Represent the Committee to the Commission, on the Executive Committee, and to other entities
- ⑥ Support and promote decisions resolved and made by the Committee when representing it, regardless of personal views

KNOWLEDGE:

- ① CDC HIV Prevention Program, Ryan White Program (RWP), and HIV/AIDS and STI policy and information
- ② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
- ③ LA County's HIV/AIDS and STI, and other service delivery systems
- ④ County policies, practices and stakeholders
- ⑤ Ryan White Program legislation, State Brown Act, applicable conflict of interest laws
- ⑥ County Ordinance and practices, and Commission Bylaws
- ⑦ Topical and subject area of Committee's purview
- ⑧ **Minimum of one year active Committee membership prior to Co-Chair role**

SKILLS/ATTITUDES:

- ① Sensitivity to the diversity of audiences and able to address varying needs at their levels
- ② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
- ③ Ability to demonstrate parity, inclusion and representation
- ④ Take-charge, "doer", action-oriented; ability to recruit involvement and interest
- ⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
- ⑥ Firm, decisive and fair decision-making practices

COMMITMENT AND ACCOUNTABILITY TO THE OFFICE:

- ① Put personal agenda aside and advocate for what's in the best interest of the Commission
- ② Devote adequate time and availability to the Commission and its business
- ③ Assure that members' and stakeholders' rights are not abridged
- ④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
- ⑤ Always consider the views of others with an open mind
- ⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
- ⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly & Alvaro Ballesteros
Committee Adoption Date: 1/18/22	Revision Dates: 1/18/22; 7/26/22; 9/7/22; 10/20/22 (new additions in RED)
Purpose of Work Plan: To focus and prioritize key activities for COH 2022	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Develop the Comprehensive HIV Plan (CHP) 2022-2026	The Committee will gather, discuss, develop and provide planning priorities for inclusion in the plan.	11/2022	PP&A will continue to agendize the CHP. The Committee is the conduit for information obtained from all Commission Committees and subgroups. ***Completed and out for public comment***
2	Monitor the implementation of the CHP	The Committee will work with DHSP and various partners to implement and monitor progress toward meeting the goals and objectives of the CHP.	Ongoing beginning 1/1/2023 – 12/31/2026	Agendize item at PP&A meetings.
3	Address Areas of Improvement from the HealthHIV Planning Council Effectiveness Assessment	The Committee will engage the broader community in developing and shaping the CHP.	**Completed**	PP&A is discussing activities to enhance community representation/engagement of underserved populations impacted by HIV in LAC. Conducted listening sessions with priority populations to help shape the CHP.
4	Strengthen Core Planning Council Responsibilities	The Committee will continue to improve the Commission's prevention and care multi-year planning process and decision-making.	**Ongoing**	PP&A has increased the scope and frequency of data reviewed in the decision-making process to optimize services offered.
5	Develop Strategies for Maximizing Part A and MAI Funding	Monitor, assess and create directives for DHSP to effectively		The Committee has used data provided by DHSP, Ending the HIV Epidemic (EHE) Plan,

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		expend Part A and MAI funds to meet the needs of the underserved with specific focus on minority communities.	03/2022 - **Ongoing**	Transgender, Women and Consumer Caucuses; Black African American Community (BAAC) and Aging Taskforces (TF) recommendations in multi-year planning efforts. ***Program Directives for PY 32, 33, and 34 approved by the COH on 6/9/22*** PP&A will create specific DHSP Directives for the use of MAI funding to fully expend funds within the allocation program year. DHSP response on the Program Directives for PYs 32, 33 and 34 due to PP&A in Oct. 2022. PP&A received funding sources and estimates ($5-$6M) of RW funds that need to be reallocated on 8/16/22. *Updated expenditures will be provided in Nov. 2022*
6	Review, discuss and understand financial information from DHSP	Review and monitor fiscal reports on all HIV funds supporting LAC HIV Care and Prevention services.	**Ongoing**	The Committee has requested DHSP provide this information on a monthly basis.
7	Annual Progress Report (APR)	Review progress report prepared for Health Resources and Services Administration (HRSA) by DHSP	08/2022 COMPLETED	Report completed per DHSP. Summary of annual progress report to be provided to PP&A (report back date TBD).
8	Rank Service Categories for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Rank (HRSA) Ryan White services numerically and obtain Commission approval to provide service rankings to DHSP for program implementation.	08/2022 COMPLETED	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before ranking services.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

				PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY 32 allocations approved by the COH 7/14/22
9	Allocations for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Determine financial resource allocation percentages for HRSA ranked services and obtain Commission approval to provide to DHSP for program implementation.	08/2022	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before determining funding allocations. ***PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY 32 allocations approved by the COH 7/14/22***
10	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.	Ongoing	The committee established a Prevention Planning Workgroup (PPW) to prepare short- and long-term prevention activities for recommendation to DHSP; DHSP to provide prevention data *****See PPW Workplan for details***** ***Increase access to syringe exchange and other harm reduction programs and services. Include HIV, STI and hepatitis c screening, education and treatment in harm reduction programs*** ***Increase in-person HIV/STI testing (including HIV self-testing)***
11	Discuss systems of care changes and impact on care and prevention planning.	Agendize the following topics for Committee discussion:	August-December	P. Ogata (DHSP) presented "Medi-Cal Expansion: Preliminary Analysis on the

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		1. Medi-Cal expansion to low-income 50+ individuals regardless of documentation status. 2. CalAIM (California Advancing and Innovating Medi-Cal) 3. Decrease in purchasing power of grant funds due to inflation 4. Making status-neutral planning the norm for PP&A and COH	2022 ***Ongoing***	Impact to Los Angeles County's Ryan White Program" 6/21/22.
12	Complete Letter of Assurance for HRSA FY23/PY33 Non-Competing Continuation Progress Report		***COMPLETED*** Report to HRSA 10/3/22	Letter of Assurance emailed to DHSP 9/2/22
13	Revise funding allocations for FY 2022, 2023, and 2024 based on estimates and landscape analysis provided by DHSP.		Sept-Dec 2022	*DHSP will provide expenditure report in Nov. 2022*

LOS ANGELES COUNTY COMMISSION ON HIV 2022 PREVENTION PLANNING WORKGROUP WORK PLAN
DRAFT/FOR REVIEW (07.13.22; Revised 7.27.22; 08.8.22; 08.15.22; 09/6/22; 10/7/22)

Prioritization Considerations: Select activities that are feasible and within the influence/capacity of the Prevention Planning Workgroup (PPW). PPW was established to infuse and strengthen prevention efforts in the Commission on HIV's planning and priority setting processes and discussions.

# of Votes	**Approval Date:**	**Revision Dates:**

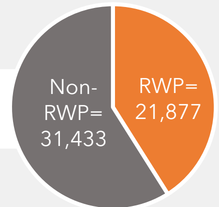
# of Votes	**TASK/ACTIVITY**	**TARGET COMPLETION DATE**
5	Increase access to syringe exchange and other harm reduction programs and services. Include HIV, STI and hepatitis c screening, education and treatment in harm reduction programs. *Combined all syringe access/harm reduction activities together.*	
4	How do we truly target populations/create standards or focus on populations that cannot access organizations based on hours. *Proposed Revision:* *Discuss standards/guidelines for prevention contracts/services to be accessible to target populations that also address social determinants of health.* *Include but not limited to hours of operation, geographic locations, mental health, housing*.	
4	Address unique prevention and health and wellness needs of youth and aging populations	
4	Provide wrap-around services for high-risk negative individuals	
4	Marketing campaign to support awareness of resources about HIV-related services (including influencers)	In progress
4	Identify primary and secondary prevention efforts and develop layered interventions, including but not limited to U=U. *Any layered intervention should include situational factors and social determinants of health, including homelessness, employment, supportive social networks, etc.*	
3	Identify strategies to *increase* in-person HIV, STD and Hep C testing and *self* HIV testing overall	
3	Merge mental health and biomedical prevention efforts/programs	
3	Navigating sex for high-risk negative individuals	
3	Address housing needs of high-risk negative individuals	

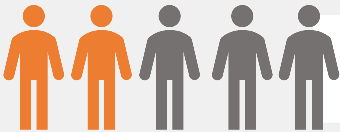
2	Conduct a thorough evaluation of existing directives to infuse prevention focus. *We should include quantitative data so that as we infuse new prevention focus, we're moving towards directives that are empirically-based and against which we can measure progress*	
2	Request data regarding HIV/STD testing, diagnosing, and PrEP for aging population. *I'm not prioritizing this separately, but as part of creating dashboards, we should break out data for the highest risk populations, including, if appropriate, ageing individuals.*	
2	Advocate for a minimum number of prevention-focused presentations each year. *These topics should be dictated in part by the results of the KAB survey and include dashboard data to provide a quantitative foundation for the presentations.*	
1	Review B/AA Task Force recommendations to identify prevention-focused items.	
1	Injectable PrEP information/education focused on navigators at organizations	
1	Recenter conversations and planning back to health districts including requesting prevention indicators (HIV and STD testing, PrEP uptake) by health district. *I think this would necessarily involve our developing a dashboard of prevention metrics that we can use to establish a baseline and against which we measure progress.*	
1	*Identify ways to increase PrEP uptake in Black and Latinx MSM population. Based on data from the AHEAD dashboard, PrEP update is low in LAC.*	
1	Look at creating space for supporting the assessment of readiness for injectable PrEP (at the provider level).	
0	Develop trainings to build the capacity of Commission members based on the knowledge, attitudes, and beliefs (KAB) survey to guide further prevention activities.	In progress
0	Support PrEP Center(s) of Excellence for women (in line with recommendations with B/AA task force). -- **Contracts have been awarded although no agencies selected to serve women exclusively.**	~~In progress~~ *Completed. No one applied to serve women.*
0	Look at ways to support the development of resources to build the capacity of smaller orgs to respond to RFAs/WOS.	In progress
0	Efforts to target monolingual populations regarding prevention information	

Ryan White Program (RWP):
Program Year (PY) 31 Utilization Report Summary

Client Characteristics

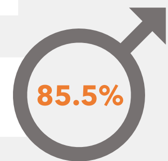
21,877 RWP clients in PY 31 (receiving at least 1 core or support service)

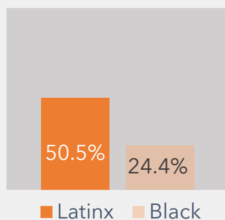




2 out of every 5 People Living with Diagnosed HIV (PLWDH) in LA County use RWP services

Most RWP clients are cisgender men





Most RWP clients are Black (24.2%) and Latinx (50.5%)

There is a continued increase in the percent of clients aged 60 and older over the past 5 years

PY 27	PY 28	PY 29	PY 30	PY 31
13.2%	14.1%	15.3%	16.3%	17.6%

Program Utilization

Increase in average # of RWP clients served per month over the last 3 years

Increase in percent of RWP clients receiving Medical Care Coordination (MCC) services over the past 5 years

Decrease in percent of RWP clients using Residential Substance Abuse and Outreach Services (LRP) over the past 5 years

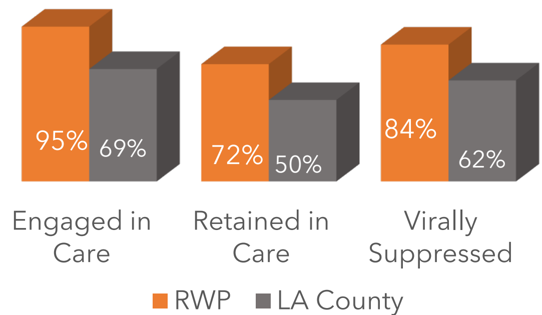
COVID-19 Impact and Recovery

- Telehealth use peaked in May 2020 (40%) and has since declined (21%)
- Significant percentages of MCC clients used telehealth each month over the past two years
- Telehealth was critical for continuity of medical care among Ambulatory/ Outpatient Medical (AOM) services clients during COVID-19
- Most telehealth clients are Latinx, cisgender men, and aged 40-59 years old
- Though the use of telehealth has declined from 56% in PY 30 to 43% in PY 31 it remains an important strategy for expanded service access

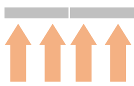
HIV Care Continuum Outcomes

RWP clients have better outcomes than non-RWP PLWDH in LAC

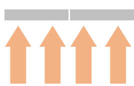
- Engagement in Care 95% vs 69%
- Retained in Care 72% vs 50%
- Virally Suppressed 84% vs 62%



Engagement in Care in priority populations exceeded local target of 90% . Highest among older clients and cisgender women and lowest among people experiencing homelessness & recently incarcerated.



Retention in Care is lower than the *Ending the HIV Epidemic* local target of 90% for all priority populations. Highest among older adults and lowest among youth.



Viral Suppression is lower than the *Ending the HIV Epidemic* local target of 95% for all priority populations. Highest in older populations and lowest among people experiencing homelessness.

Expenditures

- RWP is the payor of last resort
  - All other payor sources must be considered in addition to service-level eligibility criteria (funded vs fundable clients)
  - Not all clients who access RWP services end up having them paid for by the Division of HIV and STD Programs (DHSP)
- PY 31 DHSP paid for 16,963 (funded) of 21,877 (fundable) clients
  - Funded clients differed from fundable clients
  - Higher percentage of funded clients were uninsured and/or experiencing homelessness

Data Sources

- HIV Casewatch (local RWP data reporting system)
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

To see the full report, click here and go to page 29.

RWP: PY 31 Utilization Report Summary
11/7/22

LOS ANGELES COUNTY COMMISSION ON HIV

COUNTY OF LOS ANGELES Public Health DIVISION OF HIV AND STD PROGRAMS

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 32 AND PART B YR 32 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by November 9, 2022

1	2	3	4	5	6	7	8	9	10	11	12
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 EXPENDITURE S MAI	FULL YEAR ESTIMATED EXPENDITURE S PART A + MAI (Total Columns 5+6)	PART A + MAI EXPENDITURE S %	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURE S PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)	COH YR 32 ALLOCATION S %
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 3,732,495	$ -	$ 3,732,495	$ 5,951,829	$ -	$ 5,951,829	15.76%	$ -	$ -	$ 3,732,495	23.70%
MEDICAL CASE MGMT (Medical Care Coordination)	$ 5,243,841	$ -	$ 5,243,841	$ 9,133,907	$ -	$ 9,133,907	24.18%	$ -	$ -	$ 5,243,841	21.87%
ORAL HEALTH CARE	$ 3,280,044	$ -	$ 3,280,044	$ 7,533,983	$ -	$ 7,533,983	19.95%	$ -	$ -	$ 3,280,044	16.36%
MENTAL HEALTH	$ 149,487	$ -	$ 149,487	$ 254,938	$ -	$ 254,938	0.67%	$ -	$ -	$ 149,487	3.78%
EARLY INTERVENTION SERVICES	$ -	$ -	$ -	$ 250,000	$ -	$ 250,000	0.66%	$ -	$ -	$ 250,000	0.00%
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 1,526,290	$ -	$ 1,526,290	$ 2,093,211	$ -	$ 2,093,211	5.54%	$ -	$ -	$ 1,526,290	6.30%
CHILD CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ -	$ -	$ -	0.88%
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 834,887	$ -	$ 834,887	$ 1,330,874	$ -	$ 1,330,874	3.52%	$ -	$ -	$ 834,887	2.27%
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 307,628	$ 307,628	$ -	$ 545,317	$ 545,317	1.44%	$ -	$ -	$ 307,628	0.99%
HOUSING-RCFCI, TRCF	$ 337,439	$ -	$ 337,439	$ 759,241	$ -	$ 759,241	2.01%	$ 2,066,361	$ 4,192,560	$ 2,403,800	0.91%
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,629,249	$ 1,629,249	$ -	$ 2,909,374	$ 2,909,374	7.70%	$ -	$ -	$ 1,629,249	7.38%
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ 342,000	$ 750,000	$ 342,000	--
MEDICAL TRANSPORTATION	$ 324,779	$ -	$ 324,779	$ 488,237	$ -	$ 488,237	1.29%	$ -	$ -	$ 324,779	2.01%
LANGUAGE SERVICES	$ 1,888	$ -	$ 1,888	$ 2,832	$ -	$ 2,832	0.01%	$ -	$ -	$ 1,888	0.60%
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 1,831,893	$ -	$ 1,831,893	$ 3,563,739	$ -	$ 3,563,739	9.44%	$ -	$ -	$ 1,831,893	8.31%

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 32 AND PART B YR 32 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by November 9, 2022

EMERGENCY FINANCIAL ASSISTANCE	$ 614,772	$ -	$ 614,772	$ 1,347,955	$ -	$ 1,347,955	3.57%	$ -	$ -	$ 614,772	3.70%
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 355,492	$ -	$ 355,492	$ 1,066,477	$ -	$ 1,066,477	2.82%	$ -	$ -	$ 355,492	--
LEGAL	$ 362,120	$ -	$ 362,120	$ 537,628	$ -	$ 537,628	1.42%	$ -	$ -	$ 362,120	0.93%
SUB-TOTAL DIRECT SERVICES	$ 18,595,427	$ 1,936,877	$ 20,532,304	$ 34,314,851	$ 3,454,691	$ 37,769,542	100.00%	$ 2,408,361	$ 4,942,560	$ 23,190,665	100.00%
YR 32 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 3,098,231	$ 169,983	$ 3,268,214	$ 4,214,223	$ 378,020	$ 4,592,243		$ 281,868	$ 504,249	$ 3,550,082	
YR 32 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 415,938	$ -	$ 415,938	$ 973,910	$ -	$ 973,910		$ -	$ -	$ 415,938	
TOTAL EXPENDITURES	$ 22,109,596	$ 2,106,860	$ 24,216,456	$ 39,502,984	$ 3,832,711	$ 43,335,695		$ 2,690,229	$ 5,446,809	$ 27,156,685	
TOTAL GRANT AWARD				**$ 42,142,230**	**$ 3,780,205**	**$ 45,922,435**			**$ 5,446,809**		
VARIANCE				(2,639,246)	52,506				0		
MAI Carryover from YR 31 to YR 32	$	1,747,329									
Estimated MAI Carryover from YR32 to YR 33	**$**	**2,261,226**									

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

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

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

Purpose of PCN

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

Background

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

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

HRSA HAB has developed program policies that incorporate both HHS regulations

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

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

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

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

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

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

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

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

Eligible Individuals:

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

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

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

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

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

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

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

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

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

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

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

Service Category Descriptions and Program Guidance

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

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[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.

[3] General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

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

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

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

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

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

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

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

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

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

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

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

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

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

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

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

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*

Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

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

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

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

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

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

Early Intervention Services (EIS)

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

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

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

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

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

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

Description:

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

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

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

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

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

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

when determined to be cost effective.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key activities include:

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

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

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

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

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

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

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

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

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

See also Food-Bank/Home Delivered Meals

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

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

See also Psychosocial Support Services

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

Program Guidance:
None at this time.

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

Allowable activities include:

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

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

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

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

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

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

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:
- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

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

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

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

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

Allowable use of funds include:

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

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

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

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

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

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

Food Bank/Home Delivered Meals
Description:

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

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

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

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

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

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

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

See also Early Intervention Services

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

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

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

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

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

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

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

Legal Services
See Other Professional Services

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

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

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

Program Guidance:
Medical transportation may be provided through:

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

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

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

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

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

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

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

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

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

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

See 45 CFR § 75.459

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

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

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

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

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

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

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

See also Early Intervention Services

Permanency Planning
See Other Professional Services

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

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

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

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

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

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

See also Respite Care Services

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

Program Guidance:

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

vocational therapy.

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

Referral for Health Care and Support Services

Description:

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

Program Guidance:

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

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

See also Early Intervention Services

Respite Care

Description:

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

Program Guidance:

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

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

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

See also Psychosocial Support Services

Substance Abuse Services (residential)

Description:

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

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

Program Guidance:

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

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

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

APPROVED
COH Meeting 6-7-22

Approval Dates: Planning, Priorities, and Allocations Committee 5/17/22/; Executive Committee 5/26/22/; COH 6/9/22; DHSP Response 11/14/22

Program Directives for Maximizing Health Resources Services Administration (HRSA) Ryan White Part A and MAI Funds for Program Years (PY) 32, 33, 34 and Centers for Disease Control and Prevention (CDC) Funding

Purpose: These program directives approved by the Los Angeles County Commission on HIV (COH) on June 9, 2022 articulate instructions to the Division of HIV and STD Programs (DHSP) on how to meet the priorities established by the COH. The Ryan White PY Years 32, 33, and 34 service rankings and allocations table are found in Attachment A.

1. Across all prevention programs and services, use a status-neutral approach in service delivery models and create a connected network of services that promote access to PrEP, ongoing preventive care, mental health, substance use, and housing services. A status-neutral approach considers the steps that can lead to an undetectable viral load and steps for effective HIV prevention (such as using condoms and PrEP). The status-neutral approach uses high-quality, culturally affirming care and empowers PLWH to get treatment and stay engaged in care. Similarly, high-quality preventive services for people who are at risk of HIV exposure help keep them HIV-negative.[1] A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated the same way, with dignity and respect, and with the same access to high-quality care and services.

   DHSP Response:
   - DHSP's EHE Outreach and Education team developed HIV Testing palm cards that are status-neutral. One side of the palm card has resources for persons diagnosed with HIV, and the other side of the card contains resources for persons who are HIV negative.
   - DHSP recently released a new RFP (through Heluna Health) to fund mini-projects that will improve linkage to care, diagnoses, or engagement in care. The RFP recommends the use of a status-neutral approach and is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
   - All DHSP prevention contracts are status-neutral
   - Under vulnerable population contracts, at least four provide housing vouchers and three provide mental health services
   - Persons at risk for HIV should have access to substance use prevention and treatment if they have any private health insurance or through MediCal
   - Identification of a funding source for housing services for persons at risk of HIV has been a challenge. DHSP will advocate with CDC and HRSA to allow more flexibility with funding in order to support the status neutral approach

2. Across all funding sources for prevention and care, 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. To determine populations and geographic areas most affected by HIV, request DHSP to provide data on the following:
    a. HIV and STD surveillance
    b. Continuum of care
    c. PrEP continuum
    d. Data on low service utilization in areas with high rates of HIV
    e. Viral suppression and retention rates by service sites
    f. and other relevant prevention and care data

Priority populations are those groups defined in the Los Angeles County Ending the HIV Epidemic plan. "Based on the epidemiologic profile, situational analysis, and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include Black/African American

[1] hiv-status-neutral-prevention-and-treatment-cycle (nyc.gov)

MSM, Latinx MSM, women of color, people who inject drugs, transgender persons, and youth under 30 years of age. Although priority populations have been selected for EHE, the LAC HIV portfolio will continue to support all populations affected by HIV and will not diminish efforts to prevent, diagnose, and treat HIV for populations who remain a critical concern, including people over age 50 who account for over 51% of PLWH in LAC and people experiencing unstable housing or homelessness, among others" (pg. 21).

The Health Districts with the highest disease burden represent five cluster areas that account for more than 80% of the disease burden (LACHAS, pg. 7)

1. Hollywood Wilshire (SPA 4)
2. Central (SPA 4)
3. Long Beach (SPA 8)
4. Southwest (SPA 6)
5. Northeast (SPA 4)

See health district (HD) maps for ranking by HIV disease burden (Attachment B).

DHSP Response:

- DHSP has developed HIV and STD dashboards which present current data and trends. Health district and SPA results are available. The dashboards can be accessed at http://publichealth.lacounty.gov/dhsp/Dashboard.htm
- DHSP Data Visualization team has developed Health District-level Epi Profiles and a Power BI tool to help track clusters and inform cluster detection and response initiatives more efficiently
- DHSP has and will continue to provide responses to COH data requests. HIV and STD surveillance, RWP Utilization, NHBS, HIV testing, and MMP data were presented during 2021 and 2022. Data were also provided and included in the Comprehensive Prevention Plan.

3. Integrate telehealth across all prevention and care services, as appropriate.

DHSP Response:

- DHSP augmented some biomedical contracts to purchase telehealth software
- RWP AOM, MCC, MH, Transitional Case Management (TCM) and Home-Based Case Management (HBCM) services have had the capacity to deliver services via telehealth since March 2020, and will continue using telehealth (phone)
- Prevention programs used Zoom, Facebook and phone and will continue to use these telehealth modalities and a hybrid approach.
- DHSP will continue to monitor and evaluate telehealth usage in the RWP
- New services such as the Spanish language mental health services will require both on-site and telehealth options

4. Continue the implementation of 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:

a. 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, monitoring, and evaluation.

   DHSP Response:

   - DHSP developed a training that addresses issues of cultural humility and implicit bias last year. Three hundred people have been trained so far and this work is ongoing.

b. 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. Integrate needs assessment objectives and timelines in the 2022-2026 Comprehensive HIV Plan.

   DHSP Response:

   - DHSP has collaborated with Raniyah Copeland to obtain perspectives and feedback from the Black/African American community to develop a social marketing strategy
   - Black/African American Taskforce will conduct key informant interviews with service providers including workforce development needs
   - Conducting LACHNA is extremely labor intensive and time-consuming activity. The NHBS data can be used for prevention planning and the Medical Monitoring Project (MMP) can be used to understand HIV care needs.
   - A more targeted needs assessments can be completed by COH and AJ as part of the CHP development

c. Assess available resources by health districts by order of high prevalence areas.

   DHSP Response:

   - DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.
   - See response to item #2

- DHSP will help improve the response of local HIV efforts to address epidemic among Blacks and African Americans by enlisting new providers and working with other county departments to help make the county contracting process easier to navigate and more inclusive.

d. Conduct a study to identify out-of-care individuals, and populations who do not access local services and why they do not.

DHSP Response:

- DHSP staff are currently analyzing data from the Linkage and Re-Engagement Program (LRP) as well as other Data-to-Care activities to identify out of care individuals and better understand their service needs.
- DHSP has developed a dedicated in-house Data to Action team

e. Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in person. Develop a network of Black mental health providers to promote equity and reduce stigma and medical mistrust.

DHSP Response:

- Under the HRSA EHE grant, DHSP has secured a contractor who has conducted a Mental Health Needs Assessment. This assessment includes three levels of inquiry: systems, providers, and clients/consumers. Fifteen keyholder interviews were conducted, and surveys were collected from 35 providers and 29 consumers.
- The consultant presented preliminary findings at the October COH meeting and the final report will be available before the end of 2022.
- Based on the results of the Needs Assessment, DHSP will determine next steps to increase availability of mental health services for Black/African American women.
- Three RFPs for Black/African American or Latino MSM, Black/African American cisgender women, and Black/African American transgender were recently released (October 2022)
- To fully accomplish this goal, reform in the educational and reimbursement systems are needed which is outside DHSP's scope.

5. Earmark funds for peer support and psychosocial services for Black gay and bisexual men. The Commission allocated 1% funding for Psychosocial Support Services in PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis. 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. For 2022, SBP is developing Best Practices for Special Populations with a specific document for Black/African community across multiple service categories.

DHSP Response:

- It would be helpful to obtain more specific information on the programmatic design of these psychosocial services from the COH
- One of the recently released priority population intervention RFPs (through Heluna Health) is for Black/African American MSM. This RFP requires both MH and psychosocial support services in the program model.
- DHSP currently supports one agency that has a robust peer support program and will obtain more information from them on their program model to inform the development of a RFP. A solicitation is scheduled for release in 2023.

6. Provide Non-Medical Case Management (NMCM) 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 years). The COH's approved allocations for NMCM for PYs 32, 33, and 34 are as follows: 2.44% Part A and 12.61% MAI. The COH requests a solicitations schedule and updates from DHSP on an annual basis.

DHSP Response:

- DHSP recently released a new RFP (through Heluna Health) to fund mini-projects that will improve linkage to care, diagnoses, or engagement in care. Traditional and non-traditional service sites can be proposed. The RFP also encourages non-traditional HIV providers to apply, and the RFP is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
- Two additional RFPs (through Heluna Health) were released. There is one RFP for ciswomen and another for TG persons. A peer-to-peer model to assist with referrals, access to care, and support services is a component of these new RFPs
- One possible way to improve referral and care coordination is electronically through a new data system. DHSP plans to use EHE funds to procure a new data system in 2023.
- DHSP is also exploring the possibility of developing a program that combines psychosocial and NMCM services
- It would be helpful to obtain more specific information on the programmatic design of the requested NMCM services from the COH

7. 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, rideshare services) to clients to facilitate expanded access to food.

DHSP Response:
- The majority of HRSA CARES funds were allocated to nutritional support services for new equipment, food, and PPE
- DHSP has augmented and is currently in the processes of augmenting nutritional support contracts
- Essential non-food items are currently available at DHSP contracted nutritional support providers
- Further enhancement of contracts has been a part of DHSP's investment strategy for RWP funds in 2022

8. Food insecurity affects all people regardless of their HIV status. Support agencies that provide prevention services to have access to and the ability to provide or link clients to foodbanks, food delivery services, and nutritious meals to maintain overall health and wellness. The PrEP navigation system offers a model for linking clients regardless of their status to benefits counseling and leveraging prevention funds to link individuals to wrap- around services and social supports such as housing, transportation, job referrals, legal services, and foodbanks.

DHSP Response:
- DHSP highly recommends that all prevention contractors provide referrals to foodbanks and food delivery services
- DHSP will advocate with CDC and other prevention funders to be more flexible in allowable services/costs

9. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase the 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.

DHSP Response:
- Intensive Case Management services are available to clients participating in the Housing for Health (MAI Housing) program. Initially, Housing for Health notified DHSP that they had other funding to cover the Intensive Case Management services so it was not part of their DHSP contract.
- DHSP is working with Housing for Health to now cover the costs of Intensive Case Management Services and to expand the number of clients served under this contract. DHSP is waiting for a budget proposal from Housing for Health.

10. Continue to support the expansion of medical transportation services for all individuals regardless of their HIV status.

DHSP Response:
- Some HTS providers have transportation under their incentive line items. It is up to each provider to request a transportation line item.
- Transportation services are available and an integral part of Linkage and

Reengagement and Rapid and Ready program.
- DHSP RWP transportation contracts allow family members to utilize ride share
- DHSP will ask CDC if transportation is an allowable cost

11. 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 the paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to expedite the distribution of eligibility cards as stated by DHSP representatives. The COH requests a solicitations schedule and updates from DHSP on annual basis.

DHSP Response:
- RWP Fact Sheets for each service category are currently available on online in both English and Spanish language. These documents will be included in the welcome packet.
- Under the HRSA EHE grant, DHSP has contracted with Heluna Health and the client eligibility cards are one of the scope of work items. The Heluna Health contract was approved within the past 45 days.
- Additionally, the proposed data system will also contain eligibility information to further reduce the paperwork burden on clients

12. 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. Explore funding informal childcare for Medical Care Coordination (MCC) programs for maximum flexibility. The County's Department of Public and Social Services administers a program under CalWORKs that provides childcare allowances to foster care parents. This model may provide insights on a possible contractual or administrative mechanism to expand childcare options using Ryan White or Net County Cost funding.

DHSP Response:
- RWP transportation contracts currently exist
- The Childcare RFP is in development with new services starting in 2023

13. Continue to 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.

DHSP Response:
- All eligible PLWDH can obtain EFA regardless of which RWP service they utilize. Thus, all MCC clients can apply for EFA and a line item is not necessary
- All MCC providers (subrecipients) will be eligible to apply for a Childcare Services contract

- Note: Although not considered EFA, a contingency management program (iCARE) was launched in August 2022. This program provides financial incentives in the form of store gift cards for successfully reaching milestones in HIV care including appointment attendance, lab draws, linkage to supportive services, achieving and sustaining viral suppression for youth (age 30 or younger) and women of child bearing age that are enrolled in the Linkage and Reengagement Program (LRP).

14. Fund mobile care teams or clinics that provide holistic care for women living with HIV. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged. Mobile clinics should aim to be all-inclusive and include bilingual services, STI services, linkages to clinics for ongoing care, STI/HIV testing, PrEP, mammograms, health education, and made availability to women of all ages. Mobile clinics should have the capacity to provide community referrals to food, childcare, housing, recreation and wellness resources, and other support services. Explore partnering with existing street medicine programs to enhance mobile care teams specifically designed for women.

DHSP Response:

- DHSP is assessing the current mobile unit inventory and discussing the type and quantity of mobile units needed
- Beginning in 2019 DHSP staff developed and implemented the POWER project. The goal of the POWER Project is the identification and treatment of women with undiagnosed and/or untreated HIV or syphilis infection who may not otherwise be tested in routine healthcare settings through partnership with County agencies and community-based organizations across Los Angeles County serving women with substance use disorder (SUD), experiencing mental health challenges or experiencing homelessness to provided HIV and STI testing and treatment to these women and their partners. DPH identified three Partner Models for expanding testing and treatment in this population: CBO with DPH staff, street based medicine provider model, and hybrid model (still in development). This project is still ongoing.
- DHSP is collaborating with the USC Street Medicine Group to provide street medicine based services to PLWDH. The program will be called the HIV Transition of Care Project and the contract is currently under review.

15. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support to build a stronger sense of community, empowerment, and resilience among women living with HIV. Maximize access to psychosocial and support group services by offering services remotely and in person. The Commission allocated 1% funding for Psychosocial Support Services for PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis.

DHSP Response:

- Two recently released RFPs recommend peer models for cisgender and transgender women

- A DHSP consultant is training DHSP staff and providing psychosocial and mental health services for women enrolled in the LRP program
- It would be helpful to obtain more specific information on the programmatic design of these psychosocial services from the COH

16. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program and integrate the HIV and Aging care framework developed by the Aging Task Force. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for 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, who experience aging-related issues earlier in life (before age 50). See Attachment C for the HIV and Aging Framework.

DHSP Response:

- A DHSP workgroup will be developed to review this directive. A progress update will be provided to the Aging Caucus in January 2023.

17. Integrate a geriatrician in medical home teams and establish a coordination process for specialty care services for older adults living with HIV.

DHSP Response:

- DHSP is currently reviewing Homebased Case Management Services with the intent of developing a new RFP.

by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

	ons (PY 32) [1]			FY 2023 RW Allocations (PY 33) [2]			FY 2024 RW Allocation (PY 34) [2]		
	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI % [3]	Part A %	MAI %	Total Part A/ MAI % [3]
ies	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
ed	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
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	100.0%	**100.00%**	**100%**	**100.0%**	**100.0%**	**0.00%**	**100.0%**	**100.00%**	**0.00%**

SPA 1

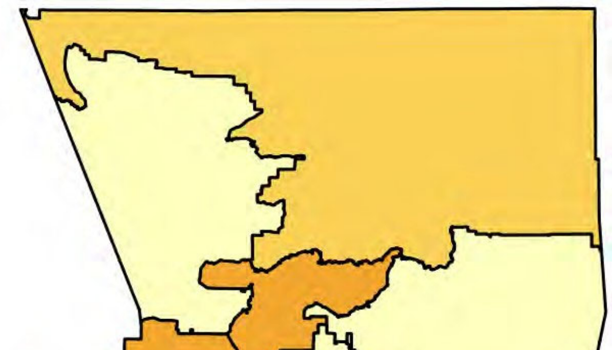
SPA 3

SPA 7

Los Angeles County HIV/AIDS Strategy Goals

By 2022:

1. Reduce annual HIV infections by 500
2. Increase diagnoses to at least 90%
3. Increase viral suppression to 90%



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	

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.