LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, April 19, 2022
1:00PM-3:00PM (PST)

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, APRIL 19, 2022|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/ypp7c7vz
**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001
Access code: 2594 004 5059

Planning, Priorities and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA	Frankie Darling Palacios, (LOA)	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: April 15, 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.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

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

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

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

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

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

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

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

II. PUBLIC COMMENT 1:04 P.M – 1:14 P.M.

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

III. COMMITTEE NEW BUSINESS 1:14 P.M. – 1:19 P.M.

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:19 P.M. – 1:25 P.M.
- a. Operational and Staffing Update
- b. Comprehensive HIV Plan 2022-2026

6. CO-CHAIR REPORT 1:25 P.M. – 1:30 P.M.
- a. Co-Chair Nominations/Elections

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:30 P.M. – 1:40 P.M.
- a. Fiscal and Program Updates

8. PREVENTION PLANNING WORKGROUP 1:40 P.M. – 2:00 P.M.
- a. Meeting Update

V. DISCUSSION

9. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP
- a. Ryan White Part A, MAI, and Prevention Programs 2:00 P.M. – 2:55 P.M.

VI. NEXT STEPS 2:55 P.M. – 2:58 P.M.

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

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

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

VIII. ADJOURNMENT 3:00 P.M.

14. Adjournment for the Meeting of April 19, 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 3/15/22

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

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
GARTH	**Gerald**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
MILLS	**Anthony**	Southern CA Men’s Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
MORENO	**Carlos**	Children’s Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

March 15, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	P
Al Ballesteros, MBA	A	Miguel Martinez, MPH, MSW	P
Frankie Darling Palacios (LOA)	A	Anthony M. Mills, MD	P
Felipe Gonzalez	A	Derek Murray	P
Bridget Gordon	P	Jesus "Chuy" Orozco	P
Joseph Green	P	LaShonda Spencer, MD	A
Michael Green, PhD, MHSA	P	Damone Thomas	P
Karl T. Halfman, MS	P		
COMMISSION STAFF AND CONSULTANTS			
Carolyn Echols-Watson, Jose Rangel-Garibay			
DHSP STAFF			
Pamela Ogata, and Jane Rohde Bowers			

*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-CONFLICTS OF INTEREST
Kevin Donnelly Committee Co-Chair, called the meeting to order at approximately 1:05 PM. Members and attendees introduced themselves.

I. ADMINISTRATIVE MATTERS

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

2. APPROVAL OF MEETING MINUTES
MOTION #2: The Committee approved the February 15, 2022, meeting minutes. Minutes can be amended up to 1 year after approval. **(Passed by Consensus)**

II. PUBLIC COMMENT

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

Lazara Paz-Gonzalez, member of the Facente Consulting for the California Department of Public Health (CDPH), Office of AIDS (OA) announced the first CDPH Integrated Strategic Plan Statewide Town Hall event. It will be held virtually on March 18, 2022, from noon to 2pm PST. People will have an opportunity to hear about the Statewide Strategic Plan: approach, process, strategies, and timeline as well initiatives implemented at the state level. Statewide structural changes will be shared by presenters from collaborating state departments (such as behavioral health, housing, and Medi-Cal). Attendees will be encouraged to engage and provide thoughts and suggestions on how to move forward. The following is the registration link for the townhall.
https://us06web.zoom.us/meeting/register/tZEkdOqvrTsiGtJ0lq2cDAZJjcDNUKebDHHS

III. COMMITTEE NEW BUSINESS ITEMS

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

There were no new business items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Committee Updates

No updates provided.

Comprehensive HIV Plan (CHP)

No report given.

6. CO-CHAIR REPORT

a. Co-Chair Nominations/Elections

K. Donnelly attempted to encourage Damone Thomas to become a Co-Chair of the Committee. Damone is now an Executive At-Large. Mr. Thomas noted his commitment to the Consumer Caucus, Operations, Executive and PP&A Committees. As an Executive At-Large member his committee assignments are now Operations and Executive.

The Committee remains in need of a Co-Chair. K. Donnelly appealed to the members of the PP&A Committee to step up to leadership position and join him in this important role.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. The Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32 Status Updates

DHSP had no additional information on the progress of items # 9 and 10 on the Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32 Status Updates.

Dr. Green did provide an update on PY 31 expenditures. DHSP anticipates Part A funds to be fully expended. The Minority AIDS Initiative (MAI) is anticipated to have a $200,000 carryover from Program Year (PY) 31 to PY 32.

Dr. Green noted, there is no final award for PY 32 to date. DHSP anticipates an award notice by May 2022. The award will provide a 36-month allocation. Health Resources and Services Administration (HRSA) will not require a funding application for three program cycles. The award amount for PY 32 is anticipated to be between $41-43 million. There will be a requirement to submit progress/annual and budget reports and a program implementation plan. DHSP is awaiting additional information from HRSA. The 3-year planning cycle for PP&A should not be affected by administrative changes from HRSA and PP&A will still conduct reallocations as needed. The review of PY performance and expenditures will continue to be reviewed on an annual basis and reallocations may still be required annually.

DHSP confirmed the Committee/Commission can implement needs assessments for both care and prevention utilizing Center for Disease Control and Prevention (CDC) and Ryan White (RW) funds. The Commission may layout needs assessments for specific populations and service categories.

Dr. King and K. Donnelly will work with the Black Caucus to elicit their feedback on the revised directives. A few of the directives from the Black Caucus are already being addressed.

K. Donnelly noted he is trying to avoid duplication of work since some of ideas related to the program directives may also be outlined in the Comprehensive HIV Plan (CHP). He will work with AJ King to identify and organize important items for inclusion in the CHP.

Kevin Donnelly reviewed the upcoming DHSP solicitation list with the Committee. (The list is included in the meeting packet.) It was noted psychosocial services was not included on the list. Dr. Green noted the childcare services is ready to be sent to County Counsel for review and they hope to release the RFP in mid-May. DHSP will need to gather more information before tackling solicitations for psychosocial support services. Evaluation and transitional case management (TCM)-jails will be handled as a direct service order with the Department of Healthcare Services. The Biomedical services RFP closes today, March 15.

DHSP requested the Committee provide feedback in developing a Transitional Case Management service for people who are aging out of Ryan White because of their eligibility for Medicare. He mentioned this suggestion to the Aging Task Force as well.

Non-Medical Case Management is back on the list of solicitations as well as psychosocial support services. TCM for youth was described as youth with HIV who are transitioning from pediatric to adult care. TCM youth services may not need changes at this point.

DHSP noted Benefit Specialty Services (BSS) current structure may not meet the future needs of clients.

As client's eligibility for Medi-Cal expands, RW services may need to be rethought being the payer of last resort. The list of benefits in CA continues to grow, thus BSS need to take into account the growing number of public benefits in the State. Because RW is the payer of last resort, DHSP will need to count on agencies to do a better job of counseling clients around benefits outside of the RW system. This may require a revamp of the BSS program to handle the additional programs that RW clients may be eligible for.

M. Martinez noted the Prevention Planning Workgroup discussed making sure that the directives reflect strong language around prevention and articulate how prevention directives relate to care.

The Committee discussed status neutral approach to planning. Dr. Green note, taking a status neutral approach would lead to a more expansive prevention programming. For example, DHSP is looking at a status neutral approach to housing, mental health and substance use. Historically, RW has been the only funding available to people who already with HIV, hence, finding resources to provide services to high-risk negatives in certain service categories is important to operationalizing status neutral approach Other jurisdictions in the country have done a good job with status neural conversations and Los Angeles County (LAC) can learn from those communities. There are some webinars and manuscripts on the topic. Under the status neutral approach, prevention planning could be mean more than just testing and biomedical interventions. It fosters a conversation about the entire continuum of care and how different services are affecting each step in the continuum.

K. Donnelly stated that having additional conversations and learning around what a status neutral approach could look like in LAC and the Commission's planning process is warranted.

D. Murray inquired if the approach indeed shifts to status neutral, would this mean that the funding becomes less restrictive? Dr. Green replied the answer depends on HRSA. He added that the intent of the EHE funding is to expand the network of agencies providing prevention services. DHSP has been advocating to get more information from Part C, D and federally qualified centers on what they are doing to respond to HIV and how they can leverage their resources to provide services to higher risk patients they serve. However, they have had limited success in being able to engage on a regular basis with any kind of continuity. This could be a starting place for thinking through how to improve the overall prevention and care service delivery in LAC.

Carolyn Echols-Watson reminded the Committee that drafting the directives should align with the service priorities and allocations approved by the Commission. The directives are aimed at bolstering the service rankings and allocations. Hence, the directives should be linked to the hierarchy of services, funding allocations and how services are delivered. Who should receive the services? The Committee may also state a specific geographic area for service delivery. The directives are to DHSP on how to deliver the services.

J. Orozco noted that he will share and discuss the housing directives in the document to determine if his office could develop additional instructions to their housing providers. Housing is discussed under directive number 5.

M. Martinez suggested that directive #1 should remain but add the priority populations; for directive #2, request DHSP updates. He supported uplifting some of the recommendations from the Black/African American Community Task Force. Staff will include the BAAC recommendations status tracker at the next PP&A meeting to show how a few of the BAAC recommendations are being addressed; some items have been completed.

For #1: list priority populations highlighted in the local Ending the HIV Epidemic plan, and high need heath districts and SPAs with unmet need or continues to highly burdened. The Committee discussed listing health districts and SPAs. Use the health district maps from DHSP Los Angeles County HIV/AIDS Strategy Report.

Dr. Green stated that DHSP has not had the capacity in surveillance to update data by health districts. The health district data is on their list to tackle. Dr. Green stated that surveillance data will always have a six-month lag, hence we will not always have the most current picture of the continuum data. D. Murray requested linkage, retention, viral suppression, care continuum data by health districts. This data would be helpful for PP&A's decision-making and justification for service prioritization.

V. DISCUSSION

8. PREVENTION PLANNING WORKGROUP

M. Martinez reported that PPW now has 2 additional Co-Chairs: Dr. King and Greg Wilson. The Co-Chairs met to discuss recentering the group around the purpose of creating the PPW which is to ensure that there is a strong prevention lens in the Commission's planning efforts. For the April meeting, the PPW will discuss what are the ways that we can establish a baseline on the COH's understanding and comfort in engaging in prevention-focused conversations. How do we do more status neutral service planning as a body? Another item for PPW discussion is looking at the current directives to ensure that they are updated, fully inclusive, and centers prevention alongside with care. There will be no PPW meeting in March due to support staff issues. Next meeting will be on April 27 from 5:30pm to 7:00pm. M. Martinez acknowledged DHSP's support in encouraging prevention providers to attend and engage with the PPW.

M. Martinez cautioned people about the use certain words like "choice" when talking about prevention or high-risk groups. People are often marginalized because of their identity. He stated the importance of thinking about people's lived experiences and to make sure we are not using language that blame individuals for their choices. Prevention is influenced by historical trauma, disinvestments in our priority populations, like transgender community, women of color and youth, and communities that do not have autonomy over their own bodies. It should not be a surprise why these communities are high on the list of communities we need to serve.

D. Thomas stated a need for broader thinking to provide education and prevention to all sexually active individuals.

Alasdair Burton inquired if anyone in the Committee or DHSP is aware of any data around seroconversion as a result of a single act of unprotected sex. He felt that this type of data might be useful to understand data around those who are sexually active and may not consider themselves to be at high risk for HIV

acquisition. Dr. Green noted that risk is self-reported and we may not know the answer to the question.

9. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. Ryan White Part A, MAI, and Prevention Programs-- *Discussion reflected under item 7.*

VI. NEXT STEPS

10. Task/Assignment Recap

- Request status reports from DHSP on health district data.
- DHSP will provide virtual suppression data
- Committee to provide feedback on psychosocial support services
- K. Donnelly will work with staff to prepare for next discussion on directives.
- Continue to encourage Committee members to fill second PP&A Committee Co-Chair seat.

11. Agenda Development for the Next Meeting -- *See Tasks/Assignment Recap.*

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

a. Adjournment:

The meeting was adjourned by K. Donnelly at approximately 2:40PM. The meeting was adjourned in acknowledgement of Carolyn Echols Watson's retirement and service to the PP&A Committee, the Commission and the County.

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS

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

Expenditures reported by April 11, 2022

1	2	3	4	5	6	7	8	9	10	11
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+8)	COH YR 31 ALLOCATIONS FOR HRSA PART A AND MAI
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 6,539,435	$ -	$ 6,539,435	$ 7,421,457	$ -	$ 7,421,457	$ -	$ -	$ 6,539,435	$ 9,258,477
MEDICAL CASE MGMT (Medical Care Coordination)	$ 9,198,809	$ -	$ 9,198,809	$ 10,857,091	$ -	$ 10,857,091	$ -	$ -	$ 9,198,809	$ 12,174,533
ORAL HEALTH CARE	$ 5,507,097	$ -	$ 5,507,097	$ 7,027,006	$ -	$ 7,027,006	$ -	$ -	$ 5,507,097	$ 5,298,780
MENTAL HEALTH	$ 338,005	$ -	$ 338,005	$ 354,521	$ -	$ 354,521	$ -	$ -	$ 338,005	$ 264,747
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,188,892	$ -	$ 2,188,892	$ 2,332,211	$ -	$ 2,332,211	$ -	$ -	$ 2,188,892	$ 2,693,515
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 1,357,247	$ -	$ 1,357,247	$ 1,426,549	$ -	$ 1,426,549	$ -	$ -	$ 1,357,247	$ 1,339,084
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ 483,127	$ 239,270	$ 722,397	$ 528,821	$ 239,270	$ 768,091	$ -	$ -	$ 722,397	$ 302,422
HOUSING-RCFCI, TRCF	$ 98,607	$ -	$ 98,607	$ 194,971	$ -	$ 194,971	$ 3,191,624	$ 3,853,300	$ 3,290,231	$403,647 Part A portion only
HOUSING-Temporary and Permanent Supportive with Case Management	$ 42,652	$ 1,996,763	$ 2,039,415	$ 42,652	$ 2,648,983	$ 2,691,635	$ -	$ -	$ 2,039,415	$ 2,967,007
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	$ 744,825	$ 785,200	$ 744,825	Part B
MEDICAL TRANSPORTATION	$ 413,849	$ -	$ 413,849	$ 428,653	$ -	$ 428,653	$ -	$ -	$ 413,849	$ 790,405
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 2,424,695	$ -	$ 2,424,695	$ 2,616,709	$ -	$ 2,616,709	$ -	$ -	$ 2,424,695	$ 2,789,438
EMERGENCY FINANCIAL ASSISTANCE	$ 1,001,034	$ -	$ 1,001,034	$ 1,131,095	$ -	$ 1,131,095	$ -	$ -	$ 1,001,034	$ -
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 459,418	$ -	$ 459,418	$ 612,558	$ -	$ 612,558	$ -	$ -	$ 459,418	$ -
LEGAL	$ 369,106	$ -	$ 369,106	$ 369,106	$ -	$ 369,106	$ -	$ -	$ 369,106	$ 88,249
SUB-TOTAL DIRECT SERVICES	$ 30,421,973	$ 2,236,033	$ 32,658,006	$ 35,343,400	$ 2,888,253	$ 38,231,653	$ 3,936,449	$ 4,638,500	$ 36,594,455	$ 38,369,155
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 4,034,450	$ 363,270	$ 4,397,720	$ 4,034,450	$ 363,270	$ 4,397,720	$ 307,585	$ 361,500	$ 4,705,305	
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 793,249	$ -	$ 793,249	$ 966,652	$ -	$ 966,652	$ -	$ -	$ 793,249	
TOTAL EXPENDITURES	$ 35,249,672	$ 2,599,303	$ 37,848,975	$ 40,344,502	$ 3,251,523	$ 43,596,025	$ 4,244,034	$ 5,000,000	$ 42,093,009	
TOTAL GRANT AWARD				**$ 40,344,502**	**$ 3,632,709**	**$ 43,977,211**		**$ 5,000,000**		
VARIANCE				0	(381,186)			0		
Estimated MAI Carryover from YR 21 to YR 22	**$**		**381,186**							

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

LOS ANGELES COUNTY COMMISSION ON HIV
APPROVED ALLOCATIONS FOR
PROGRAM YEARS (PYs) 33 AND 34 (Approved by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

	FY 2022 RW Allocations (PY 32)[1]					FY 2023 RW Allocations (PY 33)[2]			FY 2024 RW Allocation (PY 34)[2]		
PY 32 Priority #	Core/ Support Services	Service Category	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI %[3]	Part A %	MAI %	Total Part A/ MAI %[3]
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
2	S	Non-MedicalCase Management - BSS/TCM/CM for new positives/RW clients	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
7	C	Mental Health Services	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
10	C	Early Intervention Services	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
11	S	Medical Transportation	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
12	S	Nutrition Support Food Bank/Home-delivered Meals	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
13	C	Oral Health Services	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
14	S	Child Care Services	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
15	S	Other Professional Services - Legal Services	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
18	C	Home Based Case Management	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
19	C	Home Health Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
20	S	Referral	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
22	S	Language	0.65%	0.00%	0.60%	0.65%	0.00%		0.65%	0.00%	
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
24	S	Rehabilitation	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
25	S	Respite Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
26	C	Local Pharmacy Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
27	C	Hospice	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
		Overall Total	**100.0%**	**100.00%**	**100%**	**100.0%**	**100.0%**	**0.00%**	**100.0%**	**100.00%**	**0.00%**

Footnotes:

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

2 - PY 33 and 34 Allocation percentages approved by PP&A on 11/16/2021 and the Executive Committee on 12/09/2021

3 - To determine total percentages, funding award amounts for Part A and MAI must be known.

DRAFT UPDATED 4/3/22

LOS ANGELES COUNTY COMMISSION ON HIV

Program Directives for Maximizing Health Resources Services Administration (HRSA) Ryan White Part A and MAI Funds for Program Years (PY) ~~30, 31~~, 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 XXX articulates 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.

DIRECTIVE	DHSP RESPONSE/STATUS UPDATE
Across all prevention programs and services, create a connected network of services that promote access to PrEP, ongoing preventive care, mental health, substance use, and housing services. Use a status neutral approach in service delivery models. 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. 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. Request DHSP surveillance, continuum of care, and other relevant data at to determine populations and geographic areas most affected by HIV. Priority populations are those 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	Solicitations are composed using the latest data, which reflect the geography and other demographics of target populations

activities to reduce HIV-related disparities include: Black/African American 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 LAC15 and people experiencing unstable housing or homelessness, among others" (pg. 21). The Health Districts with highest disease burden represent five cluster areas account which for more than 80% of disease burden (LACHAS, p7) 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).	

2. Continue the ~~i~~implementation the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020: • Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust, and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum, and monitoring and evaluation. • 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. • Assess available resources by health districts by order of high prevalence areas. • Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not. • Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in-person. Develop a network of Black mental health providers to promote equity, reduce stigma and medical mistrust.	In progress. Some training resources still need to be identified and tested. *DHSP will provide an update on the development of B/AAC Caucus recommendations for provider training material and/or curriculum.* This should be included in the needs assessments conducted as part of the formative work for the development of the comprehensive plan. *It was recommended the B/AAC Caucus be consulted on measurement tools to use for a comprehensive needs assessment of the Black/African American Community. The information will be included in the CHP.* *DHSP to implement a LACHNA report once staff levels are restored. The division will notify the Committee when the study is implemented.* *The Committee recommended mental health providers of color, specifically Black/African American providers are identified and encourage to provide services. Special programs to increase the number of providers of color was recommended.* *Is there a different standard of care for these services for this population? There are no separate standards, however the Black members of the PP&A Committee noted that what is important is recognizing that Black mental health providers are critical partners in delivering services. Recruitment and retention of Black mental health provides was mentioned.*

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 includes 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 specific document for Black/African community across multiple service categories.	Must be allocated by PP&A. *The Commission allocated funding for Psychosocial Support Services in PY 34.* DHSP relies on SBP for guidance. *The SBP Committee workplan includes mental health and psychosocial services standards review.* *The Committee requested DHSP prioritize specific communities in RFPs for Psychosocial Support Services.*
3. 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 yrs). 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 annual basis.	Commission must allocate funds for these programs.

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.	DHSP has used EHE and HRSA CARES funds to improve capacity to store perishable, nutritious foods, and increase variety and quality of food available consistently.
5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.	The entire housing portfolio needs to be examined to determine where DHSP's limited housing resources can have the most impact. *DHSP is review methods of increased coordination and improvement of resource referrals and clearing house structure/services. Training for housing specialist was recommended to improve services. Consumers noted the training should include an emphasis on compassion and the ability to screen for multiple client's needs.*
6. Continue to support the expansion of medical transportation services.	In progress *Medical transportation services were expanded to include ridesharing services. The program is provider administered.*
7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distribution of eligibility cards as stated by DHSP representatives. The COH requests a solicitations schedule and updates from DHSP on annual basis.	In progress *A solicitation is in development to contract with an agency to develop Ryan White eligibility cards.*

8. Augment contracts to permit agencies to have an operational line-item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. 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. 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.	Childcare solicitation is nearly complete. *DHSP is working on augmenting contracts to include childcare and transportation services. The current solicitation cannot reimburse a client directly for childcare costs. Payments must go directly to childcare providers.* *The Committee express concerns about the narrow focus of the solicitation. DHSP was encouraged to find a way to support informal childcare. The Committee requested DHSP consider the use of Net County Costs (NCC) which has fewer funding restrictions. DHSP noted the NCC funding could be redirected but are currently fully allocated.* *The Committee suggested reallocating NCC-supported services to RW funding where appropriate to free up funds for childcare services that require greater funding flexibility.* *DHSP noted there is an internal discussion about using NCC for EFA services which could include childcare services.* EFA program is in place. *EFA provides client funding for rental assistance, rent deposits, moving costs and utilities services. To expand services, DHSP requested the Commission define specific services and resources*.
9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged. Mobile clinics should aim to be holistic and include bilingual services, STI services, linkages to clinics for ongoing care, STI/HIV testing, PrEP, mammograms, health education, and availability for 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	Need more information on what this would look like.

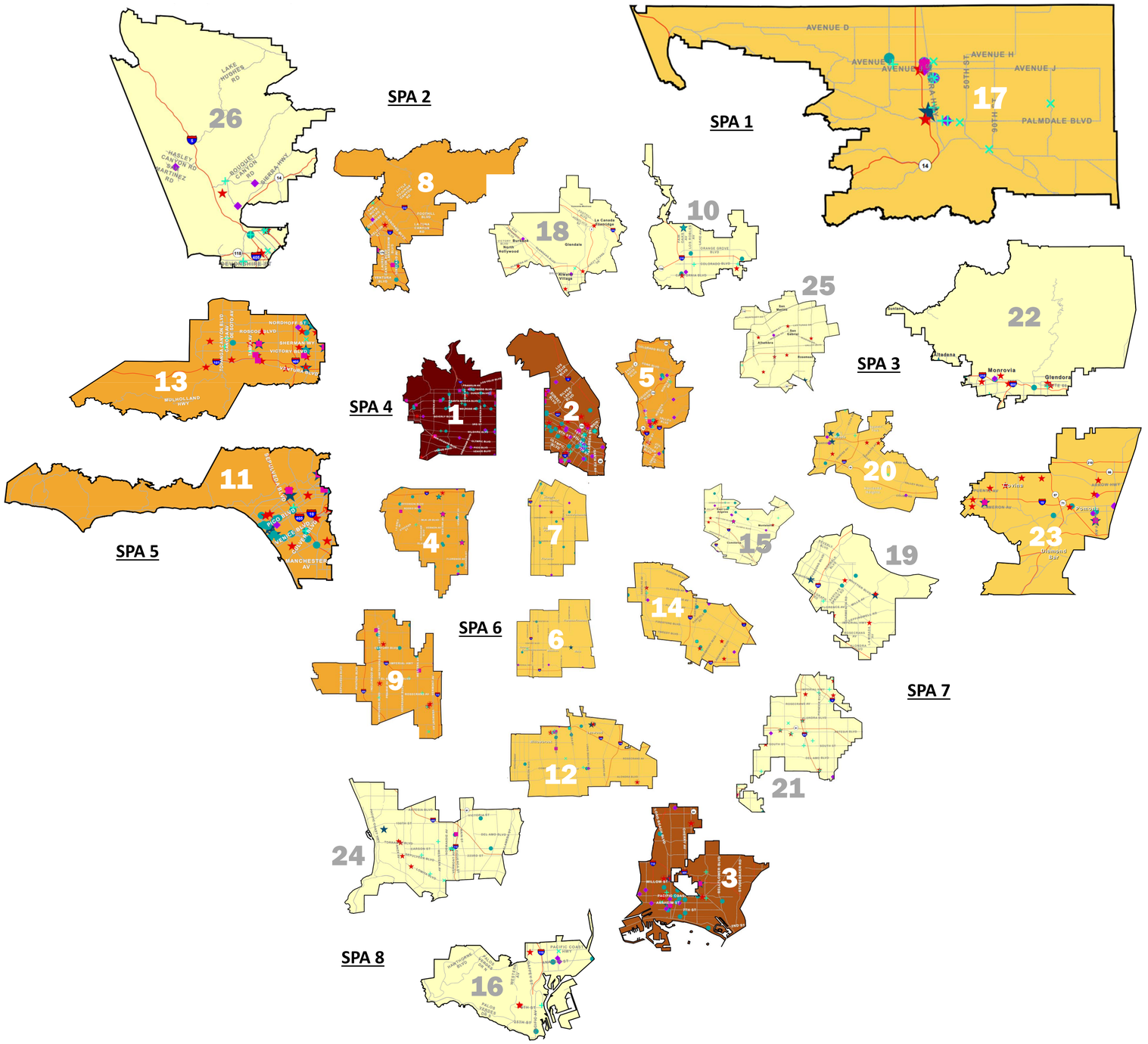
specifically designed for women.	
10. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support to build a stronger sense of community, empowerment and resilience among women living with HIV. Maximize access to psychosocial and support group services by offering services remotely and in-person. The Commission allocated 1% funding for Psychosocial Support Services in PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 includes peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis.	Commission should allocate funds accordingly.
11a. 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 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) . See attachment C for the HIV and Aging Framework. 11b.Integrate a geriatrician in medical home teams. 11c. Establish coordination process for specialty care.	

Los Angeles County Health Districts

The Health District approach allows for the development of goals for each health district and ensure that at the community level, all HIV/AIDS Strategy stakeholders, service providers and residents can see how their efforts contribute to the overall achievement of the LACHAS goals.

Health Districts ranked by highest rate of HIV transmission.

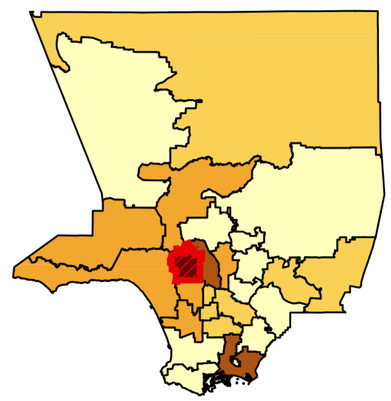
1. Hollywood Wilshire
2. Central
3. Long Beach
4. Southwest
5. Northeast
6. South
7. Southeast
8. East Valley
9. Inglewood
10. Pasadena
11. West
12. Compton
13. West Valley
14. San Antonio
15. East LA
16. Harbor
17. Antelope Valley
18. Glendale
19. Whittier
20. El Monte
21. Bellflower
22. Foothill
23. Pomona
24. Torrance
25. Alhambra
26. San Fernando



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%



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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

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

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

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

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

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

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

Black/African American Trans Women:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

Endnotes

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

BLACK/AFRICAN AMERICAN WORKGROUP TASK TRACKER

Updated 12.2.21 (Revised)

	TASKS	CORRESPONDING BAAC TF RECOMMENDATION(S)	STATUS	UPDATES+NEXT STEPS
1	**PREP MARKETING CAMPAIGN FOR THE BLACK COMMUNITY AND ITS SUBPOPULATIONS** *Develop list of 20-30 participants for DHSP to coordinate a focus group via vendor, Audacy (fka Intercom) to solicit feedback on a PrEP campaign*	General Recs #3, 6, 13, 14 Black Trans Men Rec #4 Women & Girls Recs #1, 7	**10.12.21:** Workgroup submitted list of 47 potential participants to DHSP on 10.21.21. DHSP to provide progress updates.	**12.2.21:** DHSP is reviewing resources to identify funding to support PrEP marketing for Black community; participant list submitted to Intercom/Audacy to coordinate focus group; will solicit Raniyah Copeland's assistance to help shepherd the focus group. DHSP also working on a much broader marketing solicitation. **Workgroup to follow up in early 2022**
2	**REVISE RFP MINIMUM MANDATORY REQUIREMENT (MMR) LANGUAGE TO BE MORE INCLUSIVE TO YIELD MORE SUCCESSFUL SOLICITATION AWARDS TO BLACK/AA LED ORGANIZATIONS** *Develop 3-5 specific recommendations on how to adjust Minimum Mandatory Requirements (MMR)s to allow more Black/AA led orgs to compete; i.e. allow DHSP latitude to override application scoring, waive/reduce specific requirements, etc. *Refer to example of MMRs* *DHSP to provide MMR "non-negotiables" especially around clinical licensure and billing*	General Rec #11	**10.21.21:** Workgroup agreed to amend Task #2 to a "4-bucket" strength-based approach which is to be coordinated w/ Task #3: 1. <u>Support + Mentorship Initiative</u>. Create an "incubation" period to allow smaller & larger organizations to "pair" with each other to support and mentor each other by filling capacity gaps and leverage funding and other resources. 2. <u>Administration</u>. Provide organizations technical assistance, i.e., grant writing and strengthening internal financial systems. 3. <u>Customer Service</u>. Ensure customer service is centered around cultural humility. I.e., mandatory workforce Implicit Bias training, etc. 4. <u>Minimum Mandatory Requirements (MMRs)</u>. Create a solicitation infrastructure that does not "box" out Black/AA orgs from successfully competing for RFPs while ensuring optimum service delivery without compromising quality or service integrity	**12.2.21:** DHSP developed and is currently conducting Implicit Bias training; 300 provider staff signed up for training. DHSP is developing a proposed staffing plan to aggressively train providers without compromising its training portfolio. DHSP reported current proposal pending w/ Gilead to provide TA grant to providers to assist with EHE efforts. *DHSP will provide updates*. DHSP is coordinating with the Center for Health Equity in support of its program launch to provide equitable contract opportunities for CBOs. Will continue to discuss opportunities that will help advance Black led/servicing orgs to successfully apply for County contracts. *DHSP will provide updates*. DHSP continues to communicate and relay to its DPH leadership in conjunction with the County's Anti-Racism Initiative, the workgroup's efforts to create an equitable contracting and procurement system. **Workgroup to follow up in early 2022**
3	**TECHNICAL ASSISTANCE FOR BLACK/AA LED PROVIDERS TO PROVIDE A MORE EQUITABLE PLAYING FIELD TO SUCCESSFULLY COMPETE FOR SOLICITATIONS** *Identify 5-10 agencies (preferably agencies who have not been previously awarded DHSP contracts) who would benefit from DHSP/County Technical Assistance (TA) support in competing for solicitations.* *Develop 3-5 TA recommendations Black/AA led orgs need to compete for solicitations, i.e.:* *- create an incubation period for orgs in which DHSP could provide special TA until they are able to function fully* *- provide grant writing services*	General Rec #9	**11.10.21:** Leads met to discuss the preliminary work needing to be performed before a TA/mentorship pairing program can be developed by DHSP. DHSP agreed to develop a needs assessment for potential Black led/servicing orgs to assess their needs, gaps, and barriers in applying for and successfully performing under DHSP/County contracts. Leads/Workgroup to provide list of orgs, to include: Dr. William King, Umma Community Clinic, Black Women for Wellness, Invisible Men, & Unique Women's Coalition	**12.2.21:** *Create a cohort model for the Needs Assessment & TA program.* *Workgroup to finalize list of Black led/servicing orgs that would benefit from a needs assessment. Final list to be submitted to DHSP.* *Workgroup to review DHSP 2020 Surveillance Report to identify specific examples/suggestions for increased HIV disparity data which would allow agencies to successfully compete for RFPs by having surveillance data accurately reflected for certain populations, i.e. transgender community, Asian, Native Hawaiian and Pacific Islander American communities, etc. I.e. Add additional Race/Ethnicity breakdowns by Gender, transmission categories, and age groups (D. Lee).* *Coordinate mtg w/ DHSP incl. Dr. Andrea Kim to determine ways to reformat surveillance data according to race/ethnicity breakdowns by gender, etc., prioritizing the transgender community.*

	TASKS	CORRESPONDING BAAC TF RECOMMENDATION(S)	STATUS	UPDATES+NEXT STEPS
4	**ESTABLISHMENT OF PREP CENTERS OF EXCELLENCE FOR WOMENOF COLOR** *Develop 3-4 attributes agencies should possess that should be included in RFP language re: women-centered services and/or PrEP Centers of Excellence (for Women).*	Women & Girls Rec #2	**11.22.21** D. Campbell submitted recommendations to P. Zamudio; see 11/22/21 email for details.	**12.2.21**: Paulina Zamudio (DHSP) working with contracted agencies to make updates to RFP scope of work. RFP to be released soon; services will be funded effective July 1, 2022.

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

STRATEGIES:

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

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

3. Integrate a geriatrician in medical home teams.

4. Establish coordination process for specialty care.

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

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

From Golden Compass Program

From Aging Task Force/Commission on HIV

Screenings & Assessment Definitions

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

Screening for Renal Disease

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

Screenings & Assessment Definitions (continued)

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

Other Suggestions from ATF/COH Discussions

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