LOS ANGELES COUNTY
COMMISSION ON HIV

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# Planning, Priorities, and Allocations Committee Meeting

## Tuesday, April 18, 2023
## 1:00pm-3:00pm (PST)

**510 S. Vermont Ave,**
**Terrace Conference Room TK11**
**Los Angeles, CA 90020**

***Validated Parking Available at 523 Shatto Place, LA 90020***

*Meeting will be live streamed on Facebook @hivcommissionla*

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/planning-priorities-and-allocations-committee

**Members of the Public May Join in Person or Virtually.**
**For Members of the Public Who Wish to Join Virtually, Register Here:**
https://tinyurl.com/3jz83whu

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2591 792 0608

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

*To access meeting materials via the QR code: (1) Open your camera app on your smart device, (2) Select the rear-facing camera in Photo or Camera mode, (3) Center the QR code that you want to scan on the screen and hold your phone steady for a couple of seconds, and (4) Tap the notification that pops up to open the link.*

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

# AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

# PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

**TUESDAY, APRIL 18, 2023 | 1:00 PM – 3:00 PM**

510 S. Vermont Ave
Terrace Level Conference Room A/TK11, Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://tinyurl.com/3jz83whu

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2591 792 0608

| 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 |
| Redeem Robinson | Jonathan Weedman | | |
| QUORUM: 8 | | | |

AGENDA POSTED: April 13, 2023.

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.

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 mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. 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 the Commission Office 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 Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos setenta y dos 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, Los Angeles, CA 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

## I. ADMINISTRATIVE MATTERS

| | | | |
|---|---|---|---|
| 1. | Call to Order & Meeting Guidelines/Reminders | | 1:00 PM – 1:03 PM |
| 2. | Roll Call & Conflict of Interest Statements | | 1:00 PM – 1:03 PM |
| 3. | Assembly Bill 2449 Attendance Notification for "Emergency Circumstances" | **MOTION #1** | 1:03 PM – 1:05 PM |
| 4. | Approval of Agenda | **MOTION #2** | 1:05 PM – 1:07 PM |
| 5. | Approval of Meeting Minutes | **MOTION #3** | 1:07 PM – 1:10 PM |

## II. PUBLIC COMMENT

1:10 PM – 1:15 PM

6. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

## III. COMMITTEE NEW BUSINESS ITEMS

7. Opportunity for Commission 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**

8. Executive Director/Staff Report 1:15 PM – 1:25 PM
9. Co-Chair Report 1:25 PM – 1:35 PM
10. Prevention Planning Workgroup - Status Neutral Recommendations 1:35 PM – 1:45 PM

**V. DISCUSSION ITEMS** 1:45 PM—2:50 PM

11. DHSP Unmet Needs Report
12. Data Request for Priority Setting and Resource Allocation Process
13. Stakeholder Engagement Implementation Timeline

**VI. NEXT STEPS** 2:50 PM – 2:55 PM

14. Task/Assignments Recap
15. Agenda development for the next meeting

**VII. ANNOUNCEMENTS** 2:55 PM – 3:00 PM

16. Opportunity for members of the public and the committee to make announcements

**VIII. ADJOURNMENT** 3:00 PM

17. Adjournment for the meeting of April 18, 2023

| **PROPOSED MOTIONS** | |
|---|---|
| **MOTION #1:** | Approve remote attendance by members due to “emergency circumstances”, per AB 2449. |
| **MOTION #2** | Approve the Agenda Order as presented or revised. |
| **MOTION #3** | Approve the Public Policy Committee minutes, as presented or revised. |

# HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

**Final 2.21.23**

- ☐ This meeting is a **Brown-Act meeting** and is being recorded.
  - The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
  - Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
  - Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.
  - We are happy to share that this meeting is also being live streamed via the Commission's Facebook account @hivcommissionla

- ☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

- ☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

- ☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate. Please note that all attendees are muted unless otherwise unmuted by staff.*

- ☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

- ☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

- ☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

# CODE OF CONDUCT

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

**All participants and stakeholders should adhere to the following:**

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

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22)**

LOS ANGELES COUNTY
COMMISSION ON HIV

# COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/21/23

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 |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | 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 |
| **CIELO** | **Mikhaela** | LAC & USC MCA Clinic | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **CUMMINGS** | **Mary** | Bartz-Altadonna Community Health Center | No Ryan White or prevention contracts |
| **DAVIES** | **Erika** | City of Pasadena | HIV Testing Storefront |
| | | | HIV Testing & Sexual Networks |
| **DOAN** | **Pearl** | No Affiliation | No Ryan White or prevention contracts |
| **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 |
| **FRAMES** | **Arlene** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **FULLER** | **LUCKIE** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | Nutrition Support |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV and STD Prevention Services in Long Beach |
| | | | Transportation Services |
| **GONZALEZ** | **Felipe** | Unaffiliated consumer | No Ryan White or Prevention Contracts |
| **GORDON** | **Bridget** | Unaffiliated consumer | No Ryan White or prevention contracts |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **GREEN** | **Joseph** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **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) |
| | | | Transportation Services |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **MAULTSBY** | **Leon** | Charles R. Drew University | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |

| 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 |
| **MOLLETTE** | **Andre** | 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 |
| **MURRAY** | **Derek** | City of West Hollywood | No Ryan White or prevention contracts |
| **NASH** | **Paul** | University of Southern California | Biomedical HIV Prevention |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **NELSON** | **Katja** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | Nutrition Support |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | 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 |
| **ROBINSON** | **Redeem** | All Souls Movement (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<br>LA County Department of Health Services | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |

| 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) | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **STALTER** | **Kevin** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **VALERO** | **Justin** | No Affiliation | No Ryan White or prevention contracts |
| **WEEDMAN** | **Jonathan** | ViaCare Community Health | Biomedical HIV Prevention |

LOS ANGELES COUNTY
COMMISSION ON HIV

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

**DRAFT**

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

# PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
## March 21, 2023

| COMMITTEE MEMBERS<br>P = Present \| P* = Present as member of the public; does not meet AB 2449 requirements \| A = Absent \| EA = Excused Absence | | | |
|---|---|---|---|
| Kevin Donnelly, Co-Chair | P | William King, MD, JD | P-AB 2449 "just cause" |
| Al Ballesteros, MBA, Co-Chair | P | Miguel Martinez, MPH, MSW | P |
| Felipe Gonzalez | P | Anthony M. Mills, MD | P |
| Joseph Green | EA | Derek Murray | EA |
| Michael Green, PhD, MHSA | P* | Jesus "Chuy" Orozco | P |
| Karl T. Halfman, MS | EA | LaShonda Spencer, MD | P* |
| Reverend Redeem Robinson | P | | |
| **COMMISSION STAFF AND CONSULTANTS** | | | |
| Cheryl Barrit, Dawn McClendon, Catherine Lapointe, Jose Rangel-Garibay, Lizette Martinez | | | |
| **DHSP STAFF** | | | |
| Pamela Ogata, Victor Scott | | | |

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

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

## I. ADMINISTRATIVE MATTERS

### 1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:05pm and went over meeting guidelines.

### 2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly led introductions and requested that Committee members state conflicts of interest. Cheryl Barrit, Executive Director, COH, conducted roll call vote.

**ROLL CALL (PRESENT):** A. Ballesteros, K. Donnelly, F. Gonzalez, Dr. King, M. Martinez, Dr. Mills, R. Robinson, Dr. Green (present as member of the public; does not meet AB 2449 "emergency circumstances", Dr. Spencer (present as member of the public; does not meet AB 2449 "emergency circumstances", J. Orozco

3. **Approval of Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"**
   **MOTION #1:** Approve remote attendance by members due to "emergency circumstances," per AB 2449. **(No remote attendance for "emergency circumstances")**

4. **Approval of Agenda**
   **MOTION #2:** Approve the Agenda Order **(✓Passed by Consensus)**

5. **Approval of Meeting Minutes**
   **MOTION #3:** Approval of Meeting Minutes **(✓Passed by Consensus)**

## II. PUBLIC COMMENT

6. **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

7. **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 was no committee new business.*

## IV. REPORTS

8. **Execute Director/Staff Report**
   - Cheryl Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the 2023 Commission on HIV (COH) Training Schedule has been posted to the COH website (found here) and has also been sent to Commissioners. She noted the schedule includes additional enrichment trainings not mandated by the Ryan White Program (RWP) and that all trainings will be held virtually and are open to the public.

9. **Co-Chair Report**
   - K. Donnelly asked the group to identify 1 short-term goal/success and 1 long-term goal/success for the PP&A Committee as the committee continues its work for the year. K. Donnelly began the roundtable stating his short-term goal would be to have the in-person PP&A meetings be better attended, and his long-term goal would be the integration of prevention into PP&A work as well as the Standards and Best Practices (SBP) and Public Policy Committees and the COH overall.
   - Dr. Mills added the need for reconnecting with all commissioners at all meetings to keep work progressing forward. His long-term goal is to help identify and define the future of the RWP.

- F. Gonzalez agreed with the need for reconnection as a committee. He noted a long-term goal of priority setting and resource allocation that does more to prevent new HIV infections.
- R. Robinson noted a short-term goal of building relationships and long-term goal of ending the HIV epidemic.
- A. Ballesteros stated a short-term goal to re-engage with people, get to know new commissioners, and reconnect with longer-term commissioners. His long-term goal is to restructure how PP&A approaches the work that produces tangible results.
- Dr. King noted a short-term goal of integrating the Prevention Planning Workgroup (PPW) into PP&A infusing the group with both prevention and care. His long-term goal is to look at ways to incorporate designated RFAs and develop recommendations that address health inequities that exist in LA County Service Planning Areas (SPA) such as SPA 6.
- M. Martinez noted his short-term goal is to be fully present in meetings as the COH transitions back to in-person meetings. He noted his medium-term goal is to integrate PPW with PP&A to bring prevention and care focus together and his long-term goal is to continue to work toward ending the HIV epidemic and ultimately eliminating the need for the COH and its committees.
- Dr. Spencer noted her short-term goal is to get to know new commissioners and engage them early in COH business. Her long-term goal is to focus on having solution driven meetings.
- C. Orozco noted his short-term goal of executing contracts quickly and a long-term goal of increasing long-term housing options for people living with HIV.
- Dr. Green noted his goal is to use this restructuring period to rethink of how the HIV service menu aligns with the migration of clients away from RWP supported medical care. A. Ballesteros noted the way treatment will be funded varies greatly from when RWP funds were first accepted from the federal government. He noted by the end of 2024 all CA residents who are under 138% of the Federal Poverty Line will be eligible for Medi-Cal which frees up RWP menu of funding for those services that are reimbursed through Medi-Cal. He noted it would be the responsibility of PP&A to figure out how to plan for the benefit of individuals who are receiving most of their care that is funded by a different payor. He noted there has never been a discussion in the role of the COH in causing the other healthcare systems to implement services that align with RWP standards. He noted that due to Medi-Cal's expansion, RWP funding will essentially focus on social/support services as opposed to medical services which will cause PP&A to look at planning and funding differently. Dr. Green noted it will result in huge changes in the way the RWP approaches HIV care for poor people.
- Dr. Mills commented that he felt discussions and decisions are made outside of the COH and presented to the COH after decisions have been made. He requested the COH be involved in discussions with the County before decisions are made rather than being informed after the fact. He noted the example being blindsided by the decision for County clinics to no longer use Ryan White funds to pay for services. He noted the COH is to provide input regarding HIV care/prevention from various stakeholders. M. Martinez asked for clarification regarding the County no longer accepting RWP funds. K. Donnelly noted the Department of Health Services clinics announced in June of 2022 that it stopped utilizing RWP funds retroactive to March 2022. Dr. Mills commented that the COH is the planning body for RWP funds and had concerns on where funding was now going for specific services that was part of the allocation process. A.

Ballesteros noted there was no report back to the COH on savings generated based on this decision. He noted it was previously mentioned that the Department of Public Health's (DPH) Division of HIV/STD Programs (DHSP) noted there would not be a surplus and DHSP was able to find expenses to support the care of people with HIV. Dr. Spencer noted County providers were alerted a few months after DHS's decision to no longer receive RWP funds and were also blindsided. She noted providers were not brought to the table to provide input on the decision. She noted providers continue to function as a RWP even though they no longer utilize RWP funds. Dr. Spencer explained the level of care has not been affected as teams remain unchanged and many providers believe the RWP care model works; clients are still enrolled in ADAP and referred for services. She is unsure if there will be changes in the future but noted there have been no changes to the model and level of care since clinics stopped receiving RWP funds. M. Martinez asked where the funding that was allocated for the services at DHS clinics is now going. Dr. Green commented when the announcement was made, DHSP created some projections on underspending of resources that was shared with the COH but have yet to see these come to fruition. He noted this underspending was, in part, due to DHSP and the COH working collectively to reallocate funds to services where spending was possible or where there were deficits as well as providing additional funding to contracted community-based organizations (CBOs). Dr. Green also stated billed services from DHS clinics were negligible even though a large amount of money was allocated to each clinic through memoranda of understanding (MOUs). He stated DHS declining funds ended up not being an issue and that DHSP anticipates full spending the award. He noted it is still challenging not having access to clinical information from DHS clinics but noted DHSP also does not have access to clinical information from non-RWP providers and must rely on surveillance data.

- Dr. Mills asked for the number of clients that receive services at DHS clinics. Dr. Green noted historically between 6,000-8,000 clients utilized the RWP annually and approximately 30% of clients access care through DHS clinics. Dr. Mills asked if the decrease in the number of clients (due to DHS no longer using RWP funds) would raise a red flag to the Health Resources and Services Administration (HRSA) and ultimately result in a reduction of RWP funds. Dr. Green responded stating RWP funds would not change as they are awarded based on surveillance data and not RWP utilization data.
- A. Ballesteros requested an updated funding table of all DHSP funds dedicated to HIV/HIV related services including Net County Costs (NCC). Dr. Green noted the next update will be available in a couple of months and will include RWP funds for the 2022-2023 program year that ended Feb. 28, 2023. He noted NCC costs run on the County fiscal year which differs from the RWP, and totals will be provided for NCC funds when they are available later.
- M. Martinez asked a clarifying question regarding DHS clinics no longer billing to the RWP is not an issue because it was not a true expenditure as they never really billed to the program prior to the decision to not accept RWP contracts. Dr. Green confirmed noting DHSP is unsure why DHS did not previously bill to the RWP but assumes it was due to the RWP payor mechanism differs greatly from other payor sources (such as Medi-Cal) that DHS may have opted to cover the costs and not to go through the administrative and financial hurdles to submit invoices to DHSP.
- M. Martinez asked about the Medicare reimbursement rate noting it varies by facility such as a hospital vs a Federally Qualified Health Center (FQHC). Dr. Green commented that Medicare are

reimburses per procedure whereas the RWP reimburses per visit. A. Ballesteros noted it may be a combination of reimbursement by visit and procedure based on facility type and asked if NCC funds were used to cover costs submitted by DHS clinics prior to the decision to no longer accept RWP funds. Dr. Green stated expenses were charged to the RWP whenever possible, not NCC funds.

- A. Ballesteros reiterated having a funding table of all funding sources would be beneficial for future HIV care and prevention planning noting more resources will be available as more people shift to Medi-Cal. Dr. Green agreed and added it was an opportunity to be innovative. A. Ballesteros agreed but noted the delays in establishing programs and getting RFPs out presents challenges to moving forward quickly when resources become available. Dr. Green agreed the RFP process is lengthy and has presented problems in the past but added new, quicker contracting mechanisms are now available due to changes made during the COVID-19 pandemic. A. Ballesteros noted January 2024 will free up a large amount of RWP funds as Medi-Cal eligibility expands to more individuals on top of the money that has already been freed up from those ages 50 and older who have transitioned to Medi-Cal coverage in 2022. He stated PP&A would need to start to explore what the savings would be and reviewing models/programs to recommend within the next 6 months to be able to get programs/funding out by 2024.
- Dr. Mills added that there are people in Washington [D.C.] who think RWP funds should be used for prevention activities adding that there are several bills in the House of Representatives being considered. He added incorporation of Ending the HIV Epidemic funds is also another way to support innovative approaches.
- A. Ballesteros asked Dr. Green his thoughts regarding discussion around the change and what types of programs and categories PP&A would recommend addressing with the collection of extra revenue beginning January 2024. Dr. Green stated the group should be planning now for 2024 and the need to be dynamic and creative on how to streamline services for clients to eliminate as many barriers as possible. M. Martinez requested that DHSP return to the PP&A committee with preliminary ideas of potential strategies that can be implemented while taking into consideration feasibility to avoid making recommendations that are not possible.

## V. DISCUSSION

### 10. Status Neutral CDC Brief and

### 11. Developing a common understanding of a prevention and care planning approach

- K. Donnelly opened the discussion on status neutral by providing an overview of the Status Neutral CDC Brief and the HRSA program letter dated Dec 17, 2022. See meeting packet for details. He noted PP&A and PPW cochairs met on March 14th to begin discussions on status neutral technical assistance needs for the COH to move forward planning for a service delivery system that focuses on the whole person and inclusive of everybody while breaking away from a siloed approach. M. Martinez added some initial planning has been done through the Comprehensive HIV Plan (CHP) though not mentioned explicitly. He also noted some silos are based on funding that will need to be addressed as well as thinking about ways to be inclusive to address the needs of everyone. He further added that structural change is very challenging and slow moving but ultimately rewarding.

- Dr. Green noted the COH cannot rely on the Federal government and the COH should work to figure it out. He suggested planning efforts should lead with what an all-inclusive service delivery system would look like and focusing on key populations (identified in the CHP). Once these are established, then planning would focus on identifying funding sources to accomplish interventions and strategies. He noted this strategy would help address the funding silos. A. Ballesteros expressed concern with this approach noting the potential inability to fund a service delivery system that was designed without consideration of funding sources as funding is often the most challenging barrier to overcome.
- F. Gonzalez suggested providing an incentive for providers who engage in HIV care. He asked C. Orozco what was preventing contracts from being executed in a timely manner. C. Orozco noted staff turnover and numerous vacancies both with contracted agencies and HOPWA staff. F. Gonzalez commented that a potential barrier is due to hiring practices that limit potential candidates due to lack of specific education requirements and/or experience. A. Ballesteros added low pay/salary is also a contributing factor. He noted the need to have a strong workforce that does not have retention issues to successfully implement status neutral programming. He recommended engaging the HIV workforce on the proposed service delivery system (once initial planning is complete) to gather feedback. R. Robinson suggested hosting regional townhalls throughout the County. M. Martinez recommended centering conversations around the priority populations that are served such as young MSM, transgender populations, etc.
- A. Ballesteros requested regional townhalls as a strategy to help the planning process moving forward. He recommended providing a summary document explaining the purpose and goals of the townhalls. He also recommended convening healthcare systems outside of RWP funded systems who provide HIV care and prevention to see how they are meeting the needs of HIV+ and high-risk populations. Lilieth Connelly (member of the public) added access to care continues to be an issue. Dr. Green noted the need to create a care system that is easy to enter and navigate with navigators for all HIV+ individuals and that more people know about.
- M. Martinez expressed concern over focusing on planning for the structural change and suggested identifying short-term goals that will drive the larger discussion but will also produce tangible results. Dr. Spencer recommended one way to do this is to engage with local Community Advisory Boards (CABs) of funded agencies prior to hosting regional townhalls to get initial feedback on desired outcomes (i.e., what is needed, what does clinical care look like, etc.) while also using them to get the word out on the townhalls. She also recommended using social media to advertise the proposed townhalls. A. Ballesteros recommended a survey format developed in partnership with DHSP for distribution to the CABs. K. Donnelly noted much of this work has been done previously through the process of developing the CHP. Dr. Spencer noted specific information is missing that is needed. Information from the surveys would then be synthesized into categories to help inform townhall discussions. L. Connelly recommended utilizing social media to distribute the survey to promote more visibility and gather additional feedback. She also offered to help use her social media skills to promote COH work moving forward. F. Gonzalez recommended that the survey be simple and accessible for all potential responders – it should be short and use simple language.
- Alasdair Burton recommended the COH to introduce the group to the various CABs to help foster sustained engagement with the COH. He also suggested providing information that is helpful to

the CABs and helps to inform their work to help address membership turnover. A. Ballesteros noted this would be an unrealistic expectation of PP&A/COH. M. Martinez suggested providing CAB facilitators with some prompts to facilitate candid conversations on what status neutral means to them and what they need to implement this approach may be more impactful than a survey.

- M. Martinez noted that the next Prevention Planning Workgroup meeting would be Wed. March 22 where there would be continued discussions on status neutral with the goal of providing specific, tangible items to bring back to PP&A to help with planning moving forward.
- A. Ballesteros noted Community Health Centers (also known as FQHCs) were also highlighted in the CDC brief for implementing status neutral quickly due to the nature of the funding. He suggested conducting an analysis of a few community health centers on how patients seeking HIV tests move through the healthcare system and how they are treated throughout the process. Results would inform future status neutral approaches.

## VI. NEXT STEPS

**6. Task/Assignments Recap**

**a.** C. Barrit noted three strategies moving forward. She noted planning for the following: townhalls/listening sessions, discussion prompts and surveys for engaging CABs, and selecting a few FQHCs to conduct an analysis of how patients (both HIV+ and HIV-) move through their system when seeking an HIV screening test.

**b.** K. Donnelly recommended taking advantage of L. Connelly's offer to assist with COH social media efforts to raise the COHs visibility throughout LA County.

**7. Agenda Development for the Next Meeting**

**a.** Continue planning on three strategies to help inform the planning around status neutral.

## VII. ANNOUNCEMENTS

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

*There were no announcements.*

## VIII. ADJOURNMENT

**9. Adjournment for the Meeting of March 21, 2023.**

The meeting was adjourned by K. Donnelly at 3:00pm.

April 12, 2023

Dear Recipients:

In recent years, numerous HIV outbreaks among people experiencing homelessness and housing instability have been identified[i]. Housing status is a social determinant of health that has a significant impact on HIV prevention and care outcomes. The experiences of homelessness and housing instability are linked to higher viral loads and failure to attain or sustain viral suppression[ii] among people with HIV. The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) clients with unstable or temporary housing have lower levels of viral suppression than those with stable housing (77.3% clients versus 90.8%) clients [iii]. Homelessness and housing instability are also associated with increased vulnerability for HIV acquisition. Stable housing provides a foundation from which people can participate in HIV prevention services and is associated with reductions in behaviors associated with getting or transmitting HIV[iv].

The National HIV/AIDS Strategy for the United States (2022-2025) sets a bold target to decrease homelessness and housing instability for people with HIV by 50 percent. The Strategy also calls for improved coordination among federal, state, and local governments and community-based organizations to quickly detect and respond to HIV outbreaks[v]. As such, the Centers for Disease Control and Prevention (CDC) Division of HIV Prevention, the U.S. Department of Housing and Urban Development (HUD) Office of HIV/AIDS Housing (OHH), and HRSA's HIV/AIDS Bureau (HAB) have partnered on recent responses to HIV outbreaks among people experiencing homelessness and housing instability.

Based on the lessons learned through our joint outbreak response efforts, CDC, HUD, and HRSA encourage communities to take the following actions to effectively prepare for and respond to these outbreaks:

- Health departments and housing providers should integrate and assess HIV prevention, care, and housing data on individuals impacted by outbreaks to

determine the extent to which they are experiencing homelessness or housing instability and to identify gaps and coordinate service delivery to improve housing stability and health outcomes.

- Personnel involved with outbreak response should assess HIV prevention, care, and treatment needs and leverage all available resources to establish integrated models of service delivery that meet people where they are.
- Individuals engaged in local outbreak response efforts should identify and leverage housing resources to assist people experiencing homelessness and housing instability in their community in addition to those available through HUD's Housing Opportunities for Persons With AIDS (HOPWA) program. Although HOPWA is a critical housing program for people with HIV, current funding does not meet the need for housing services for this population. In addition, HOPWA is unable to serve people who do not have HIV. Information on non-HOPWA housing resources can be found in the attached APPENDIX Federal Support for Housing Services and HIV Outbreak Response.
- Housing providers should implement Housing First and other low-barrier housing models that offer flexibility, individualized support, and client choice in the provision of housing assistance and supportive services, including integration with substance use disorder services.
- Housing providers should explore shared housing arrangements to foster social connection, decrease housing costs, and expand available units to people with HIV and those without HIV who need prevention services.
- Housing providers should use grant funds for housing navigator positions to partner with HIV prevention and care outreach workers to provide linkage and referrals to housing programs and resources for people experiencing homelessness or housing instability.

These recommendations are based on experiences in communities with HIV outbreaks among people experiencing homelessness and housing instability. In these communities, people with HIV may also experience a variety of additional challenges, including substance use, mental health disorders, other infectious and non-infectious diseases, incarceration, food insecurity, unemployment, trauma and loss, and stigma[vi]. Some communities experienced difficulties in responding to these outbreaks due to a lack of low-barrier or Housing First housing options, including insufficient options for people with a history of incarceration or people who actively use injection drugs. Another barrier to HIV prevention efforts was limited capacity for substance use disorder services. In addition, the jurisdictions reported a need for flexible housing assistance models to serve those at different

stages of homelessness or housing instability, regardless of their HIV status, to transition to safe, stable housing with social support.

The lessons learned from these recent outbreak response efforts underscore the need for ongoing collaboration among state and local public health, healthcare, housing, and social services providers to prepare for and respond to HIV outbreaks, reduce HIV transmission, and improve HIV care and viral suppression outcomes. In at least two of these communities, Homeless Management Information System (HMIS) data provided important insights to HIV surveillance staff in identifying needs and guiding efforts to determine eligibility for and link people to appropriate housing and services as available.

In all the communities that experienced outbreaks, the assessment of service gaps played a critical role in addressing both immediate and long-term service needs. State and local health departments worked with service providers to expand service delivery, including co-location of services, training and capacity development at sites, and the establishment of new partnerships with trusted providers in the community. Many of these activities can be done before an outbreak occurs, as identifying gaps and developing new models of service delivery strengthen the overall system of care for all people regardless of HIV status.

As we work to end the HIV epidemic, collaboration among public health, healthcare, housing, and social services providers is critical for effective detection and response to outbreaks and the prevention of future outbreaks among people experiencing homelessness or housing instability. Community efforts to provide safe and stable housing, reduce new HIV infections, and increase access to care and support for people with HIV, are necessary in order to achieve the goals of the National HIV/AIDS Strategy and the Ending the HIV Epidemic in the U.S. (EHE) Initiative. We look forward to our continued federal collaboration and work with our state and local partners to take actions to end the HIV epidemic in the United States.

Sincerely,

/Jonathan Mermin/
Jonathan H. Mermin, MD, MPH
Rear Admiral and Assistant Surgeon General, USPHS
Director

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

/Jemine A. Bryon/
Jemine A. Bryon
Deputy Assistant Secretary
Office of Special Needs
Housing and Urban Development

/Laura Cheever/
Laura Cheever, MD, ScM
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration

**APPENDIX**
**Federal Support for Housing Services and HIV Outbreak Response**

## HUD

It is especially important that HUD-funded organizations engage in HIV outbreak response efforts to house and stabilize people with HIV and people who do not have HIV but would benefit from prevention services. Grant funding under HUD's Housing Opportunities for Persons With AIDS (HOPWA) program can be used to support a range of housing assistance types and supportive services for low-income people with HIV and their families. Grant funding under HUD's Continuum of Care (CoC) and Emergency Solutions Grants (ESG) programs can be used to provide emergency, transitional, and permanent housing, outreach, and supportive services to individuals and families experiencing homelessness who are either HIV-positive or those who need HIV prevention services. In addition, these programs can fund housing search activities for eligible individuals and families.

The HOPWA, CoC, and ESG programs allow for shared housing arrangements where one or more individuals or households agree to share the space and cost of a permanent rental housing unit. The benefits of shared housing models include increased social connection and decreased isolation, reduced housing costs, and opportunity to access better housing options. These programs also promote the adoption of Housing First principles by funded housing providers, which include having few programmatic prerequisites, low-barrier admission policies, quick and successful connection to permanent housing, proactively offered but voluntary supportive services, and a focus on housing stability.

HUD staff and technical assistance (TA) providers can offer guidance and support to communities encountering an HIV outbreak among people experiencing homelessness or housing instability. Individuals engaged in outbreak detection and response efforts should contact their local HUD Office of Community Planning and Development (CPD), which can provide information and facilitate connections to local housing and service providers and can coordinate with Office of HIV/AIDS Housing and other HUD staff to provide guidance and technical assistance to assist with outbreak response efforts on the HUD Exchange TA portal. HMIS Privacy and Security Standards: Emergency Data Sharing for Public Health or Disaster Purposes includes information for communities covered under HMIS Privacy and Security Standards of the capabilities and limitations of sharing client information during public health or disaster emergencies.

As people of color are overrepresented in both the HIV epidemic and in the numbers of people experiencing homelessness, HUD recognizes the need for communities to better understand and address these issues. The Racial Equity page on the HUD Exchange website includes resources, data toolkits, and research reports related to identifying disparities and implementing responses to address the overrepresentation of people of color in the homeless system.

Congress appropriated significant additional resources to HUD to help communities respond to COVID-19 and the resulting economic crisis, including funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan (ARP) that are being utilized to address homelessness and housing instability. The HOPWA and ESG programs were allocated supplemental grant funds under the CARES Act that communities may use for COVID-19 preparedness and response activities, including rental assistance, homelessness prevention, and supportive services for people with HIV and people experiencing homelessness. ARP funding is being administered through HUD's HOME Investment Partnerships (HOME) program and has the purpose of assisting individuals or households who are homeless or at risk of homelessness and other vulnerable populations by providing housing, rental assistance, supportive services, and non-congregate shelter, to reduce homelessness and increase housing stability.

**HRSA**

RWHAP funding can be used for a variety of support services, including housing, that help people with HIV stay in HIV care and treatment. RWHAP recipients determine which services to fund depending on community needs and resources. The allowable support services, such as housing, can help bridge gaps that exist in the current services and help limited resources stretch further.

The RWHAP AIDS Education and Training Center (AETC) Program provides training that is critical to capacity development in areas experiencing an HIV outbreak or at risk for an outbreak. Available training includes HIV testing, preexposure prophylaxis (PrEP), HIV treatment, and integrating mental health and substance use treatment into HIV care, as well as other topics that can help address service needs. Communities have been able to successfully expand HIV care and treatment in non-traditional settings that have resulted in integrated models, such as one-stop shops.

In 2017, HRSA and HUD released a joint statement to funded organizations encouraging the sharing of data across systems to better coordinate and integrate

medical and housing services for people with HIV. In 2019, the agencies released a toolkit for service providers with best practices for sharing data and improving service coordination.

The Bureau of Primary Health Care's (BPHC) National Health Care for the Homeless Program supports community-based organizations to provide high-quality, accessible health care, including HIV prevention services, to people experiencing homelessness.

**CDC**

CDC's Division of HIV Prevention provides technical assistance and support for responding to HIV clusters and outbreaks. CDC support can include assistance with epidemiologic analysis and interpretation, connection with peers across the country doing similar work, identification of promising best practices and innovative delivery of prevention activities, and assistance with planning and implementing response activities for specific clusters or outbreaks. Organizations with needs or interests related to HIV outbreak response in their community should contact their state or local health department, who can facilitate collaboration with CDC as needed.

CDC also funds a Capacity Building Assistance (CBA) Provider Network to provide free CBA services to state and local health departments, community-based organizations, and healthcare organizations to support their implementation of high-impact HIV prevention initiatives. Providers can provide support in several areas, including addressing social determinants of health, HIV services for disproportionately impacted populations, such as those experiencing homelessness or unstable housing, and cluster detection and response. More information on each organization funded can be found in the CBA Provider Service Directory. Additionally, online, virtual, and in-person trainings are available, including a training on homelessness for public health providers.

CDC funds state and local health departments to implement evidence-based, high-impact programs to improve access to HIV and other health and social services; this includes a range of activities related to detecting and responding to HIV clusters and outbreaks. CDC also prioritizes hearing from and collaborating with people with HIV through roundtables, town halls, and ongoing community listening sessions focused on issues that intersect with HIV and affect health outcomes, including housing.

Through the Ending the HIV Epidemic in the U.S. Initiative (EHE), CDC funds 32 state and local health departments to implement locally tailored and integrated solutions to meet the unique needs of their communities, including flexibilities to use funds to support housing. CDC also funds over 100 community-based organizations and their clinical partners to deliver comprehensive HIV services to communities disproportionately affected by HIV. In addition, CDC supports the Housing Learning Collaborative, a virtual learning community to build capacity of EHE jurisdictions to develop and implement innovative programs to respond to housing-related needs. CDC published an issue brief on the role of housing in Ending the HIV Epidemic and federal efforts to address housing and HIV more broadly.

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[ii] Aidala, A. A., Wilson, M. G., Shubert, V., Gogolishvili, D., Globerman, J., Rueda, S., Bozack, A. K., Caban, M., & Rourke, S. B. Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *American Journal of Public Health*, 106(1), e1–e23. 2016.

[iii] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2021. ryanwhite.hrsa.gov/data/reports. Published December 2022.

[iv] Aidala, et al. 2016.

[v] The White House. National HIV/AIDS Strategy for the United States 2022–2025. Washington, DC. 2021.

[vi] Lyss, et. al. 2020

# ISSUE BRIEF

# Status Neutral HIV Care and Service Delivery Eliminating Stigma and Reducing Health Disparities

**Today, powerful HIV prevention and treatment tools can keep people healthy and help end the HIV epidemic.** Combining these tools in a status neutral approach can help people maintain their best health possible, while also improving outcomes in HIV prevention, diagnosis, care, and treatment. A status neutral approach to HIV-related service delivery aims to deliver high-quality, culturally affirming health care and services at every engagement, supporting optimal health for people with and without HIV. This approach is especially important now to reduce the unacceptably high number of annual HIV infections and help close the persistent gaps along the HIV prevention and care continuum, which indicate that not enough people are being engaged or retained in HIV prevention and treatment.

## Many Barriers May Keep People from Being Engaged in HIV Care.

- **HIV testing, treatment, and prevention services are often offered separately,** can be challenging to navigate, and further emphasizes a division between people with HIV and people who could benefit from prevention.
- **Separating HIV services from other routine healthcare** misses opportunities to engage people in HIV testing, prevention, and treatment when they seek sexual health or other non-HIV-focused services.
- Providing critical support services—like housing, food, and transportation assistance—is essential to keeping someone in ongoing care, but these **services are not necessarily offered** alongside what are considered "traditional" HIV care and prevention services.
- **Stigma** embedded in the experience of many people seeking HIV treatment and prevention services can stop people from visiting health care providers labeled as "HIV" or "STD" clinics.
- Everyone has **implicit biases** that affect their perceptions of others. The HIV care or prevention services someone receives may be affected by healthcare and other service providers' implicit biases on race/ethnicity, sexual orientation, gender identity, age, and other factors. These biases, in some cases, may be why a person does not return for care and services.

Many HIV prevention experts believe a status neutral approach can help improve care and service provision and eliminate structural stigma by meeting people where they are, offering a "whole person" approach to care, and putting the needs of the person ahead of their HIV status. The status neutral approach aims to advance health equity and drive down disparities by embedding HIV prevention and care into routine care. Integrating HIV prevention and care with strategies that address social determinants of health can help reduce barriers to accessing and remaining engaged in care.

The status neutral approach also aims to increase efficiency, since the clinical and social services that prevent or treat HIV are nearly identical and can be unified in a single service plan rather than different plans based on an individual's HIV status. Adopting a status neutral approach is one way to help deliver better prevention and care and ultimately decrease new HIV infections and support the health and quality of life of people living with HIV in the United States.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

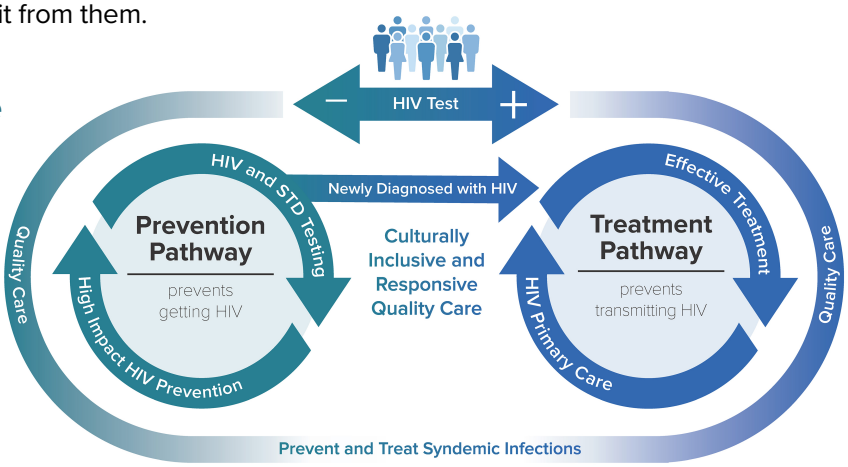
# Understanding Status Neutral HIV Care

**The status neutral framework provides care for the whole person by offering a "one-door" approach:** people with HIV and people seeking HIV prevention services can access treatment, prevention, and other critical services in the same place. Normalizing HIV treatment and prevention helps to destigmatize both. In a status neutral approach to care, a provider continually assesses and reassesses a person's clinical and social needs. The goal is to optimize a person's health through continuous engagement in treatment and prevention services without creating or deepening the divide between people with HIV and people who could benefit from prevention.

**A status neutral approach is unique because both of the harmonized pathways promote continual assessment** of each person's needs and ongoing engagement in HIV prevention and care, including access to support services, for anyone who could benefit from them.

## Status Neutral HIV Prevention and Care

People whose HIV tests are **negative** are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.




People whose HIV tests are **positive** enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

**Status neutral HIV service delivery is:**

- **Healthcare** that encompasses HIV testing, treatment, and prevention services.
- **HIV treatment and prevention** that is offered alongside other local medical healthcare services frequently used by the community—for example, sexual health, transgender and other LGBTQ-focused care, healthcare for people who use drugs, and general primary care.
- **Service delivery** that recognizes and includes broader social services that support the path to optimal HIV and other health outcomes—like housing, food, transportation, employment assistance, harm reduction services, and mental health and substance use disorder services—regardless of the HIV status of the people seeking care.
- **Culturally affirming, stigma-free HIV treatment and prevention,** delivered by supportive and accepting providers who have been trained to recognize and address implicit racial/ethnic, sexual orientation, and other biases (thoughts and feelings that providers are not consciously aware of), and provided in settings that consider and prioritize a positive experience for the person seeking services.

**Status neutral service begins with an HIV test—the pathway to prevention and treatment.** In a status neutral approach, an HIV test spurs action regardless of the result by recognizing the opportunity created by a negative or positive result for an individual to achieve better health:

- **If a person receives a negative HIV test result,** the provider engages the person in HIV prevention and offers powerful tools that prevent HIV, such as pre-exposure prophylaxis (PrEP). The prevention pathway emphasizes a consistent re-evaluation of the engaged person to match prevention and social support strategies to the individual's needs. Being engaged in such preventive services also means expedited connection to HIV care in the event of a new positive HIV test result. Condoms and harm reduction services are also an important part of this prevention pathway, especially for people who are not ready or eligible for PrEP.
- **If a person receives a positive HIV test result,** the provider offers a prescription for effective treatment to help them become virally suppressed and maintain an undetectable viral load as well as other clinical and support services to help support general health and achieve a high quality of life. Studies have shown that people with an undetectable viral load do not transmit HIV to their sexual partners, this is often referred to as "U=U."

## Why a Status Neutral Approach Is Needed

**HIV treatment and prevention services have not been fully used by all who need them:** Only 66 percent of people with diagnosed HIV in the United States are virally suppressed. PrEP remains greatly underused—just 23 percent of the estimated one million Americans who could benefit are using the intervention. Stigma and structural barriers are major obstacles that deter people from seeking HIV prevention and care. People with HIV and people who could benefit from HIV prevention are not two distinct populations, but rather one group with similar medical and social service needs. Adopting a status neutral and "whole person" approach to **people in need of prevention and care services can address these similar needs, along with HIV-related stigma.**

**Health departments implementing models of status neutral HIV care have reported benefits such as:**

- **Decreasing new HIV infections.** A status neutral approach to care and service delivery means that regardless of HIV status, people have access and support to stay on highly effective public and personal health interventions like PrEP and HIV treatment. When people are supported to fully use these interventions, the outcome is the same—HIV infections and other infections are identified, prevented, and treated. For example, New York City's status neutral approach to HIV prevention and care, first introduced in 2016, contributed to annual declines in new HIV diagnoses thereafter. New York City saw a 22% decrease in new HIV diagnoses from 2016 to 2019.

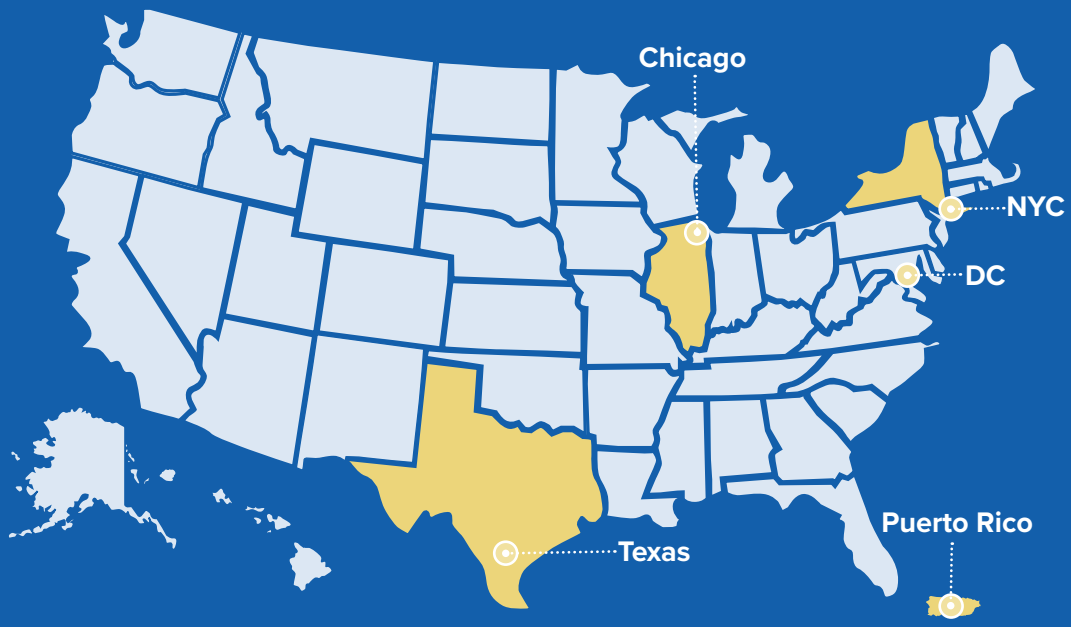
- **Supporting and enabling optimal health through continual engagement in comprehensive, "whole person" care.** By offering HIV services alongside other local health care and social support services used by the community, HIV prevention and treatment can become part of the fabric of holistic care designed to meet the needs of each person. As their needs evolve, a person can be seamlessly connected to new services. Potential outcomes include improved HIV care, as well as better overall health and social stability for every individual. For example, Chicago has created comprehensive status neutral health homes that offer the same services to people with HIV and people who could benefit from prevention services. Services include primary care, medications, care coordination, and behavioral health.

- **Opportunities for more efficient service delivery.** Parallel services and structures historically created for people with HIV or people who could benefit from prevention services can impede the most efficient use of resources. This can also inadvertently hinder connection to care by maintaining stigmatizing structures in health care. Identifying opportunities to resolve these divisions allows for more streamlined and integrated care. Washington, D.C. has seen increased capacity and improved outcomes and engagement at organizations using a status neutral approach. Using this approach has increased viral suppression rates 3% across all funded jurisdictions and increased linkage to preventive services like PrEP and harm reduction for people who tested negative for HIV.

- **Improving health equity.** The status neutral framework integrates HIV and prevention services to better address social determinants of health regardless of HIV status. The framework also encourages the delivery of culturally affirming care by ensuring providers recognize and address their implicit biases on issues like race, ethnicity, sexual orientation, or gender identity. These biases sometimes prevent people from returning for care and other services. Likewise, countering stigma is essential to ensure that people with HIV are not defined by their status, and that people seeking HIV prevention and care services are empowered to access these tools without facing judgment or being reduced to the result of a lab test. Addressing racial bias and stigma results in better care experiences for patients and increases the likelihood that they remain in care and stay healthy.

## **SPOTLIGHT:** Status Neutral HIV Care in Action

**Here's how some jurisdictions across the country are integrating a status neutral approach into their HIV care services:**




- **Chicago: Integrating all HIV and sexually transmitted infection (STI) services**. The Chicago Department of Public Health recently restructured its entire HIV services portfolio to adopt a status neutral approach. Based on feedback from its community members over a two-year community engagement process, the portfolio now integrates HIV and STI funding to deliver comprehensive care that links people to healthcare services like STI screening, substance use disorder treatment, mental health, housing, financial assistance, and psychosocial support in addition to HIV treatment and prevention. Anyone can access these services regardless of HIV status.

- **New York City: Expanding sexual health and rebranding to reduce stigma.** Stigma associated with HIV and STIs can prevent people from seeking care in STI clinics. To address this, the New York City Department of Health and Mental Hygiene rebranded its STI clinics as sexual health clinics and transformed services so that they fully meet clients' sexual health needs. These changes have resulted in more diverse populations visiting the clinic for care.

- **Puerto Rico: Delivering affirming, trauma-informed care for transgender people**. Centro Ararat in Ponce, Puerto Rico delivers integrated, tailored sexual health and primary care to the transgender community. The center's innovative clinic provides comprehensive, trauma-informed health services for transgender people alongside HIV and STI care. These services include hormone therapy and level testing, mental health services, support with name changes, and assistance finding trans-sensitive housing.

- **Texas: Improving access to social services for all people.** *Achieving Together* is the community plan to end the HIV epidemic in Texas. It lays out a vision for status neutral HIV care that supports all people in accessing services that meet their priority needs. This approach addresses social determinants of health, including housing, transportation, and food assistance, helps with insurance navigation, and increases access to mental health and substance use disorder treatment.

- **Washington, D.C.: Eliminating HIV prevention and treatment barriers early.** DC Health developed a status neutral approach through its regional early intervention services initiative, which supports engaging people early in HIV care and prevention services throughout the DC metropolitan area. The initiative has made strides in integrating prevention and treatment services, which previously operated independently, and consists of five pillars to promote equity and whole person health spanning HIV outreach, education, testing, and linkage to and retention in care.

## What CDC Is Doing to Advance Status Neutral HIV Care

**CDC is providing funding, conducting implementation science to improve programs, and partnering with organizations across the U.S. to support integrated, status neutral approaches to HIV care:**

- **Encouraging grantees to deliver integrated services.** Several of CDC's major funding programs provide flexible resources for health department and community-based organization (CBO) partners to deliver integrated HIV prevention services. Additionally, CDC encourages health departments that receive funding through CDC's flagship prevention and surveillance program to use these resources to support programs that adopt status neutral approaches to HIV prevention and treatment.

  - ***Ending the HIV Epidemic* initiative implementation:** In July 2021, CDC awarded the second major round of EHE funding — approximately $117 million — to health departments representing 57 prioritized jurisdictions to scale up focused, local efforts designed to address the unique barriers to HIV prevention in each community. CDC encourages grantees to coordinate with STD and viral hepatitis programs, LGBTQ health centers, criminal justice and correctional facilities, and other providers to deliver HIV services. In addition, the new program provides funding to a subset of jurisdictions to strengthen HIV testing, prevention, and treatment services at dedicated STD clinics.

  - **High-impact HIV prevention through CBOs and health departments:** CDC funded more than 90 CBOs to develop high-impact HIV prevention programs and partnerships, beginning in 2021. These CBOs are required to create HIV programs with the greatest potential to address social and structural determinants of health. CBOs can use CDC funding to help clients navigate essential support services. The program will also support integrated screening for STIs, viral hepatitis, and TB, and referrals for subsequent treatment.

- **Conducting implementation science.** CDC is conducting a pilot program to evaluate a project designed to deliver status neutral HIV services to transgender people. The pilot will support transgender healthcare providers and CBOs in integrating HIV, STI, viral hepatitis, and harm reduction services alongside transgender-specific healthcare. The pilot aims to establish best practices for creating a "one-door" approach for testing and other interventions that can improve the health of transgender people.

- **Building partnerships.** CDC is working with other federal agencies and organizations focused on issues that intersect with HIV and affect health outcomes, like sexual health, mental health, housing, incarceration, employment, and substance use disorder to advance status neutral approaches to HIV prevention and care. For example, the HIV National Strategic Plan incorporates the status neutral framework, creating opportunities to improve systems so they support the provision of status neutral services in the national HIV response. These partnerships will enable the sharing of knowledge and best practices that translates to better implementation science, programs, and services. These partnerships can also support better integration of programmatic efforts in communities.

## The Way Forward

**It will take time for a status neutral approach to be adopted across the country.** Federal agencies, state and local health departments, healthcare providers, and CBOs can take steps now to begin promoting and integrating this approach into their programs and service delivery models if appropriate for their organization or jurisdiction and supported by their community:

- Federal health agencies can provide training, support, and technical assistance to state and local health departments, healthcare providers, and CBOs looking to implement status neutral HIV care. They should prioritize strategies that support front-line providers in more easily creating and implementing status neutral programs. They should also promote cross-agency collaboration to integrate HIV treatment and prevention services over time with other primary care, behavioral health, and social services.

- State and local health departments can review their current funding and care delivery models to further integrate HIV into STI and primary care settings, especially community health centers, sexual health clinics, and health access points for people who use drugs. They should also identify ways to braid funding from multiple sources, and work with CBOs and other providers to gather and share best practices and lessons learned in implementing status neutral HIV care.

- Healthcare providers and CBOs can offer dynamic, supportive care that integrates culturally affirming messages and prioritizes each patients' individual needs. They can consider providing non-HIV services that can improve patients' overall health, such as STI and viral hepatitis screening, mental health care, and substance use counselling, as well as linkage to social services. They can also participate in regular trainings on recognizing and addressing implicit racial/ethnic and other biases.

## REFERENCES


1 Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed June 2, 2021.

2 Walcott M, Kempf MC, Merlin JS, Turan JM. Structural community factors and sub-optimal engagement in HIV care among low-income women in the Deep South of the USA. Cult Health Sex. 2016;18(6):682-94.

3 Eaton LA, Driffin DD, Kegler C, et al. The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. Am J Public Health. 2015;105(2):e75-e82.

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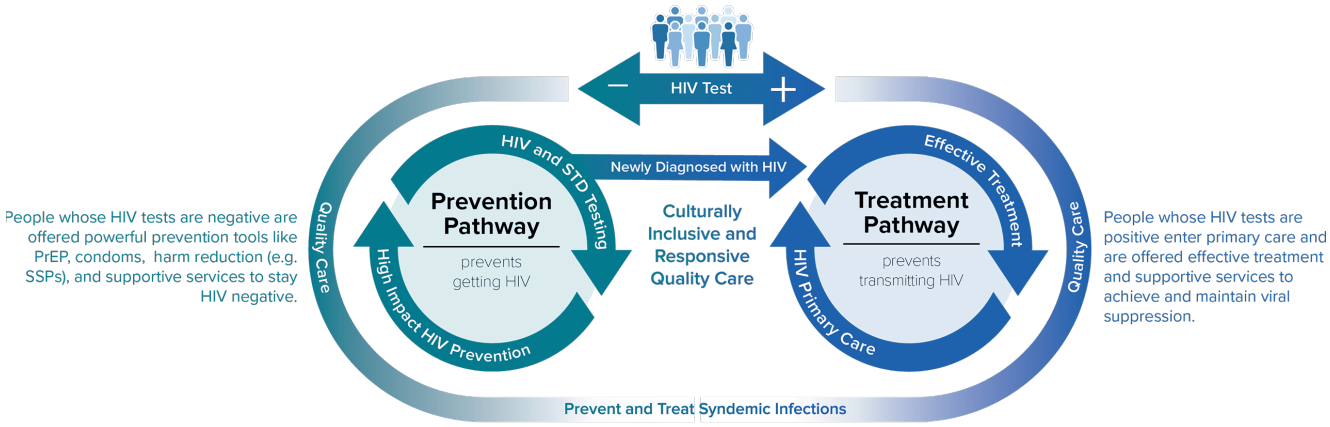
**Prevention Planning Workgroup – Status Neutral Recommendations**
**https://www.cdc.gov/hiv/pdf/policies/issue-brief/Issue-Brief-Status-Neutral-HIV-Care.pdf**

# Status Neutral HIV Prevention and Care




Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

| CDC | Recommended edits |
|---|---|
| Does not include STIs | Includes STIs |
| Status Neutral HIV Prevention and Care | Status Neutral HIV & STI Service Delivery System |
| **Status neutral HIV service delivery is:**<br>• **Healthcare** that encompasses HIV testing, treatment, and prevention services.<br>• **HIV treatment and prevention** that is offered alongside other local medical healthcare services frequently used by the community—for example, sexual health, transgender and other LGBTQ-focused care, healthcare for people who use drugs, and general primary care.<br>• **Service delivery** that recognizes and includes broader social services that support the path to optimal HIV and other health outcomes—like housing, food, transportation, employment assistance, | **Status neutral HIV & STI Service Delivery System provides increased emphasis on:**<br>• **Service delivery** - supportive services for both HIV+ and HIV- individuals. Need to identify resources to support HIV- individuals in need of supportive services (e.g., housing, mental health, etc.)<br>• **Culturally affirming, stigma-free HIV and STI delivery system –** with providers who are supportive and provide a culturally affirming and stigma-free service delivery system. Increase need for providers with lived experience and are racially/culturally/ethnically diverse |

| | |
|---|---|
| harm reduction services, and mental health and substance use disorder services—regardless of the HIV status of the people seeking care.<br>• **Culturally affirming, stigma-free HIV treatment and prevention,** delivered by supportive and accepting providers who have been trained to recognize and address implicit racial/ethnic, sexual orientation, and other biases (thoughts and feelings that providers are not consciously aware of), and provided in settings that consider and prioritize a positive experience for the person seeking services. | |
| **Target Populations:** Focus on HIV- or HIV+ | **Target Populations:** Focus on priority populations identified via data<br>• Latinx men who have sex with men (MSM)<br>• Black/African American MSM<br>• Transgender persons<br>• Cisgender women of color<br>• People who inject drugs (PWID)<br>• People under the age of 30<br>• People living with HIV who are 50 years of age or older |

# Characterizing Late Diagnoses: Results from Health Resources and Services Administration-HIV/AIDS Bureau's Updated Approach

Wendy Garland, MPH
Chief Epidemiologist
Program Monitoring & Evaluation
Division of HIV and STD Programs

Los Angeles County Commission on HIV
April 13, 2023

# Presentation Overview

- Follow up to presentation at annual meeting on updated approach to estimate unmet need

- One of three presentations to discuss estimates
  - **Late diagnoses (April 2023)**
  - Unmet need for medical care (May 2023)
  - In care but not virally suppressed (June 2023)

- Define of unmet need measures and populations, present results and discuss how to use in our work

# What is Unmet Need?

- Defined by HRSA HIV/AIDS Bureau as:

  " the need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary [HIV] health care."
- Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
- New and expanded methodology released 2021 and implemented in 2022

1."HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

# Evolving Definition of Unmet Need

**2005**

- Focus on people aware of their HIV/AIDS diagnosis but not in regular HIV medical care
- People living with diagnosed HIV and AIDS with no evidence of care (at least one **viral load [VL]** or **CD4 test** or **ART prescription**) in past 12 months

**2017**

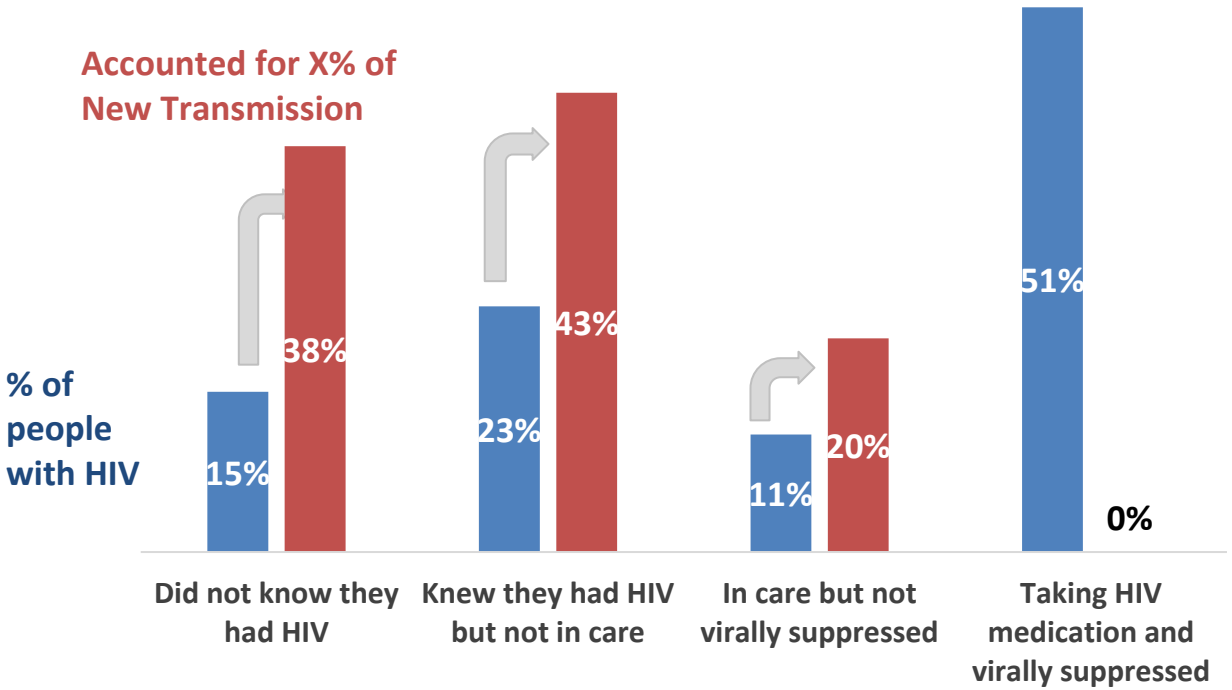
- Care markers updated to align with HIV Care Continuum Definitions
- People living with diagnosed HIV and AIDS with no evidence of care (2 or more **medical visits** or **VL** or **CD4 tests** at least 90 days apart) in past 12 months

**2021**

- Revised care markers and expanded populations
- People living with **diagnosed HIV** with no evidence of care (at least one **VL or CD4 test**) in the past 12 months
- Adds two new indicators:
  - Persons diagnosed with HIV in the past 12 months with **LATE DIAGNOSIS (Stage 3 (AIDS)** diagnosis or an **AIDS-defining condition** ≤ 3 month after HIV diagnosis**)**
  - Persons living with diagnosed HIV **IN MEDICAL CARE** (at least one VL or CD4 test) who were **NOT VIRALLY SUPPRESSED** in the past 12 months

# Unmet need estimates attempt to measure the gaps between the HIV care continuum

- To reduce HIV transmission

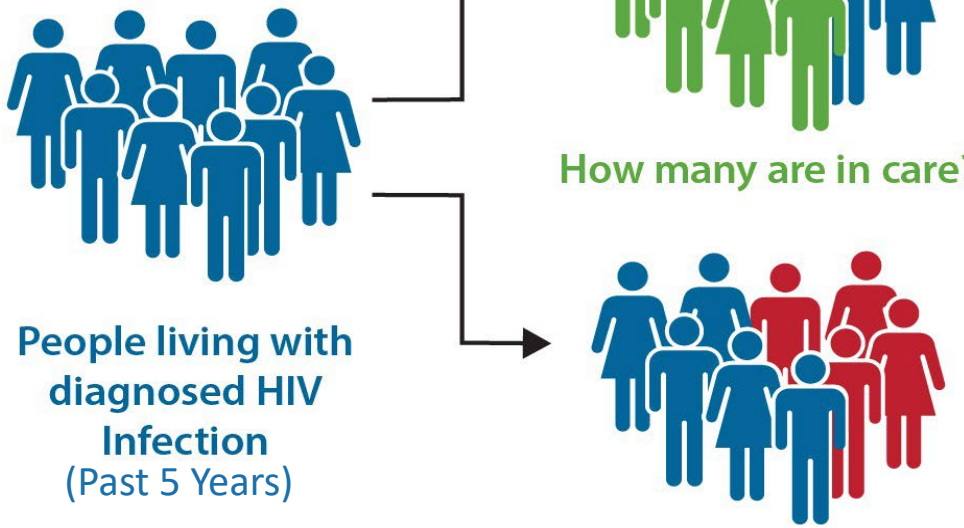



**HIV Transmissions in the United States, 2016**[1]

- To improve health outcomes among PLWDH
  - Start ART early in infection
  - Reduce HIV comorbidities, coinfections and complications
  - Slow disease progression
  - Extend life expectancy
  - Reduce HIV-related mortality


1. Li Z, Purcell DW, Sansom SL, Hayes D, Hall HI. *Vital Signs:* HIV Transmission Along the Continuum of Care — United States, 2016. MMWR Morb Mortal Wkly Rep 2019;68:267–272. DOI: http://dx.doi.org/10.15585/mmwr.mm6811e1 .
2. National HIV/AIDS Strategy for the United States (2022-2025). https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf

# LAC Populations for Estimates of Unmet Need



What do the data look like for three priority populations (chosen by jurisdiction)?

1. Hollywood-Wilshire HD
2. Central HD
3. Long Beach HD

# Approaches to Identify Disparities and Gaps - Examples

## Across Group Comparison*

- Helpful for describing a population
  - Latino males made up 24% of LAC residents in 2020

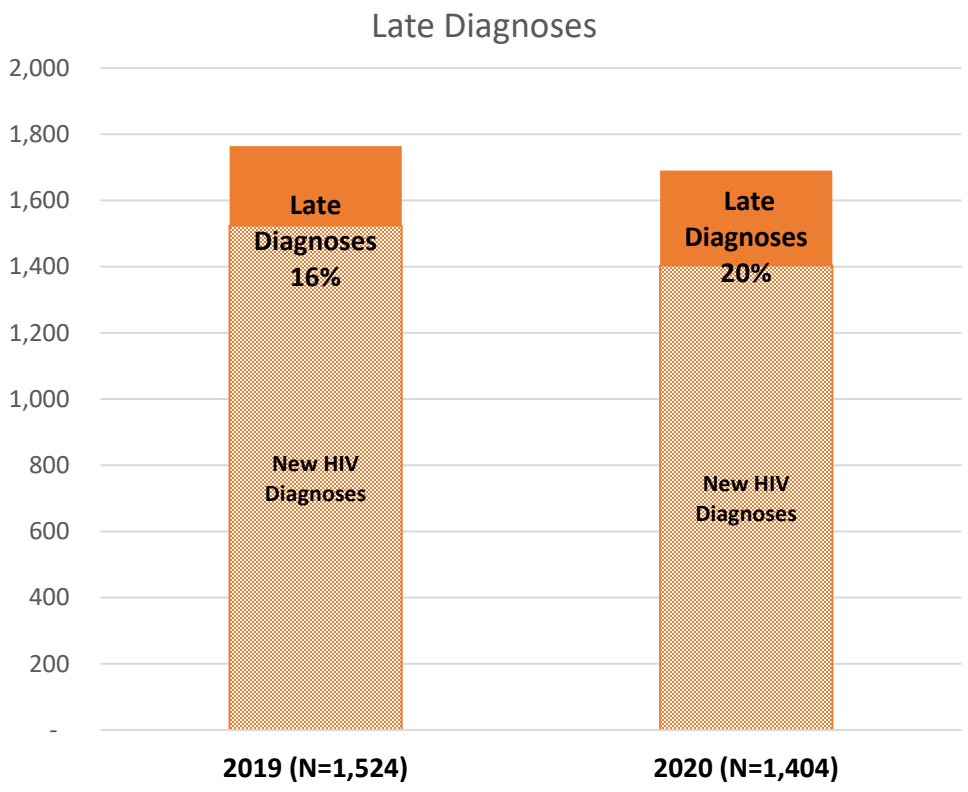
- Identify disparities across populations
  - Latino males made up 53% of LAC residents newly diagnosed HIV in 2020
  - Proportional difference between residents who were Latino males (24%) to compared to new diagnoses who were Latino males (53%)

## Within Group Comparisons*

- Helpful to understand how specific groups are impacted compared to each other
  - Linkage to care among 170 newly diagnosed Hollywood-Wilshire HD residents (85%) compared to among 126 newly diagnosed among Central HD residents (67%) compared to 92 newly diagnosed Long Beach HD residents (80%)

*Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.

# Considerations when thinking about this data




- These data represent the characteristics of LAC residents with confirmed new HIV diagnoses in 2020 reported to DHSP
- These data do not reflect
  - How, where and to whom HIV testing services are available or accessed
  - Testing behaviors or frequency among LAC residents
- For example, changes in new diagnoses and late diagnoses from 2019 to 2020 may be due to
  - Decreased testing access or availability due to COVID-19
  - Fewer people seeking testing services

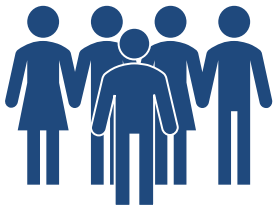
# Unmet Need Estimate:  Late Diagnoses in LAC, 2020

# Context for Late Diagnoses

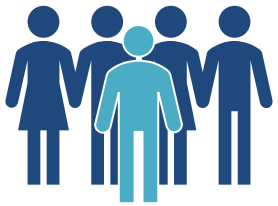
- National goal: reduce late diagnoses by 25%
  - In LAC that means decreasing the percent of late diagnoses from 24% to 18% by 2025[1]
- On average, it takes 8 years to progress to late stage disease from time of infection to diagnosis[2]
- Identification of late diagnoses is not done at point of care – providers are not likely to know degree of disease progression at time of testing
  - Helpful to track how well our care system is identifying infection early and across populations but cannot guide services


1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.
2.Lodi S, et al. Time from human immunodeficiency virus seroconversion to reaching CD4+ cell count thresholds <200, <350, and <500 cells/mm(3): assessment of need following changes in treatment guidelines. *Clin Infect Dis*. 2011;53(8):817–825.

# Late Diagnosis Estimate in LAC, 2020



1,404 New Diagnoses



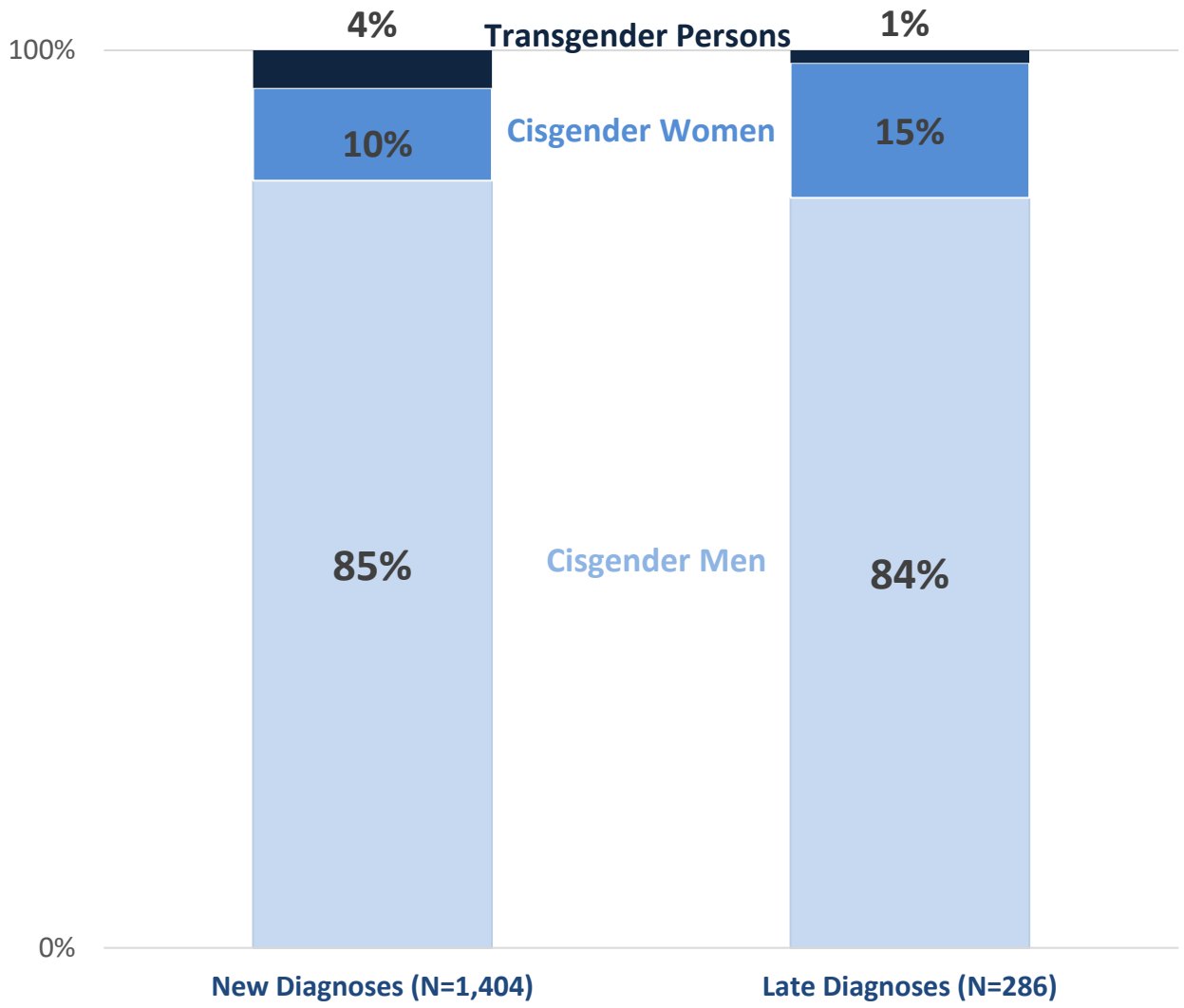
20% Late Diagnoses (N=286)

PART A Geographic Priority Populations

- 15% Hollywood-Wilshire HD (N=171)
- 15% Central HD (N=19)
- 15% Long Beach HD (N=14)

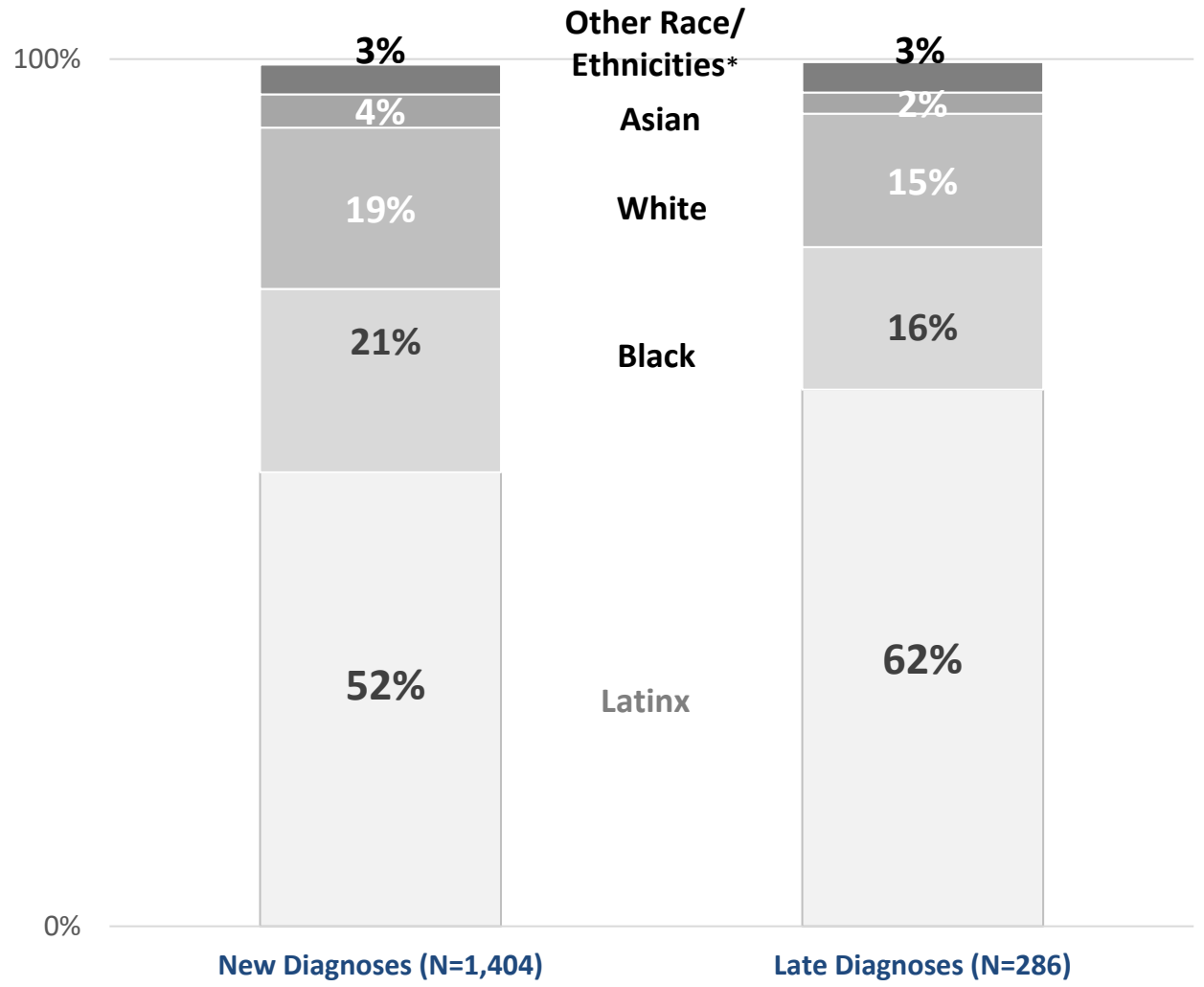
# New and Late HIV Diagnoses by Gender Identity, 2020

- The largest percent of new diagnoses and late diagnoses were among cisgender men
- While 10% of new diagnoses were among cisgender women, they represented 15% of late diagnoses



# New and Late HIV Diagnoses by Racial/Ethnic Group, 2020

- The largest percent of new diagnoses and late diagnoses were among Latinx residents
- While 52% of new diagnoses were among Latinx residents, they represented 62% of late diagnoses

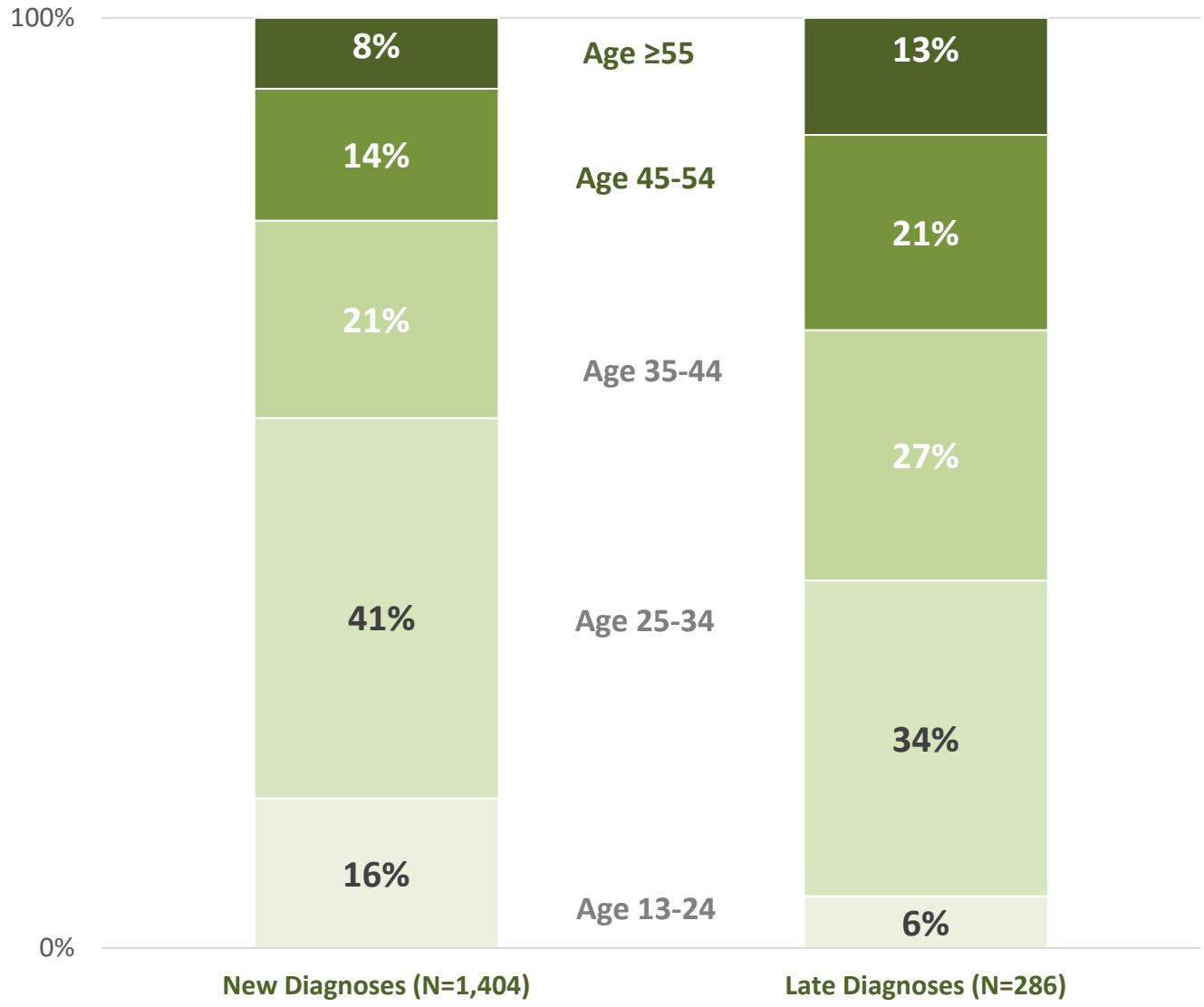



*Among new diagnoses, persons of other racial/ethnic groups include: Multiple race (n=42), American Indian/Alaska Native (n=5), and Native Hawaiian/Pacific Islander (<5). Race/ethnicity was not reported for 9 cases.

# New and Late HIV Diagnoses by Age Group, 2020

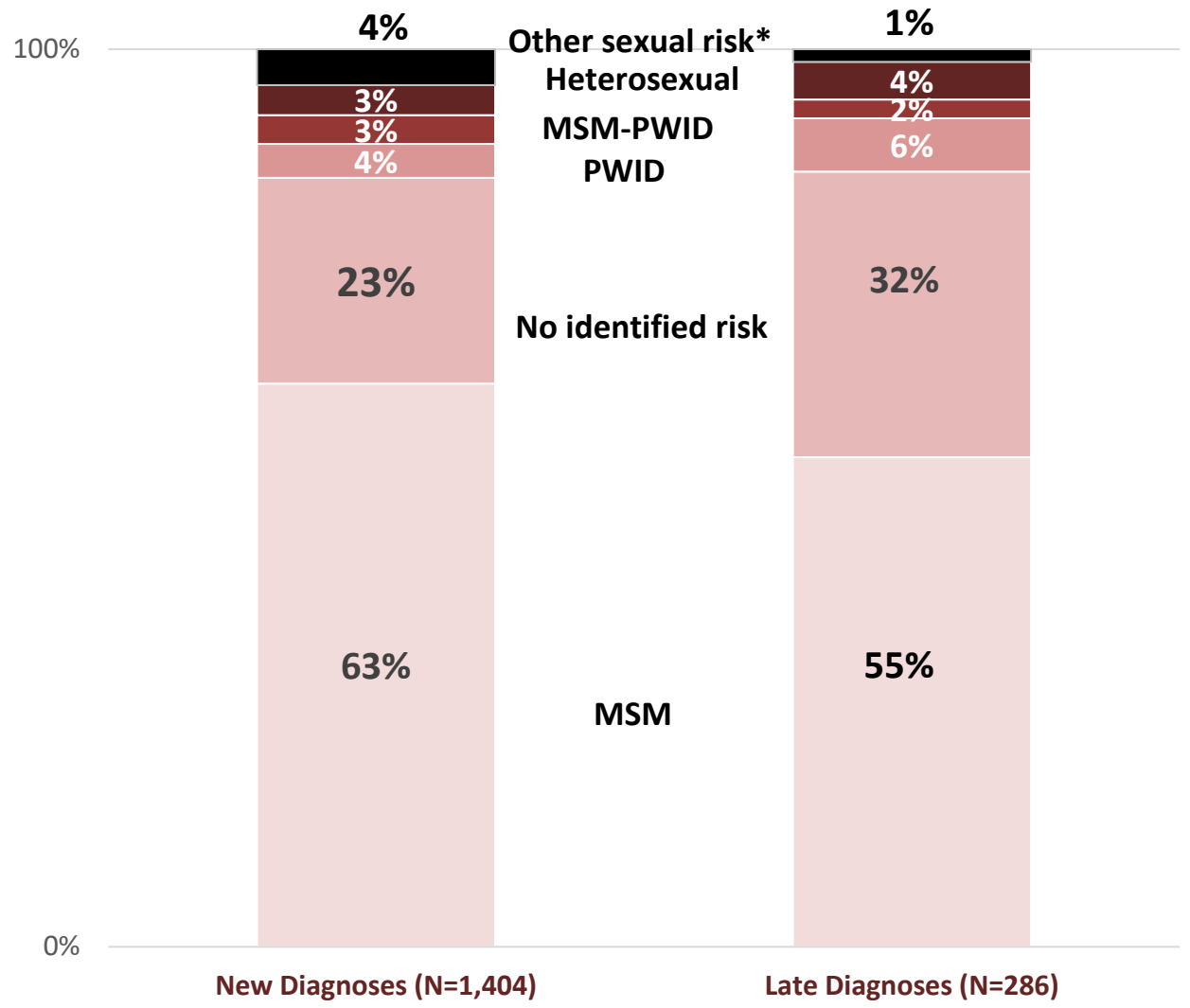
- The largest percent of new diagnoses and late diagnoses were among residents age 25-34 represent the largest percent of new diagnoses (62%) and late diagnoses (61%)

- Older age groups represent larger percentages of late diagnoses compared to residents in younger age groups



# New and Late HIV Diagnoses by Exposure Category, 2020

- The largest percent of new diagnoses and late diagnoses were among men who have sex with men (MSM)
- While 23% of new diagnoses were among persons with no identified risk exposure reported, they represented 32% of late diagnoses



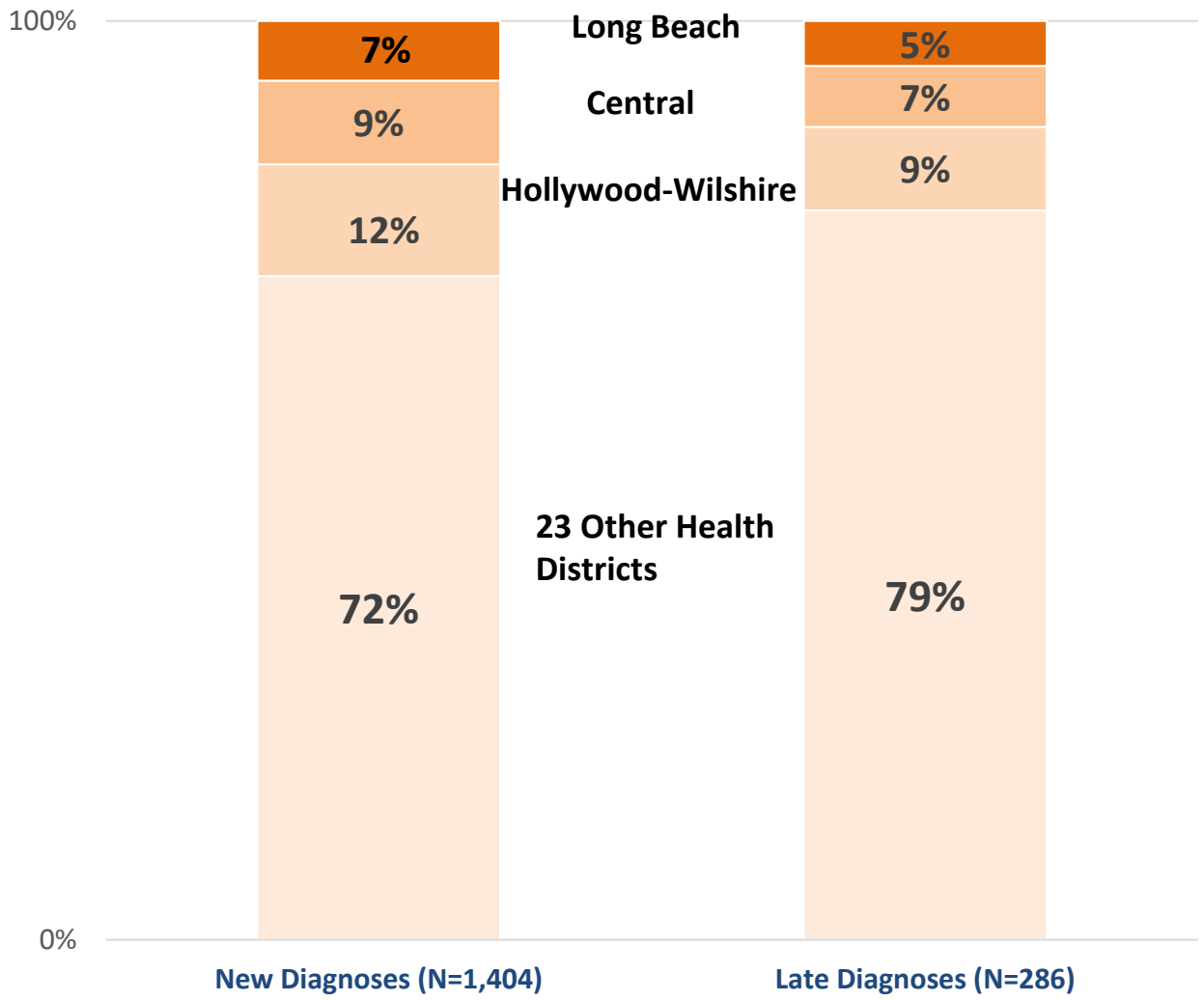

Definitions: MSM: Men who have sex with men; PWID: People who inject drugs

*Among new diagnoses, other sexual risk includes: sexual contact among transgender individuals(n=48), sexual contact and PWID among trans individuals (n=8).

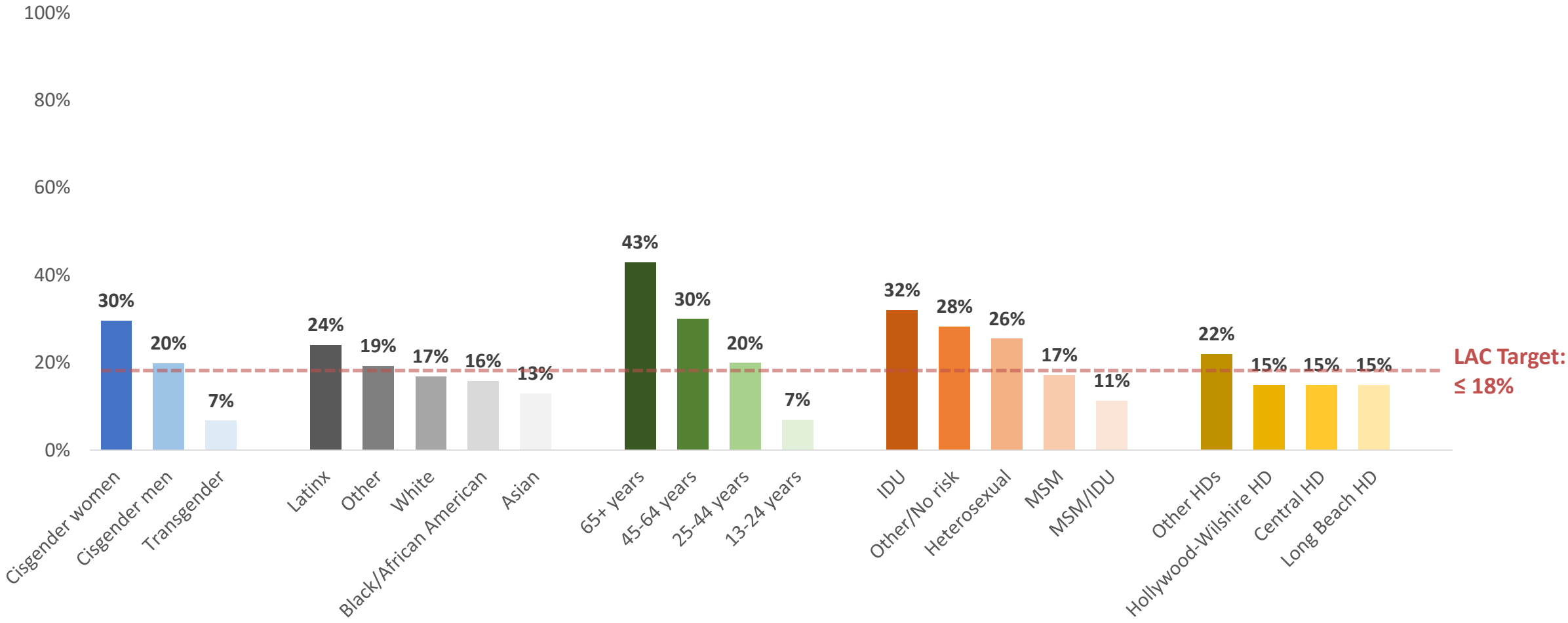
# New and Late HIV Diagnoses by Health District, 2020

- The largest percent of new diagnoses and late diagnoses were reported for residents in other health districts

- Nearly 30% -- or 1 out of every 3 new diagnoses was among residents of Hollywood-Wilshire, Central and Long Beach HD



**Late diagnoses** within each category were highest among cisgender women, Latinx, PLWDH aged 65+ and injection drug users (IDU)




Los Angeles County PLWDH Population-Level Late Diagnoses Estimates within Categories of Age, Gender, Race/Ethnicity and Transmission/Risk Categories, 2020.

# Key Takeaways

The majority of new diagnoses were timely - 80% identified soon after infection

- How can we build on what is working?

Identified disparities in late diagnoses

- How and where can we improve for impacted populations?

**Largest burden of late diagnoses**

- Cisgender men
- Latinx
- Age 25-34
- MSM

**Unequal % of late vs all diagnoses**

- Cisgender women
- Latinx
- Age ≥ 35
- No identified HIV risk

**Highest % of late diagnoses within population**

- Cisgender women
- Latinx
- Age ≥ 45
- PWID

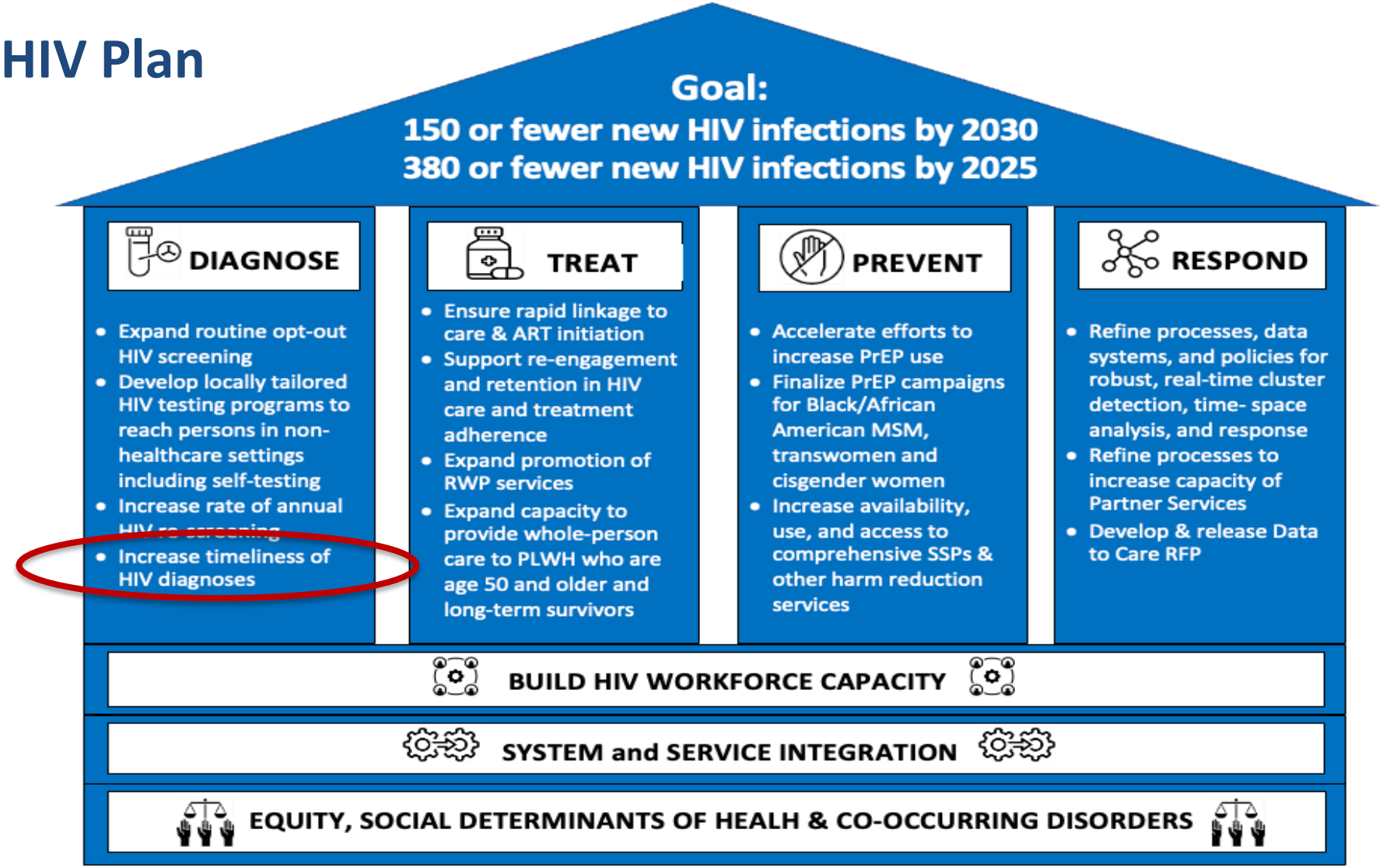
# Questions

# Discussion – using the late diagnosis estimate for planning

# LAC Comprehensive HIV Plan Snapshot

**Priority Populations**

- Latinx MSM
- Black/African American MSM
- Transgender persons
- Cisgender women of color
- PWID
- Persons < age of 30
- PLWH ≥age 50




Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2022- 2026), December 2022: 1-136.

# What are strategies to improve diagnosis timeliness?[1]

- Focus on those populations that account for a large portion of residents who are unaware of their HIV infection
  - LAC: persons age 13-34 and Latinx[2]
- Focus on targeting and routine testing for younger age groups to reach people earlier in infection
- Identify barriers to HIV testing and stigma among older populations
- Work with providers to promote routine testing in health care settings
  - DPH Sexual Health Clinics (formerly STD Clinics)
  - Vaccine programs (COVID, Mpx)

**HIV TESTING RECOMMENDATIONS**

**US Preventative Services Task Force (2019)**

- Persons age 15-65
- <15 and >65 based on risk
- All pregnant women

**CDC (2006)**

- General population: ≥ 1 ever
- Persons with risk factors: ≥ 1 annually

1.Krueger A, et al. 2019. HIV Testing, Access to HIV-Related Services, and Late-Stage HIV Diagnoses Across US States, 2013-2016. doi: 10.2105/AJPH.2019.305273. PMCID: PMC6775941
2.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.
3.Traynor SM, Rosen-Metsch L, Feaster DJ. 2018. Missed opportunities for HIV testing among STD clinic patients. doi: https://link.springer.com/article/10.1007/s10900-018-0531-z

# How can our services improve timely diagnoses and HIV awareness?

- More testing programs?
  - Routine vs. targeted
  - Clinical vs. non-clinical
- Rescreening
- Expand existing access points
  - Storefront and social and sexual network programs
  - Mobile or street-based
  - HIV self testing
  - Public health clinics
  - Emergency rooms
- New access points
  - Pharmacies?
  - Other non-clinical settings?
- Linguistically and culturally appropriate services
- Service promotion

# Next Steps for Unmet Need Estimates

- Continue measure-focused presentations to COH
  - Unmet Need (Out of Care)– May
  - In Care but Not Virally Suppressed – June
  - Will include separate analyses for Ryan White Clients

- Further analyses are needed to
  - Identify predictors of late diagnoses among LAC residents
  - Describe care continuum outcomes for late compared to timely diagnoses

- Summary report completed mid-2023


Special thanks to the following people without whom this presentation would not be possible:

Sona Oksuzyan, PhD

Janet Cuanas, MPP

Virginia Hu, MPH

Michael Green, PhD, MHSA

# References and Resources

- Webinar video and slides:  Enhanced Unmet Need Estimates and Analyses: Using Data for Local Planning https://targethiv.org/library/enhanced-unmet-need-estimates-and-analyses-using-data-local-planning

- Webinar video and slides:  https://targethiv.org/library/updated-framework-estimating-unmet-need-hiv-primary-medical-care

- Methodology for Estimating Unmet Need:  Instruction Manual https://targethiv.org/library/methodology-estimating-unmet-need-instruction-manual

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# PP&A Stakeholder Engagement and PSRA Timeline - DRAFT

| Month | Key Activities |
|---|---|
| April/May | • CAB Questionnaire and Discussion Prompts Development and Distribution<br>• Identify locations for regional townhalls (SPA, health district)<br>• Identify data needs to inform PSRA process |
| May | • Review CAB Questionnaire and Discussion Responses.<br>• Analyze and Develop Discussion Topics for Regional Townhalls<br>• Secure locations for regional townhalls<br>• Engage with various County Commissions to identify opportunities for partnership to extend sphere of influence |
| June – July | • Promote and host regional townhalls throughout LA County<br>• Review data from DHSP (and other existing data from CHP)<br>• Review HIV/STI Prevention |
| Aug – Oct | • Priority setting and resource allocation<br>• Submit priority ranks and allocations to HRSA |
| Oct – Dec | • Ryan White (RW) Part A and Minority AIDS Initiative (MAI) Directives PY 34, 35, 36 |