LOS ANGELES COUNTY
COMMISSION ON HIV

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Planning, Priorities, and Allocations Committee Meeting

Tuesday, August 15, 2023
1:00pm-3:00pm (PST)

510 S. Vermont Ave,
Terrace Conference Room
Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

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

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-616, Sacramento, CA 95814

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/5n7uv9kr

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2536 453 2771

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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, AUGUST 15, 2023 | 1:00 PM – 3:00 PM

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

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
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MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://tinyurl.com/5n7uv9kr
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Password: PLANNING Access Code: 2536 453 2771

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros MBA, Co-Chair	Lilieth Conolly	Felipe Gonzalez
Joseph Green	Michael Green, PhD	Karl T. Halfman, MS	William King, MD, JD
Miguel Martinez, MPH, MSW	Anthony M. Mills, MD	Derek Murray, MSW	Jesus "Chuy" Orozco
Dechelle Richardson (Alternate)	Redeem Robinson (LOA)	LaShonda Spencer, MD	Jonathan Weedman
QUORUM: 8			

AGENDA POSTED: August 10, 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.

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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.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, 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 Committee members to recommend new business items for the full body or a

committee level discussion on non-agendized Matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

8. Executive Director/Staff Report 1:18 PM – 1:30 PM
    a. HRSA Site Visit Findings
    b. Bylaws Review Taskforce Updates
    c. LAHSA Report Update
9. Co-Chair Report 1:30 PM – 1:40 PM
    a. New Member Welcome and Introductions
    b. Recap July 26th Prevention Planning Workgroup Meeting
    c. Memo to DHSP Regarding Medi-Cal Expansion Strategies
    d. Renewal Committee-Only application for Miguel Martinez, MPH, MSW
    MOTION #4 Approve the Renewal Committee-Only application for Miguel Martinez, MPH, MSW and elevate to the Operations Committee
10. Division of HIV and STD Programs DHSP Report 1:40 PM – 2:10 PM
    a. Fiscal Year 2022 Expenditures and Utilization Report
    b. RWP FY 2024 Non-Competing Progress Report Requirements and Deadline

V. DISCUSSION ITEMS 2:10 PM—2:50 PM

11. Community Listening Sessions Questionnaire Review
12. Recap HIV & STDs Surveillance and Data Challenges for LA County Native American Communities Part 1

VI. NEXT STEPS 2:50 PM – 2:55 PM

13. Task/Assignments Recap
14. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

16. Adjournment for the meeting of August 15, 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 Planning, Priorities and Allocations Committee minutes, as presented or revised.
MOTION #4	Approve the Renewal Committee-Only application for Miguel Martinez, MPH, MSW and elevate to the Operations Committee

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/10/23

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**	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Transportation Services
			Biomedical HIV Prevention
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
CONNOLLY	**Lilieth**	Unaffiliated consumer	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DANIELS	**Shonte**	Unaffiliated consumer	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**	No Affiliation	No Ryan White or prevention contracts
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
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
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	No Ryan White or prevention contracts
ROBINSON	**Mallery**	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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
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
SOLIS	**Juan**	UCLA Labor Center	No Ryan White or prevention contracts
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

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES APRIL 18, 2023

COMMITTEE MEMBERS 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
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	A
Felipe Gonzalez	P	Anthony M. Mills, MD	P
Joseph Green	A	Derek Murray	P
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	P
Karl T. Halfman, MS	EA	LaShonda Spencer, MD	P
Reverend Redeem Robinson	A	Jonathan Weedman	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Jose Rangel-Garibay, Lizette Martinez			
DHSP STAFF			
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

Al Ballesteros, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:10pm and opened with news of the passing of Dr. Wilbert Jordan. He shared fond memories of Dr. Jordan and Dr. Spencer and Dr. King also shared memories and kind words.

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, D. Murray, Dr. King, Dr. Mills, Dr. Green, Dr. Spencer, 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 Committee members invoked attendance under AB 2449; no vote held.)**

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 noted the Health Resources and Services Administration (HRSA) site visit report is still pending but noted the Commission is already working to address areas for improvement that were noted during the exit interview with DHSP. The report will be shared with Commissioners as soon as it is available.
   - C. Barrit also reminded the Planning, Priorities, and Allocations (PP&A) Committee of the Mandatory and Supplemental Training series. She noted that the trainings are open to the public and encouraged committee members to share the registration links for the virtual sessions with any interested stakeholders. The training schedule is available on the Commission website under the "Events" tab. She reminded commissioners that HRSA requires annual training for commissioners and that this training series covers that requirement. For those not able to attend the live training session, they can access the training recordings on the Commission website and notify Commission staff that they viewed the training to receive credit for the mandatory trainings. Lastly, C. Barrit thanked PP&A co-chair, K. Donnelly for leading the Priority Setting and Resource Allocation (PSRA) section of the most recent training.
   - C. Barrit shared that the Women's Caucus will be reviewing the most recent directives to DHSP

in their upcoming July meeting to provide feedback and recommendations to the PP&A Committee in preparation for the next PSRA cycle.

- C. Barrit called attention to the April 12, 2023, Dear Colleague letter from HRSA focusing on HIV and housing. See meeting packet for details. She reminded the PP&A Committee to consider housing (and other) data needs to help fill in gaps and inform the PSRA process while reviewing the document.
- Finally, C. Barrit noted a summary of status neutral recommendations from the Prevention Planning Workgroup (PPW) were available and in the meeting packet. See meeting packet for details. She noted that PPW has been having continued discussions on how to incorporate prevention into status neutral approaches and have several recommendations that will be shared with the PP&A Committee for review and approval.

9. Co-Chair Report

- There was no co-chair report.

10. PPW Recommendations on Status Neutral

- The report was deferred to next month. Recommendations regarding status neutral will be provided.
- Dr. King noted a major goal of incorporating prevention strategies into existing programs such as incorporating HIV and STI testing in Syringe Services Programs (SSPs).
- A. Ballesteros noted the need to connect with Substance Abuse Prevention and Control (SAPC) program and the Public Health Commission to collaborate to push through recommendations and create policy/practice changes. He mentioned how he wonders how the various programs within the Department of Public Health (DPH) collaborate and come together to create synergy between HIV and SUD strategies. Dr. King noted HIV and STIs have not been discussed in the few SAPC Medical Director Meetings he has attended in the past.
- A. Ballesteros noted to move the agenda forward, the Commission on HIV (COH) needs to a develop specific, shared priorities and action items and take them directly to the Board of Supervisors (BOS). For example, HIV screening tests for all individuals entering a residential SUD program within the first 30 days.
- Dr. King asked Dr. Mills and Dr. Spencer, both of whom work with residential substance abuse programs, if an HIV or STI screening is included in part of the required physical examination for individuals entering a residential SUD program. Both Dr. Spencer and Dr. Mills commented that they do not recall a requirement of HIV or STI screening as part of the physical examination. Dr. King noted it may be a recommendation that may be easy to implement.
- D. Murray asked if there were any SSPs that do not include routine HIV screening tests noting he was under the assumption that all SSPs are required to conduct HIV screening tests. Dr. King shared that some mobile outreach teams offer HIV screening tests based on information that was shared at a previous PPW meeting but he was unsure if it was done at all SSP sites or during all mobile outreaches. A Ballesteros confirmed it is not a requirement. Dr. Green added that routine HIV cannot currently be mandated at SSPs because programs are funded with federal dollars. He noted he was shocked when he discovered HIV screening tests were not mandated and that many SSP programs that do offer HIV tests need to collaborate with other programs to

provide this service.

- Dr. Green continued to say DHSP has worked extensively to develop a partnership with SAPC to help extend and complement services, but efforts have not been successful. He noted that DPH remains siloed within itself, and programs do not share data or have a willingness to share data. He urged the Committee to go directly to the BOS with their recommendations rather than DPH.
- A. Ballesteros agreed and reiterated the need to think and approach the HIV epidemic more broadly within the County. He noted the process should be formalized and methodical going through a vetting process within the Commission starting with PP&A and getting full support from the entire COH and forwarding for action to have conversations with SAPC and the BOS on recommendations and provide services that would be mutually beneficial. He noted the process will take some time to accomplish as County processes take time to implement. He recommended that the COH attend health deputy meetings and provide testimony to help further the COHs agenda.
- Dr. Green recommended finding a champion within a Board office to help and noted Supervisor Horvath may be a great ally. He noted Federal agencies are not reliable to help move the agenda forward and have no concrete solutions. He also recommended engaging with SAPC to have a representative on the COH, noting SAPC previously had a representative participate on the COH.
- A. Ballesteros noted with renewed energy the work can be accomplished. Dr. Green added that there is still a lot of money available that can be used towards large scale public health infrastructure improvements. He noted the COVID pandemic opened new opportunities to be creative/innovative in public health approaches.
- Dr. King asked what the timeline was for the next PSRA process to ensure PPW recommendations are incorporated with the new funding cycle. Dr. Green confirmed a timeline of 1-2 years. He noted new funding cycle discussions may take place in approximately 10 months and noted a new CDC funding cycle will be coming as well opening the door for innovative programming.
- K. Donnelly recalled a presentation from SAPC during a PPW meeting last October noting their mobile outreach team's willingness to provide HIV tests but facing challenges with navigating dangerous situations and difficulty collecting demographic data from clients.

- C. Orozco provided a HOPWA update to the PP&A Committee. He noted HOPWA will be undergoing a handful of structural changes to help streamline efforts around the Mayor of LA's the homelessness "state of emergency" to help. One change is the proposal of contracts being extended to five years, a two-year increase from the current three-year model. HOPWA providers noted challenges as the first year of a three-year cycle is spent learning the program/requirements, second year continuing to make large strides and by the third year the programs are running smoothly only to result in a new cycle at the close of the year. The current cycle makes it challenging to gain momentum. The change to a 5-year cycle will need city council approval but other contracts within the city use a 5-year cycle, such as Community Development Block Grants, as a model for the proposed RFP. In addition, procurement processes will be added to allow providers to subcontract with other groups to allow better engagement with hard-to-reach communities. New HOPWA services RFPs will be released in July 2023 with program services set to begin in July 2024. In addition, HOPWA will be reverting previous changes that had cut down on the number of contracts

but inadvertently resulted in legal services being subcontracted out from a provider, making it challenging to monitor directly as well as challenges with coordination/communications between regional offices. HOPWA will move toward directly monitoring legal services. Walk-ins will no longer be allowed, and referrals will be needed so that services remain strictly housing related. The HOPWA data system will also change. It previously aligned with the Los Angeles Homeless Services Authority (LAHSA) system, but it did not work well to provide timely case management and reports. The new system is familiar with HOPWA needs/requirements will streamline data management, reporting, and coordination with providers. HOPWA will also reinstate the Central Coordinating Agency that will start on July 1, 2023. HOPWA will also be reassessing the goals of the Supportive Services and Housing Assistance services as both saw a decline from previous years. HOPWA believes the decline may be due to the restructuring of HOPWA. Finally, Chuy announced HOPWA received 5% increase in funding, the majority of which will be allocated to the scattered site lease program.

- D. Murray asked if the federal government requires HOPWA providers to lease housing units for the scattered site lease program and, if so, are there are challenges with evictions. C. Orozco confirmed HOPWA providers do lease housing units and sublease to individuals/families and are required to report on numbers. He noted the program has seen challenges but not due to evictions but rather high maintenance and repair costs.
- Dr. Spencer asked if there were additional funding sources to help individuals avoid eviction and pay back rent through Emergency Financial Assistance on top of the $5,000 that is provided. Dr. Green noted the funding can be increased and that DHSP has considered increasing the amount to $10,000 but noted current participants are not exhausting the $5,000. C. Orozco highlighted HOPWA legal services that focus on evictions and coordination with Measure ULA on legal services related to eviction. C. Barrit also reminded the group of the no-cap rental and utilities assistance that is available under the City of Los Angeles Short-term Rental, Mortgage and Utilities (STRMU) program. C. Orozco noted there is still approximately $1 million in left funding for the program from COVID response dollars.

V. DISCUSSION

11. DHSP Unmet Needs Report

- Dr. Green opened the discussion on the DHSP Unmet Needs Report that was provided by Wendy Garland during the April 13 COH meeting. He noted there was a question from D. Murray regarding HIV among the growing unhoused population. Dr. Green noted the unmet needs report does not factor housing status but offered other data sources to help address HIV among people experiencing homeless noting the Ryan White Program Utilization report (found here) and the 2021 HIV Surveillance Report (found here). He also recommended reviewing LAHSA 2022 Homeless Count data (found here). He noted that 1337 individuals who have diagnosed HIV were identified in the 2022 homeless count.
- Dr. Green noted a big challenge to DHSP and the COH on ending HIV is identifying individuals who are at risk for experiencing homelessness. He is not aware of any reliable data where this information can be found.
- D. Murray inquired if the RWP Utilization report and the HIV Surveillance Report include information on Linkage Retention and Viral Suppression among the unhoused. Dr. Green

confirmed that they do include this information.

- Dr. King asked if intake questions for RWP providers ask about risk of becoming unhoused. Dr. Green confirm that they do but noted the risk of becoming unhoused goes beyond RWP clients. He noted of the 50,000 people with confirmed HIV within LA County, only 20,000 to 22,000 people utilize RWP services.
- D. Murray commented that conversations around the unhoused are needed when discussing unmet needs and should include needs for supportive services/resources in addition to housing needs. He noted the high number of unhoused people expiring on the street and stated information is needed on the number of people experiencing homelessness, what their needs are and what resources are available to them. This would help determine which resources to allocate.
- Dr. Green reminded the group that homelessness continues to be a key issue in the mayor's office but is unsure if conversations are being had regarding data gathering on people experiencing homelessness, their health outcomes, and their needs and conceptualizing innovative strategies. He noted the City of LA, and the BOS are reluctant to partner but people need to be asking key questions in these spaces.
- C. Orozco noted that the City of LA was looking at the cost of living measure to assess if people are in danger of becoming unhoused before the pandemic because the federal government did not do a good job of defining poverty in LA. He is unsure if discussions are continuing now with the current mayor.
- Dr. Green also noted that a large number of LA County residents would not qualify for HUD assistance due to residency status and that needs to be taken into account during these discussions as well as identifying other funding options for those who are ineligible.
- D. Murray added that another issue is outreach providers who not affiliated with DHSP funded organizations not having enough knowledge around HIV or working with individuals who have HIV, particularly those who are chronically homeless with severe mental illness. He noted more education/training and outreach is need for these providers in addition to resource sharing.
- Dr. Green noted that LAHSA Homeless Count data does not include how the data is used aside from providing a snapshot of homelessness at the time the data is gathered. He noted the data lacks specifics, does not include comorbidities, and does not answer questions the COH may have such as the number of people with mental illness who are HIV positive, that have a physical impairment who are veterans. He noted if their data system is Power BI, the information can be drilled down to get more specifics.
- D. Murray asked C. Barrit if a formal report from LAHSA can be requested. C. Barrit noted LAHSA report can be requested and preparing specific questions ahead of the report are needed to give to LAHSA. She cautioned that previous reports have failed to answer specific questions despite COH staff meeting with the LAHSA team to identify information needed or discrepancies in the data.
- A. Ballesteros recommended requesting LAHSA to modify their questions to include more robust information. He noted the request was made before but is not sure what came of the suggestion.
- F. Gonzalez asked if housing services are available to homeowners or just renters. C. Orozco

confirmed services are available for homeowners and renters. F. Gonzalez noted the need to promote services for homeowners who are at risk of losing their homes as they may not be aware that programs are available to them.

12. Data Request for Priority Setting and Resource Allocation Process

- C. Barrit asked the PP&A Committee to start to think of the data needed to inform the upcoming Priority Setting and Resource Allocation (PSRA) process to allow DHSP enough time to prepare. She noted starting with requesting a report from LAHSA.
- DHSP staff noted the next funding cycle will begin in 2025 and a Notice of Funding Opportunity will be released next year pushing the beginning of the PSRA process to Feb. 2024.

13. Stakeholder Engagement Implementation Timeline

- L. Martinez, Commission staff, provided a brief overview of a proposed timeline for community engagement/feedback activities. See meeting packet for details. C. Barrit noted the Unmet Needs Report will help identify target locations and populations for engaging Community Advisory Boards (CABs) and planning regional townhalls.
- A. Ballesteros recommended engaging with CABs that do not engage in the RWP. C. Barrit noted potential to reach out to Federally Qualified Health Centers who are receiving HIV prevention funding for the first time. She noted the potential to connect to other CABs through collaboration efforts with other County Commissions.
- C. Barrit reminded the group of the goal behind engaging with CABs to identify how to create a status neutral system – how does an individual travel through their system and access care and resources regardless of their HIV status.
- A. Ballesteros noted it may be beneficial to include information on newly infected on where they were in the healthcare system when first learning of their positive status to identify potential gaps in the system, engagement in the system and general HIV-related knowledge.
- F. Gonzalez agreed with the suggestion noting the lack of knowledge on HIV in the community. He also expressed concern in hearing of an individual engaging in risky behaviors and not taking preventative medication because if they do become positive, they will need to take medication.
- A. Ballesteros also expressed shock and noted the shift in thinking around HIV among younger populations.
- Dr. Mills noted a similar situation he had with a PhD student who also indicated no desire to use PrEP noting if they become positive, they will need to take medication anyway quoting “why would I take a pill everyday to keep me from taking a pill every day?”
- Dr. Spencer noted the need to change messaging around PrEP. A. Ballesteros commented that he checked PrEP brochures and noted it does not include information on the advantages of taking PrEP and not becoming positive. A. Ballesteros indicated that many providers do not deliver U=U messages to their clients.
- Dr. Spencer added that more provider education is needed noting that some of her new patients were in regular care with their providers when diagnosed and the only reason they were tested was because DHS now has a tickler for an HIV test. F. Gonzalez noted the need to increase testing among heterosexual individuals noting it is standard for gay individuals to be test.

- Dr. King noted there are challenges in covering everything in one patient visit especially if a patient comes in with a specific need for instance high blood pressure. He noted most providers are focused on primary care and few have a vested interest in HIV care/prevention. He suggested providing a premium for an HIV test.
- F. Gonzalez also suggesting placing HIV-related posters/materials in medical offices to help encourage patients to discuss HIV with their providers.
- It was noted that the next funding cycle will begin in 2025 and not 2024 as previously thought. The community engagement timeline will be adjusted to the new timeline and will be proposed at the next PP&A Committee meeting.
- In preparation for the PSRA process, Dr. Green suggested reviewing data in cluster of services and dividing into smaller pieces to allow for a deeper review and understanding and voting on priority before moving onto the next cluster of data. A. Ballesteros recommended the PP&A Committee begin to look at data in August/September of this year.
- F. Gonzalez recommended simplifying the data as much as possible and creating data sheets/infographics to help make the information easier to review and understand.

VI. NEXT STEPS

14. Task/Assignments Recap

a. C. Barrit noted revising the timeline and approaches for stakeholder engagement

b. Allow time for continued discussion of the second unmet needs presentation

15. Agenda Development for the Next Meeting

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

VII. ANNOUNCEMENTS

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

D. Murray announce the City of West Hollywood would be highlighting their "Yes Means Yes" campaign in April for Sexual Assault Awareness month on April 28th from 6:00-8:00pm. The City will be handing out test strips to test drinks for drugs around the Rainbow District and the Sunset Strip. He also announced the City of West Hollywood opted into the Janssen opioid settlement money and will be receiving 0.001% for 18 years. The City will be using the settlement money to purchase Narcan for the community and service providers located within the City.

VIII. ADJOURNMENT

17. Adjournment for the Meeting of April 18, 2023.

The meeting was adjourned by K. Donnelly at 3:10pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES MAY 16, 2023

COMMITTEE MEMBERS 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
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	EA
Joseph Green	EA	Derek Murray	EA
Michael Green, PhD, MHSA	A	Jesus "Chuy" Orozco	P*
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
Reverend Redeem Robinson	A	Jonathan Weedman	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Jose Rangel-Garibay, Lizette Martinez			
DHSP STAFF			
Victor Scott, Pamela Ogata			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
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*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 1:15pm.

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): K. Donnelly, F. Gonzalez, K. Halfman, Dr. King, M. Martinez, Dr. Spencer, J. Orozco (just cause)

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 Committee members invoked attendance under AB 2449; no vote held.)**

4. **Approval of Agenda**
   MOTION #2: Approve the Agenda Order **(✓Quorum was not reached; no vote held.)**

5. **Approval of Meeting Minutes**
   MOTION #3: Approval of Meeting Minutes **(✓Quorum was not reached; no vote held.)**

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.**

   F. Gonzalez recommended exploring ways to allocate increased funding to SPA 6 to help facilitate increased HIV testing to the June PP&A Committee meeting agenda.

IV. REPORTS

8. **Execute Director/Staff Report**
   - C. Barrit also reminded the Planning, Priorities, and Allocations (PP&A) Committee of the Mandatory and Supplemental Training series. She noted that the trainings are open to the public and encouraged committee members to share the registration links for the virtual sessions with any interested stakeholders. The training schedule is available on the Commission website under the "Events" tab. She reminded commissioners that HRSA requires annual training for commissioners and that this training series covers that requirement. For those not able to attend the live training session, they can access the training recordings on the Commission website and notify Commission staff that they viewed the training to receive credit for the mandatory trainings.
   - C. Barrit shared the Equity Lens for Decision Making handout with the Committee as a resource to help priority setting and resource allocation discussions ensure equity; see meeting packet for details.
   - C. Barrit provided an update to the committee's request for Los Angeles Housing Services Authority (LAHSA) data on PLWH who are homeless discussed during the April PP&A Committee meeting. She noted the report was requested to include information on PLWH

experiencing homelessness along with demographic data and service utilization. LAHSA has indicated the report will be ready on May 19th. The data will be reviewed during the June PP&A Committee meeting.

- Dr. King asked how data is presented – whether in terms of Health Districts or Service Planning Areas (SPAs). C. Barrit noted both methods are used and P. Ogata, DHSP staff, confirmed data is presented at both the Health District and SPA level as a way of understanding different geographic level data. She noted it has been challenging to cluster health district data in a way that is meaningful due to variability of size and proximity to adjacent districts as well as location of service providers.

9. Co-Chair Report

- K. Donnelly reminded the Committee of the January 2024 Medi-Cal expansion to individuals ages 26-49 regardless of immigration status and the need to begin planning on how that would impact RWP allocations.
- Dr. King asked which health care systems eligible individuals would be migrated to and K. Donnell noted any Medi-Cal delivery is through third party administrators. Dr. King noted that the transition would result in delays in care and asked approximately how many people would transition from RWP to Medi-Cal.
- A. Ballesteros recalled approximately 5,300 individuals would transition from RWP to Medi-Cal noting those whose income is above 138% of the federal poverty line would not be eligible.
- Dr. King asked how the COH can work to create a smooth transition so individuals can quickly find providers and ensure continuity of care. K. Donnelly suggested early enrollment beginning in Nov/Dec 2023 and recommend individuals select their provider in advance. Dr. Spencer commented that many LA County sites may already be preparing for the transition. Dr. King added that the transition would require a lot of hand holding/navigation assistance.
- M. Martinez asked if the Rapid Start program can be used as a model to assist with covering costs for individuals during the transition period to avoid gaps in care. He added that the existing cap of 45 days is too short and should be extended to at least 60 days. A. Ballesteros recommended following up with DHSP to see if funding would be allowed for a transitional visit and to cover costs associated with Medi-Cal enrollment (collection of paperwork, documentation of income, etc.). The Committee agreed with this potential strategy.
- A. Ballesteros recommended making a formal request to DHSP if there is a transitional billing code that can be used as people transition from RWP to Medi-Cal to cover expenses incurred during an individual's transition period using the Rapid Start program as a model for implementation but with an extended the time frame of at least 120 days. Additionally, if this transition coverage is feasible, DHSP should provide an estimated allocation amount for all eligible individuals.

Dr. King provided an update on the Prevention Planning Workgroup's (PPW) work around status neutral.

- Dr. King noted a full report would be provided to PP&A in June. PPW co-chairs Dr. King, M. Martinez, and G. Wilson met to discuss final edits to recommendations on status

neutral which will be presented to the full workgroup at their next meeting on May 24th for final review and approval.

- Dr. King commented that the workgroup expressed concern on developing recommendations on status neutral that include prevention interventions and strategies without specific funding allocated towards prevention services.
- M. Martinez added that it is unclear how much input and guidance towards the priority setting and resource allocation process the PP&A Committee has noting that prevention funding flows into various departments and programs within the County, not just DHSP. Dr. King added that the workgroup will also review prevention standards.
- Dr. King asked if funding is available for HIV/STI testing in specific geographic areas. P. Ogata confirmed targeting specific geographic areas is part of the current DHSP planning process for services. She added that it is always important to continue to develop prevention strategies that help address the needs of vulnerable populations and that prevention standards should be reviewed and updated with status neutral methodologies in mind. She noted DHSP can also do an addendum to the Comprehensive HIV Prevention plan to include the updated prevention standards to serve as part of the service roadmap and potential to leverage partnerships with other County programs that receive prevention funding such as SAPC.
- M. Martinez commented it is critical to know if DHSP is open to a priority setting and resource allocation (PSRA) process for prevention that parallels the current PSRA process focused on care. He noted receptivity will help dictate what strategies can be recommended.
- A. Ballesteros commented the COH is more than just a RWP Planning Council and that the COH has the authority to make recommendations to the Board of Supervisors that ensure HIV/STI prevention strategies are infused in various County programs and not just DHSP. He gave an example of mandating HIV/STI screening in substance use disorder treatment facilities and the Department of Mental Health screening for PrEP noting collaborative/ integrated efforts are what is needed to end the HIV epidemic.
- Dr. King commented adding bloodwork for HIV and Hepatitis C testing be integrated into mandated medical assessments in substance use disorder treatment centers. M. Martinez recommended looking into what County contracted agencies have HIV/STI screening/testing requirements and, if so, are they adequate.
- Dr. Spencer commented that DHS has HIV screening as a reminder in their electronic health system but noted it is not mandatory and less likely to be enforced.
- A. Ballesteros noted that the large systems are they key to identifying HIV+ individuals and identifying those who are at high risk and prescribing PrEP due to the large volume of people within each system. He recommended meeting with LA Care and HealthNet to discuss what is being done and potential recommendations.

10. DHSP Report

a. Ryan White Program Fiscal Year 2022 Expenditures

- DHSP staff, Victor Scott, provided a review of the Ryan White Program 2022 Program Year Expenditures. DHSP is still processing invoices and is expected to close out the fiscal year by the end of June. See meeting packet for expenditure table.
- Part A award and FY 2021 carry over funds are anticipated to be fully expended and there will be approximately $1.3 million of Minority AIDS Incentive (MAI) funds that will be carried over to the next fiscal year in addition to the FY 2023 award amount.
- Dr. King asked if MAI funds be used for targeted interventions for priority populations. DHSP staff confirmed it was possible, but it would depend how quickly money would be released through an RFP process. They also reminded the Committee that interventions must align with Part A service categories.
- Dr. Spencer asked if the carry over funds could be diverted to a third-party administrator (such as Heluna Health, as done previously) for a short-term intervention to bypass the length County contracting process and expedite funding needed services.
- M. Martinez asked if standards are required or if there was flexibility in the standards to allow for more innovation, like Ending the HIV Epidemic (EHE) funds. V. Scott noted EHE does allow for more innovation but still has perimeters that it must follow. P. Ogata also noted standards are helpful for developing RFPs.
- P. Ogata asked the group if they had any potential short-term projects in mind. M. Martinez recommended navigation support for cisgender women in targeted geographic areas. Other recommendations included retention in care programs, rapid start programs and Doxy-PEP programs.
- Transportation support was also recommended as a potential short-term intervention. A. Ballesteros recommended creating a transportation hub to coordinate transportation to medical visits for clients alleviating the burden on both clients and providers. C. Orozco noted that HOPWA utilized a similar central transportation hub model with APLA that was successful.

b. Approve Revised Fiscal Year 2023 Service Category Recommendations MOTION #4 - Item moved to June meeting due to lack of quorum.

V. DISCUSSION

11. DHSP Unmet Needs Report II – Out of Care

- K. Donnelly opened the discussion will a brief recap of the Unmet Needs report; see meeting packet for details.
- A. Ballesteros commented that unmet needs are calculated annually yet there is no mention of what strategies are being done to address these unmet needs. He is unsure if the community understands why unmet needs are measured and that the COH recommendations and DHSP led services, such as retention and reengagement, are developed to address the unmet needs.
- F. Gonzalez agreed it is unclear what is being done and how progress is measured.

- Dr. King asked how much the Data to Care and Linkage to Care programs cost. P. Ogata shared that one program that focuses on reengagement in care costs approximately $900,000 annually and serves roughly 120 of the hardest to reach clients.
- P. Ogata noted that EHE funding will be used for street medicine providers to provide care on the street.
- P. Ogata reminded the Committee that Wendy Garland, DHSP staff, and her team are analyzing data to identify the predictors of unmet need and will share results once available that will contribute to future priority ranking and resource allocation discussions.
- A. Ballesteros noted that PP&A can make the recommendation to allocate a large portion of funding to linkage and reengagement programs if determined to be critical to ending the HIV epidemic. He noted that anticipated savings due of Medi-Cal expansion would allow for a large investment into case finding programs.
- A suggestion was made to take the idea to the EHE Steering Committee. K. Donnelly noted that he would like the COH to partner with EHE strategies but noted funding is much smaller at approximately $7 million. V. Scott commented that EHE funds end in 2025 and is unsure if funding will continue beyond 2025.
- C. Barrit requested a detailed report from DHSP on EHE funding and programs with a formal presentation to PP&A. This would allow the Committee a full understanding of all DHSP programs/services and funding being use toward HIV. This would give the Committee a complete picture from a status neutral perspective and aid in determining priorities and allocations as well as opportunities for innovation. She noted that some members of the COH are unaware of the much of the progress that is being made via EHE efforts.
- M. Martinez added that it would be helpful to have an EHE member in each COH Committee as a shared learning opportunity to give perspective and help inform decisions.

12. Review Revised Stakeholder Engagement Implementation Timeline & Development of CAB Questionnaire

- Review of the revised stakeholder engagement implementation timeline and development of CAB questionnaire was pushed back to the June PP&A Committee meeting due to time constraints.

VI. NEXT STEPS

13. Task/Assignments Recap

a. Prevention Planning Workgroup Status Neutral Recommendations
b. Review revised stakeholder engagement implementation timeline and begin developing CAB questionnaire.
c. Recap of reallocations proposed by DHSP

14. Agenda Development for the Next Meeting

a. Review LAHSA report
b. Recap of the third installment of the unmet needs report
c. Questions to DHSP regarding Medi-Cal Expansion and FY 2022 Carry Over Allocation

Exploring ways to allocate increased funding to SPA 6 to help facilitate increased HIV testing

VII. ANNOUNCEMENTS

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

C. Orozco called attention to a Los Angeles Times news article (found here) where a recent study found that many LA County homeless service workers cannot afford housing themselves due to low wages which often results in high staff turnover.

VIII. ADJOURNMENT

16. Adjournment for the Meeting of April 18, 2023.

The meeting was adjourned by K. Donnelly at 3:03pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
June 20, 2023

COMMITTEE MEMBERS 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	EA
Al Ballesteros, MBA, Co-Chair	A	Miguel Martinez, MPH, MSW	EA
Felipe Gonzalez	P	Anthony M. Mills, MD	P
Joseph Green	A	Derek Murray	P
Michael Green, PhD, MHSA	A	Jesus "Chuy" Orozco	EA
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
Reverend Redeem Robinson	A	Jonathan Weedman	EA
COMMISSION STAFF AND CONSULTANTS			
Dawn McClendon, Lizette Martinez			
DHSP STAFF			
Victor Scott, Wendy Garland, Pamela Ogata			

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

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

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.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly led introductions, conducted roll call vote, and requested that Committee members state conflicts of interest.

ROLL CALL (PRESENT): K. Donnelly, F. Gonzalez, K. Halfman, Dr. Mills, Dr. Spencer,

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 Committee members invoked attendance under AB 2449; no vote held.)**

4. **Approval of Agenda**
   MOTION #2: Approve the Agenda Order **(✓Quorum was not reached; no vote held.)**

5. **Approval of Meeting Minutes**
   MOTION #3: Approval of Meeting Minutes **(✓Quorum was not reached; no vote held.)**

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**
   a. **LAHSA Report Update**
      - Lizette Martinez, Commission staff, provided an update to the Los Angeles Housing Services Authority (LAHSA) report that was requested during the April PP&A Committee meeting. She noted the report was still pending as LAHSA staff had high priority requests to fulfill and have now resumed pulling the committees data request. Staff will share the report with committee members as soon as it is available.

   b. **CDC/HRSA Feedback on Integrated Plan**
      - L. Martinez shared the CDC/HRSA Integrated Plan feedback highlighting key areas for improvement, data sharing and community/consumer engagement, noted in the report. See packet for details.

   c. **Anti-LGBTQ+ Legislation Impact Report**
      - L. Martinez called attention to the Human Rights Campaign's Anti-LGBTQ+ Legislation Impact Report highlighting current anti-LGBTQ+ legislation throughout the United States. See meeting packet for details.

9. **Co-Chair Report**
   a. **May 24th Prevention Planning Workgroup Meeting Recap**
      - L. Martinez reported that the Prevention Planning Workgroup (PPW) last met on May 24th

and continued their discussion around status neutral. The workgroup finalized a status neutral framework specific for LA County utilizing the existing CDC Status Neutral Framework and the Commission on HIV's HIV Care Continuum. The workgroup requested a follow up presentation from the Substance Use Prevention and Control (SAPC) division on Syringe Service Programs to help inform additional status neutral recommendations. The next PPW virtual meeting will be Wednesday, July 26th at 4:00pm – 5:30pm.

b. Bylaws Review Taskforce Updates

- K. Donnelly reported on the progress of the Bylaws Review Taskforce noting that the group was created because of the Health Resources & Services Administration (HRSA) audit in February 2023 where HRSA noted that the Commission should be reviewing their bylaws annually. He noted the last time the bylaws were reviewed was in 2013.
- Alasdair Burton, Bylaws Review Taskforce co-chair, provided a brief recap of the first two meetings noting discussions focusing on streamlining inefficiencies, addressing stipends and number of meetings. He noted the taskforce would seek additional input from all committees and caucus prior to approving changes.
- All Bylaws Review Taskforce meetings are open to the public and all commissioners are encouraged to attend to provide input. The next Bylaws Review Taskforce has not yet been scheduled but will occur sometime in July.

c. Memo to DHSP Regarding Medi-Cal Expansion Strategies

- K. Donnelly provided a brief recap of the Medi-Cal expansion strategies that were discussed during the May PP&A Committee meeting highlighted in the memo to DHSP. See May PP&A meeting minutes for more details. The memo is currently under final review and will be sent to DHSP.

10. DHSP Report

a. Review Revised Fiscal Year 2023 Service Category Allocations Fiscal and Programmatic Updates

- Victor Scott, DHSP staff, provided a brief recap of the Revised Fiscal Year 2023 Service Category Allocations that were approved at the June COH meeting. He noted changes to several service categories including Early Intervention Services, Outpatient and Ambulatory Services, Medical Case Management (also known as Medical Care Coordination), Housing Services and Emergency Financial Assistance to name a few. The total reallocation was less than 10% of the total award. See meeting packet for details of reallocation categories and total amounts.
- Dr. Mills requested a spreadsheet of allocation trends over the last 10 years to see changes in allocations and priorities over time.
- Wendy Garland, DHSP staff, requested feedback from the PP&A Committee regarding upcoming Ryan White Program (RWP) Utilization Report presentation format. Rather than providing one lengthy report on RWP Utilization Data, DHSP would like to present the data

into a series of smaller presentations grouped by similar service categories to allow for a more in-depth review to identify potential gaps or disparities.

- The committee agreed to the proposed format. Dr. Mills commented that larger presentations are often hard to follow, and Felipe Gonzalez noted that the use of infographics is helpful. Dr. Spencer commented that the presentations will help the committee and COH help focus meetings on discussing what strategies to implement based on the data.
- W. Garland noted that DHSP is working to provide regular utilization report data in conjunction with expenditure reports. DHSP will provide utilization data with an expenditure report next month.
- F. Gonzalez asked if the report would show a correlation of services and money spent. W. Garland commented that the utilization data provides an estimate of units per client noting that the focus is on how many people are being served (by service category).

V. DISCUSSION

11. DHSP Unmet Needs Report III – In Care, Not Virally Suppressed

- K. Donnelly opened the discussion will a brief recap of the Unmet Needs report; see meeting packet for details.
- W. Garland reminded the committee that, unlike other Unmet Needs data where RWP clients had better outcomes, outcomes for people in care but not virally suppressed were similar for both RWP clients and Los Angeles County (system of care/non-RWP) clients. She asked the group think about what factors contribute to viral suppression such as age, demographics, etc.
- F. Gonzalez recalled a comment that was made during the COH meeting that it may be challenging for long-term survivors to achieve viral suppression due to resistant HIV strains.
- Dr. Mills commented that medication adherence is crucial but other social or behavioral health factors, such as homelessness, may prohibit people from taking medications that lead to a lack of viral suppression for those who are in care but not virally suppressed. Dr. Spencer agreed noting a safety net is needed that addresses the social determinants of health.
- W. Garland asked if people who are in care but not virally suppressed good candidates for Long-Acting Injectable (LAI) therapies. Dr. Spencer stated that some may be, but the current recommendation is not to use LAIs if experiencing issues with virological suppression.
- A recommendation was made to provide monthly home-delivery of medications to avoid gaps in medication adherence due to delays in filling prescriptions. It was noted this may not work for people who are experiencing homelessness.
- F. Gonzalez asked if contingency management/use of incentives has been successful in boosting medication adherence. Dr. Spencer indicated use of incentives appears to be successful in a current study she is involved but has been proven successful in other studies. She commented it has been successful in certain populations (e.g., low-income populations) but not others and cautioned that it is not a one size fits all approach. She also noted that this approach is not sustainable.
- W. Garland shared additional strategies that were mentioned at the COH meeting including:

increasing health literacy interventions, use of incentives, improving mental health services, improvements at the site level on how strategies are implemented, support for providers and peer support.

- W. Garland noted that viral suppression is not as low for MCC clients vs. RWP clients but attributes this to MCC clients having more complex cases. She highlighted a UCLA study that showed increased viral suppression over the course of three years in clients that had cooccurring conditions such as mental health and unstable housing noting it takes these clients much longer to achieve viral suppression.
- Dr. Spencer also noted that not all MCC teams are created equal, and some may need more training than others. Dr. Mills added that it is very difficult to maintain MCC teams noting that staff turnover is high.
- Derrick Murray commented that the street medicine approach may be helpful in increasing viral suppression. He noted successful street medicine strategies for injectable PrEP for unsheltered populations.
- W. Garland commented that there has been a lot of innovation around Ending the HIV Epidemic (EHE) funding but there needs to be great flexibility in funding and innovation in RWP Part A that are responsive to the current needs of HIV+ individuals.

12. Explore Opportunities to Increase HIV/STI Screening in SPA 6

- K. Donnelly opened the discussion by reminding the committee that Commissioner F. Gonzalez requested that the group look at opportunities to increase HIV and STI testing in SPA 6.
- Dr. Spencer noted that DHS has doubled their testing in SPA 6 over the last three months by adding a reminder notice for providers during client appointments. She stated this shows that increased testing does work when a primary care provider is given a reminder but noted there may be challenges with linking positive individuals to care if they do not provide HIV care.
- F. Gonzalez stated his goal is to ensure agencies have funding to provide tests and remove any administrative barriers that may impact testing such as responding to RFPs. He noted the importance of ensuring continued funding for screening.
- K. Donnelly commented that there needs to be an expansion of prevention strategies in SPA 6 and that screening can be used as a prevention tool. Dr. Spencer added that it is part of the status neutral approach for all testing programs (HIV, STIs, etc.). K. Donnelly asked how to ensure that those conversations are happening.
- Dr. Spencer stated it is hard at the provider level, particularly at the primary care provider level, to get providers to understand that a test is just a first step and there needs to be continued discussions around PrEP. She noted providers only have 15 minutes for a visit and it is not enough time to cover everything or build rapport to establish comfort with patients. She noted the need for wraparound services to assist providers and the use of navigators in helping to have discussions around PrEP. Dr. Spencer added that this is service must be secured through grant funding and it takes a lot of time to apply for grants taking away time for patient care. She added that case management is not currently reimbursable through Medi-Cal.
- F. Gonzalez recommended multi-year grants with longer terms or extension of grants. W.

Garland noted that these suggestions may be beyond DHSP scope and fall under general LA County contract terms and procedures.

- Dr. Spencer recommended outsourcing contracts to a third-party administrator to bypass strict County contract terms. V. Scott noted potential limitations with this approach citing time limits for funds to support 3rd party administrators and funding that is influenced at the federal level, particularly one-time grant funds.
- Dr. Spencer commented that there is an opportunity and need to engage the community within SPA 6 that is culturally sensitive to help increate efforts. She noted a lot of medical mistrust throughout the community. Dr. Mills added that many people also go outside of the community to get case because they believe they will receive better care in a different area.
- Dr. Mills commented that it is challenging to create a safe space for all target demographics. He noted SoCal Club was created as a safe space for Black/Latinx MSM but opens its doors to the community a couple of days a month which weakens the trust that the agency worked hard to build with the target demographic. Scheduling blocks for different populations and non-traditional hours were recommended. Dr. Mills noted these methods have been used in the past but are expensive and again require additional grant funding.
- Dr. Spencer noted there is a need to think of different ways to fund services with Medi-Cal expansion on the horizon. She noted limitations with HRSA funding and the need to think outside of the box to accomplish goals.
- Dr. Mills commented that there are current efforts with leadership from several agencies that are working with the Department of Public Health leadership to identify additional funding for STI testing and treatment services.
- Dawn McClendon, Commission staff, noted ongoing efforts to advocate for additional STI funding with the Board of Supervisors and their health deputies. Meetings are currently being scheduled with health deputies. D. Murray asked to be invited to the District 3 meeting and Dr. Spencer asked to be invited to the District 2 meeting.
- K. Donnelly called attention to Assembly Bill 1645 that provides funding for STI testing. Katja Nelson added that the bill provides for cost sharing for STIs and PrEP. K. Donnelly commented that the bill is currently in the Senate and that the governor has indicated he will sign if passed.

13. Review Revised Stakeholder Engagement Implementation Timeline & Development of CAB Questionnaire

- K. Donnelly began the discussion by reviewing the proposed stakeholder engagement implementation timeline noting the plan extends into June 2024; see meeting packet for details.
- K. Donnelly asked the group if they were aware of any agencies/organizations that had a client advisory board, to identify potential engagement opportunities. Organizations included Federally Qualified Health Centers (FQHCs), AIDS Serving Organizations (ASOs), research universities, RWP Part C and Part D recipients, etc. He clarified that the proposed questions will be geared towards both stakeholders and clients.
- K. Donnelly recommended developing questions that fill in data gaps. F. Gonzalez recommended ensuring confidentiality to encourage clients to answer accurate/honest responses. He

encouraged the use of anonymous drop boxes in lieu of submitting paperwork to the front office. Dr. Spencer noted that providers need to allow space for criticism and feedback to work toward improvements and recommended the use of QR codes to address anonymity.

- Dr. Mills noted the two questions that his agency regularly asks clients are "How can we help you engage in healthcare?" and "What do you need?"
- Additional recommendations included use of peer-to-peer surveys were to encourage honest responses, inclusion of questions regarding supportive services and other needs, utilizing peer support groups to elicit feedback, encouraging CAB members to include clients that are less likely to be involved (to ensure diversity of responses) and the use of incentives.
- Questions will be developed for the next meeting for review and discussion

VI. NEXT STEPS

14. Task/Assignments Recap

a. Development of discussion prompts for CAB engagement sessions
b. Review FY 32 RWP Expenditures

15. Agenda Development for the Next Meeting

a. Recap of first session of RWP Utilization Report: MCC and AOM
b. Review CAB questionnaire/discussion prompts
c. LAHSA Report Review

VII. ANNOUNCEMENTS

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

K. Donnelly announced that the Aging Caucus will host an event in celebration of HIV/AIDS and Aging Awareness Day on September 22 focusing on Sexual Health for Older Adults.

VIII. ADJOURNMENT

17. Adjournment for the Meeting of June 20, 2023.

The meeting was adjourned by K. Donnelly at 2:55pm.

RYAN WHITE PART A SUBRECIPIENT SITE VISIT LOS ANGELES EMA

FEBRUARY 14-17, 2023

PLANNING COUNCIL

Summary of Planning Council/Body (Part A only): Los Angeles EMA established the Los Angeles (LA) Commission on HIV, a community planning body responsible for assessing the needs of people with HIV, establishing service priorities, and allocating grant funds. The commission is comprised of 37 representatives, including seven unaffiliated client representatives. The commission has formal bylaws, policies/procedures, and several standing committees: Executive, Operations, Standards and Best Practices, Planning, Priorities, and Allocation and Public Policy.

The LA commission also has various caucuses: Consumer Caucus, Black/African American Caucus, Women's Caucus, Transgender Caucus, and Aging Caucus. Los Angeles County has a designated LA Commission on HIV website www.hiv.lacounty.org. It is comprehensive and contains information on membership recruitment, bylaws, assessment of the administrative mechanism, service standards, committees/caucuses, grievance procedures, and membership application.

The commission strongly emphasizes member recruitment/retention, as evidenced by meeting minutes and focused membership drive activities. The commission also has a member reimbursement policy and a mentoring program to help acclimate new members and ensure their attendance/participation. The commission's Executive Committee's interaction with HRSAHAB's site visit team was substantive and enthusiastic. The commissioners were engaged, candid, and well-versed on the issues of requirements, operations, HIV service needs, available resources, and their unique challenges. Executive Committee members demonstrated a strong sense of commitment and dedication to the needs of people with HIV in the Los Angeles EMA area.

At the request of the LA Commission on HIV Consumer Caucus, the HRSA HAB's site visit team hosted a listen-only session on February 16, 2023. The session summary is uploaded as a separate document for the Project Officer's review. Summary of Persons with Lived Experience/Community Meeting: The people with lived HIV experiences panel consisted of six participants who self-identified their gender and race: one woman, five men, one Hispanic/Latinx, one African American and four White. Five participants were between 51 to 65 years. One participant reported being between 20-65 years. The number of years receiving HIV care ranged from 6 to 21 years. Participants reported receiving medical care, oral health, mental health, housing, emergency financial assistance, food, and medication assistance. All participants stated the providers generally well protected their confidentiality/privacy.

Most clients reported being aware of the formal grievance process at their agencies. Identified as most important services were medical, oral health, housing, and food. Identified concerns and unmet needs included dealing with non-HIV medical issues, such as diabetes, hypertension, and cancer. Homelessness, lack of housing options, and stigma were identified as significant barriers that impact clients' ability and willingness to access/remain in HIV care and support services. These barriers ultimately lead to poor viral suppression, negative overall health, and negative quality of life outcomes. Additional reported challenges included: health disparities in communities of color, mental health, financial assistance, better case management, status neutral housing, and the need to streamline the

system. Overall, participants were satisfied with the medical care and support services. They gave a rating of 7.9 out of 10 for the overall quality of RWHAP Part A services in the LA EMA service area. In addition, some participants expressed gratitude and appreciation for the services they received. The site visit team participated in a listen-only session at the request of the LA Commission on HIV Consumer Caucus. The summary of this session is captured in Appendix A at the end of this report. III. Finding Categories for Review: The information below provides guidance on the meaning of each option. applicable = this section is not part of the site visit and therefore not reviewed.

Finding identified = The recipient does not currently comply with a legislative requirement and/or programmatic expectation of the Ryan White HIV/AIDS Program (RWHAP). All identified findings must be addressed via a corrective action plan (CAP).

• Improvement Options: (optional) Any area of the program that complies with legislative and programmatic requirements of the program at a satisfactory level but was identified to have the capacity to improve.

• Program Strengths (optional): Any area of the program that complies with legislative and programmatic requirements of the program beyond a satisfactory level.

A. Administration: Finding(s) identified.

1. Findings and Recommendations Governance and Constituent Involvement:

Finding(s) identified Finding 1: Legislative Description: Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement. (L) Finding Description: Lack of compliance with the requirement to ensure separation of Planning Council and recipient roles. The Director of DHSP, who also functions as a CEO designee for the jurisdiction, is a voting member of the LA Commission on HIV and a voting member of the Executive Committee. Citation: Section 2602 (7)(a) of the PHS Act

Recommendation: The recipient must ensure separation of Planning Council and recipient roles to avoid any actual and/or perceived conflict of interest. Per Section 2602 (7)(a) of the PHS Act, a separation of Planning Body and the recipient is necessary to avoid a conflict of interest. A recipient's representative, whose positions are funded by RWHAP funds, provides in-kind services, or has significant involvement in the HIV award, shall not occupy a seat on the Planning Council, nor have a vote in the deliberation of the Planning Council. For additional guidance, the recipient should review HRSA's Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectation Letter which clarifies HRSA expectation on the required community input process for RWHAP Part A awards, specific to the separation of Planning Council and recipient roles.

Finding 2: Legislative Description: Lack of compliance with the requirement for Planning Council membership to comply with representation and reflectiveness. (L) Finding Description: Los Angeles (LA) Commission on HIV currently has three vacancies for the following legislatively mandated categories: a) RWHAP Part C Provider, b) Hospital Planning Agency or Health Care Planning Agency, and c) Representatives of Individuals who Formerly were Incarcerated. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: LA Commission on HIV must ensure that its operations committee prioritizes and expedites its efforts to recruit, review, and nominate qualified candidates for the currently vacant

legislatively mandated categories for subsequent submission for Chief Elected Official (CEO)'s review and appointment. The CEO should prioritize their review, consideration, and timely appointment of commissioners to ensure smooth and uninterrupted operations of the HIV Planning Council.

Finding 3: Legislative Description: Lack of compliance with the requirement for Planning Council membership to comply with representation and reflectiveness. (L) Finding Description: LA Commission on HIV currently has 37 CEO-appointed members, including seven unaffiliated client representatives. This represents 19 percent, which is below the 33 percent unaligned client representation requirement for planning bodies, as stated in Section 2602(b)(5)(C) of the PHS Act. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: The LA Commission on HIV, through its Operations Committee, should review, revise, prioritize, and expedite its efforts to recruit and nominate unaffiliated clients for subsequent submission for CEO review and appointment to ensure consistent compliance with the unaligned client participation requirement. To that effect:

1. Operations Committee should proactively and consistently solicit input and assistance from the established Commission on HIV Caucuses, specifically, its Consumer Caucus, Black/African American Caucus, Transgender Caucus, Women's Caucus and Aging Caucus. This will allow the Planning Council to increase the pool of potential eligible/qualified applicants from diverse backgrounds to improve overall representation and reflectiveness of the Commission.

2. Recipient and the Planning Council should engage its provider network in a deeper, more proactive, and consistent recruitment effort that may include a) conducting designated trainings for providers on the importance of recruitment, b) having hard-copy membership applications (in English and Spanish) available at funded agencies, c) conducting Planning Council recruitment "Meet and Greet" events at providers' agency support groups and other client meeting, etc.

3. Establish a "Bring a Friend" Day, when unaffiliated commissioners can bring their friends to PC meetings to get a better understanding of the PC and be able to apply for membership on the spot, if interested.

4. Establish a Commission on HIV Community Recruitment Annual Schedule that will ensure the Commission on HIV's prominent presence and participation in the most important community events, such as during Pride Events, World AIDS Day Events, (December), National HIV Black Awareness Events, (February), National Latino HIV Awareness Events (October), National Women's Awareness Events, (March), etc.

Finding 4: Legislative Description: Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement. (L) Finding Description: Currently, there is one commissioner listed on the membership roster, (Mr. Stalter), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner is a co-chair of the Standards and Best Practices Committee and a member of the Executive Committee. There is another commissioner listed on the membership roster, (Mr. Moreno), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner represents the legislatively

mandated category of Health Care Providers and is a member of the Operations Committees. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: Steps recommended for compliance:

1. Recipient and the commission should review and consistently follow the nominating process outlined in the currently approved LA Commission on HIV Bylaws in Article 4: Nomination Process, p. 9, and LA Commission on HIV Policy and Procedure #09.4205, Commission Membership Evaluation and Nominations Process (approved in May 2018).

2. Recipient and the commission support staff should review HRSA's Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectation Letter, which provides clarification on HRSA's expectation on the required community input process for RWHAP Part A awards, specific to PC term limits and membership rotation.

3. The commissioner nomination and re-appointment process should begin early to allow the CEO ample time to review, consider and make approval decisions on member applications.

4. The CEO should prioritize its review, consideration, and reappointment of commissioners whose term is expiring to avoid prolonged vacancies and to ensure smooth and uninterrupted operations of the commission.

Finding 5: Legislative Description: Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement. (L) Finding Description: Lack of compliance with the conflict-of-interest requirement for PC members. The LA Commission on HIV currently has 37 duly appointed PC members. There is no documentation of current, completed, and signed Conflict of Interest (COI) declaration for any of the appointed commissioners. Most of the COI declarations are outdated, going back to 2018 and 2019. The most recent COI declaration is dated June 2021. In addition, several commissioners who are affiliated with currently funded providers declared "No Conflict" on their COI declarations. Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded, most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity.

Recommended steps of action:

1. LA Commission on HIV support staff members must ensure that all commissioners have a current, completed, and signed COI declaration.

2. LA Commission on HIV support staff members should review the Conflict-of Interest requirements for Planning Councils, as outlined in the RWHAP Part A Manual, Section X, Chapter 8, pp. 143-152.

3. LA Commission of HIV support staff should review the Los Angeles County Conflict of Interest Policy #12.0001, approved in June 2008, specifically item 2 under the Procedures section on p. 4.

4. LA Commission of HIV support staff should conduct a COI refresher training for all commissioners to ensure uniform understanding with participation documentation on file.

5. The recipient and PC support staff members must maintain up-to-date documentation of all members' terms, appointments, representation categories, and agency affiliations.

Los Angeles Commission on HIV Consumer Caucus Listen-Only Session Summary (Reference only; not reviewed)

At the request of the LA Commission on HIV Consumer Caucus, the HRSA HAB's site visit team hosted a listen-only session on February 2, 2023. Below, please see a summary of the feedback provided by the Consumer Caucus members.

1. Introductions and Rationale: • We asked for this meeting, as it is important for HRSA to hear us and move on this. We are looking for action. • We would like to find a way for our messages to get through. • We are most grateful for this meeting. • We are not focusing on the past; we want to fix the problems. • Consumer Caucus is focusing on social determinates of health. This is what we are talking about today.

2. Ryan White and EHE: • I would not mind being on the EHE Steering Committee, but I have to be paid. I sent in my resume and never heard from anyone. Not sure if they need us. • There is a need to merge Ryan White and EHE money. • We need to better coordinate Ryan White and EHE efforts. • We are not included in EHE activities, as if we do not exist. • I would like to participate in the EHE Steering Committee and will bring information back. • There is no prevention for positives anymore. EHE is a whole another world. How do you do status neutral?

3. Incentives and reimbursements for persons with lived experiences: • Reimbursement rates for consumer participation do not work, they are low. • $5 gift card is not enough for my expertise. • Consumers on the Commission need help. How many people got their master's degrees and PhDs based on our stories? • Employees at agencies are getting raises and we are stuck with incentives, yet we are the ones dealing with HIV.

4. LA EMA Site Visit Client Meeting (2/15/2023) follow-up: • I am surprised that there were so few clients at yesterday's client meeting. • I did not receive any emails about the client meeting. • I did not receive the link to the client meeting, as if they did not want us there.

5. LA Commission on HIV concerns : • There are deep issues on the commission. Big stuff needs to be addressed. • There is an anti-white thing going on in the Commission. • Last site visit consumers were unhappy, but the report stated otherwise. • If we do not show up to meetings, there will be no programs.

6. Service Delivery System concerns: • There is lack of staff to help with the paperwork. • Proof of HIV diagnosis and proof of income should be enough for eligibility. • Services should be local, there are no services where I am. • Agencies are not listening to consumers. There is desperation. • I was ignored by

a staff member who now is promoted to supervisor. • Even as a Co-Chair of the Commission, I cannot get through sometimes, I have to ask for assistance from someone else. • If someone like me cannot get through the system, there is no way others can do it. • People are not getting the services that they need. The system delivery is wrong. • We need help. • We have had these issues for a long time, we have to be people friendly.

7. Services for Immigrants: • System is not set up to help immigrants, especially black immigrants. If we do not help them, they will use their bodies to get what they need. • I tried to initiate conversations about immigrant crisis. It is sad. Yes, there is treatment, but that is it. • I have a good family support, but not everyone has the kind of support that I have.

8. Stigma • Why do buildings for HIV services have HIV listings on them? We have to eliminate stigma. People still are ignorant. I would like to see change.

9. Housing : • Housing is very important. I experienced homelessness, spent nights walking. I tried to get into some services just to have an opportunity. • People live on the streets, there are no services available for them. • I applied for housing and heard from them 3 months later.

10. Peer Technical Assistance (TA) : • I participated in the RW Conference and heard from a lot of good programs. • There has to be a way to identify programs that are working well and to share their processes. • My local agency has excellent results, (90% viral suppression). This should be replicated in other places.

11. Follow-up: • We want to hear from HRSA, to acknowledge our words. Please provide a statement of things we talked about to us. • It is important to get true, quality feedback. We have to have back-and-forth capabilities to help each other. • We ask HRSA to send us a summary of the meeting notes, it will be useful and helpful for our collective efforts. • What can we, as consumers, change to improve our services? Some guidance will be helpful. • What can consumers do regarding what HRSA wants us to focus on? Please send us some guidance. • How can we as consumers help you, HRSA, to work towards common goals? • Consider grassroot agencies, women owned agencies for grants.

12. Acknowledgement and thank you: • The Consumer Caucus members are interested to work with HRSA. • We are grateful to be here today and to have an opportunity to speak. • We would like to give you credit for being dedicated civil servants. • Thank you for taking the time to meet with us.

LOS ANGELES COUNTY
CORRECTIVE ACTION PLAN (CAP) FOR 2023 HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) SITE VISIT CONDUCTED ON FEB. 14-17, 2023 RWHAP PART A GRANT #H89HA00016 (Rev 7.14.23)

FINDING DESCRIPTION	PERSON(S) RESPONSIBLE	TARGET/DUE DATE	CORRECTIVE ACTION PLAN	PROGRESS TO DATE
#1: Lack of compliance with the requirement to ensure separation of Planning Council and recipient roles. The Director of DHSP, who also functions as a CEO designee for the jurisdiction, is a voting member of the LA Commission on HIV and a voting member of the Executive Committee. Citation: Section 2602 (7)(a) of the PHS Act	Commission on HIV (COH) staff, Commission on HIV Bylaws Review Task Force, Operations Committee, County Counsel	December 30, 2023	The Bylaws Review Taskforce (BRT) is working with COH staff and County Counsel to change the language in the bylaws to designate DHSP staff including the Director of DHSP as "non-voting representatives" rather than as "members". Guidance from County Counsel is an integral part of the process as the bylaws changes will trigger a corresponding ordinance change for the COH as well. Until the bylaws changes are approved, DHSP staff on the COH and committees will abstain from voting to separate roles between the grantee and PC to avoid any actual or perceived conflict of interest	Prior to the 2023 HRSA site visit, the Operations Committee has begun a review of the COH's bylaws and subsequently decided to form a taskforce to engage a broader group of Commissioners and stakeholders in the review process and facilitate a dedicated group and time for the sole purpose of updating the bylaws. The Bylaws Review Taskforce (BRT), formally convened for an initial meeting on April 10 to address findings from the HRSA site visit and other governance issues of importance to the COH. The COH is working with County Counsel in revising the PC bylaws and ordinance to address site visit findings. The BRT will continue to meet monthly and prioritize changing the section of the bylaws regarding DHSP membership on the COH.

#2: Los Angeles (LA) Commission on HIV currently has three vacancies for the following legislatively mandated categories: a) RWHAP Part C Provider, b) Hospital Planning Agency or Health Care Planning Agency, and c) Representatives of Individuals who Formerly were Incarcerated. Citation: Section 2602(b)(5)(C) of the PHS Act	Commission on HIV, Operations Committee, Commission on HIV staff	a) March 21, 2023 b) February 29, 2024 c) September 30, 2023	a) <u>Part C Representative:</u> At the time of the HRSA site visit, an application for the seat was being processed and was in the pipeline for the Board's approval. The Board approved Mr. Leon Maultsby's application to serve as the Part C representative on the COH on March 21, 2023. b) <u>Hospital Planning Agency or Healthcare Planning Agency:</u> Filling the hospital planning or healthcare planning agency has been a recuring challenge for the COH. COH staff will continue to reach out to LACare, Kaiser Permanente, Molina, Blue Shield, Anthem, and Hospital Association of Southern CA (HASC) to engage them in the work of the COH and fill this vacant seat.	a) <u>Part C Representative:</u> Seat was filled on March 21, 2023 b) <u>Hospital Planning Agency or Healthcare Planning Agency:</u> Recruitment efforts entail direct one-on-one outreach to HealthNet, Kaiser Permanente Southern CA, and LACare. The most recent outreach with Dr. Positron Kebebew, Regional Medical Director for HealthNet yielded a high level of interest, however, she regrettably declined, as advised by the Chief Medical Officer due to her expansive duties with HealthNet. Some consumers have also referred their HIV doctors from local health plans to staff for membership application support, however, none have submitted applications despite follow-up from staff. COH staff will continue to reach out LACare, Kaiser Permanente, Molina, Blue Shield, Anthem, and Hospital Association of Southern CA (HASC) to

			c) <u>Representatives of Individuals who Formerly were Incarcerated:</u> COH staff acknowledge the challenges with filling this seat (i.e., fear of disclosing status, life priorities, significant time commitment required for COH service). Outreach efforts with the Office of Diversion and Re-entry, and local agencies serving justice-involved individuals will continue until the seat is filled. Because of the exacerbated challenges faced by justice involved individuals in the re-entry process, COH staff will need to acclimate potential candidates to the work of the COH first and coach them through the application process. COH Operations Committee will fill this vacancy by the end of September 2023.	engage them in the work of the COH and solicit membership applications. c) <u>Representatives of Individuals who Formerly were Incarcerated</u>: COH staff has reached out to the Los Angeles County Office of Diversion and Re-entry (ODR) for recruitment opportunities. Additionally, COH staff continue to work with PC members who work with justice-involved individuals for recruitment opportunities and referrals. ODR provided referrals to the Los Angeles Centers for Alcohol and Drug Abuse (LACADA) for possible candidates. COH staff have subsequently made several attempts to connect with LACADA staff and is awaiting a response. A Commissioner also promoted membership applications at Healing Village and Resource Fair for formerly incarcerated on June 24, 2023. Additionally, staff will attend upcoming LA Re-entry

				Regional Partnerships to promote the COH and solicit membership applications. A membership application for a representative of formerly incarcerated individuals from the Center for Health Justice was received on July 12, 2023.
#3: LA Commission on HIV currently has 37 CEO-appointed members, including seven unaffiliated client representatives. This represents 19 percent, which is below the 33 percent unaligned client representation requirement for planning bodies, as stated in Section 2602(b)(5)(C) of the PHS Act. Citation: Section 2602(b)(5)(C) of the PHS Act	Commission on HIV Operations Committee, COH staff	January 31, 2024	The COH undertakes all the recommendations provided by HRSA noted in the site visit report for unaffiliated consumers (UCs) recruitment and will continue to work the caucuses to attract applications from UCs. Membership recruitments are scheduled for the following upcoming events/activities: • Taste of Soul (October 21, 2023) • Community listening sessions to be led by the Black Caucus (Sept-Dec 2023) • World AIDS Day community events • Planning, Priorities and Allocations Committee service	As of July 5, 2023, the COH has 40 members and 3 alternates. Among the 40 members, 10 are UCs (25%); among the alternates, 1 is a UC. As of July 6, 2023, there are five applicants who may potentially occupy a UC seat; staff are in the process of verifying their application information.

			needs townhalls (Jan-April 2024) • Local Community Advisory Board and Service Provider Network meetings • Women's Caucus Virtual Lunch and Learn educational events • Transgender Summit (Nov 2023) • HIV, Aging and Sexual Health educational event (Sept 2023) • Digital COH promotion toolkit on website • Ongoing social media promotion	
#4: Currently, there is one commissioner listed on the membership roster, (Mr. Stalter), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner is a co-chair of the Standards and Best Practices Committee and a member of the Executive Committee. There is another commissioner listed on	Commission on HIV Operations Committee, COH staff	December 30, 2023 and ongoing	During the site visit and in a follow-up email, staff explained to HRSA auditors that all members, once appointed, serve at the pleasure of the Los Angeles County Board of Supervisors (BOS) and provided the following excerpts from the ordinance and examples of BOS motions on approved membership renewal with waivers of term limits:	**Kevin Stalter Update:** At its meeting held Tuesday, March 7, 2023, on recommendation of the Commission on HIV, the Los Angeles County Board of Supervisors reappointed Mr. Stalter as a member of the Commission on HIV for an unexpired term of office expiring on July 11, 2023. His application is also included in the membership renewal slate which is set to appear before the full body for approval in

the membership roster, (Mr. Moreno), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner represents the legislatively mandated category of Health Care Providers and is a member of the Operations Committees. Citation: Section 2602(b)(5)(C) of the PHS Act			"All members and alternates shall serve at the pleasure of the Board of Supervisors. Any member whose employment, status or other factors no longer fulfill the requirements of the membership seat to which he/she was appointed shall be removed from the Commission as determined by the Board of Supervisors….No member may serve on the Commission for more than two (2) full consecutive terms, unless such limitation is waived by the Board of Supervisors." The BOS applies a general waiver of term limits in an effort to maintain all of its (400+) commissions' membership; without this waiver, all County commissions would find it incredibly difficult to maintain a reflective and representative membership, especially ours. This language is included in our County Ordinance as well as on the Board of Supervisors'	August which will thereafter move to the Board for approval. Seats are filled and active unless specifically vacated by the Board. **Carlos Moreno Update:** Mr. Moreno resigned from the COH on February 7, 2023.

			statement of proceedings when a member(s) is appointed. For corrective action and enhanced documentation for membership renewals, staff will include links to full BOS statement of proceedings to document waiver of term limits and place electronic copy in members' folders or in cohort renewal BOS approval folder. In addition, the COH Operations Committee will strengthen description of process in existing policies and procedures for seat changes/membership management; include approval process from Operations and Executive. Seat changes do not require BOS approval.	
5: Lack of compliance with the conflict-of-interest (COI) requirement for PC members. The LA Commission on HIV currently has 37 duly appointed PC members. There is no	Commission staff	a) Completed b) December 30, 2023	a) On March 23, 2023, the COH developed a separate Ryan White Program Part A-specific COI form to be filled out and signed by each	Ryan White Program Part A-specific COI forms have been collected from existing members; new members will complete Ryan White Program Part A-specific COI form during

documentation of current, completed, and signed Conflict of Interest (COI) declaration for any of the appointed commissioners. Most of the COI declarations are outdated, going back to 2018 and 2019. The most recent COI declaration is dated June 2021. In addition, several commissioners who are affiliated with currently funded providers declared "No Conflict" on their COI declarations. Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded, most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act			member at the time of BOS appointment and annually, listing any agency contracts (if applicable). All County Commissioners fill out an IRS 700 form to declare their economic interests. At the time of the site visit, staff did not have access to the electronic files, however, moving forward, staff have been granted access and will use the completed electronic IRS 700 filings as additional records for conflicts of interest matters. b) In addition, as part of the bylaws update, the COH will add explicit language requiring members who are affiliated with contracted agencies to abstain from voting on allocations for which their agencies are funded. In addition, staff will work with the Co-Chairs and parliamentarian to remind	onboarding/new member orientation. Annually all members will fill out a new Ryan White Program Part A-specific COI form at the beginning of the year.

			and reinforce the section of the existing COH bylaws that states “all members must declare conflicts of interest involving Ryan White-funded agencies and their services, and the member is required to recuse him/herself from discussion concerning that area of conflict, or funding for those services and/or to those agencies.”	

LOS ANGELES COUNTY
COMMISSION ON HIV

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August x, 2023

To: Mario Perez, MPH, Director of the Division of HIV and STD Programs, Department of Public Health, County of Los Angeles

From: Al Ballesteros and Kevin Donnelly, Planning, Priorities and Allocations Committee Co-Chairs

Re: Maximizing Ryan White Program Funds ahead of Medi-Cal Expansion

Beginning January 1, 2024, adults ages 26 through 49 will qualify for full-scope Medi-Cal, regardless of immigration status. This new phase of Medi-Cal expansion will result in significant impacts on the Ryan White HIV care system. Furthermore, Medi-Cal expansion presents opportunities and challenges in modernizing comprehensive and integrated HIV care for PLWH. This expansion further underscores the need for multiple payor sources and for healthcare systems to improve coordination, communication, and service delivery. As such, the Los Angeles County Commission on HIV's Planning, Priorities and Allocations (PP&A) Committee is committed to working collaboratively with the Division of HIV and STD Programs (DHSP) to identify and implement innovative strategies to maximize both Medi-Cal and the Ryan White HIV care system as payor sources before the January 1, 2024, Medi-Cal expansion.

During the May 16, 2023, Planning, Priorities and Allocations Committee meeting, the Committee discussed potential strategies to maximize Ryan White Program funds as related to Medi-Cal expansion. The PP&A Committee has proposed the following strategies to help guide HIV prevention and care efforts through the Medi-Cal expansion:

- Instruct all RWP providers to assess how many clients are eligible for and expected to transition to Medi-Cal ahead of the January 1, 2024, roll out for ages 26 to 49
- Assist eligible individuals with early enrollment into Medi-Cal before January 1, 2024, to allow them to remain in care
- Utilize Ryan White Program funds to cover costs as individuals transition from the Ryan White Program to Medi-Cal using the Rapid Start program as a model framework. Funding would cover medical care visits as well as costs associated with Medi-Cal enrollment (collection of paperwork, documentation, etc.) for up to 120 days.
- Identify opportunities for the RWP to complement/supplement services that are not covered by Medi-Cal

In addition, the PP&A Committee recommends utilizing fiscal year (FY) 2022 Minority AIDS Incentive (MAI) carry over funds of approximately $1.3 million to complement Medi-Cal expansion through increased targeted efforts to priority populations. Potential strategies include:

- HIV/STI testing and treatment as prevention services in specific geographic areas (SPA 6) focused on priority populations (Black/Latino MSM, cisgender women, transgender persons, etc.)
- Channel funds to a third-party administrator to issue a request for proposal for a short-term intervention targeting priority populations (e.g., navigation support for cisgender women)
- Creation of a centralized transportation hub to assist with transportation services for PLWH accessing medical and supportive services
- Increase funding for the Linkage and Reengagement Program to scale up efforts to re-engage PLWH who have intermittent care or lost to care

We remain committed to working with you on addressing the needs of PLWH and identifying innovative strategies to maximize Ryan White Program funds in the advent of another phase of Medi-Cal expansion and eagerly await the opportunity to discuss these ideas with you.

cc: Bridget Gordon
Luckie Fuller
Michael Green, PhD
Pamela Ogata
Victor Scott

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

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

Expenditures reported by July 24, 2023

1	2	3	4	$ 5	6	7	8	9	10	11
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	PART A + MAI EXPENDITURES %	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	5,884,932	$ -	$ 5,884,932	$ 5,884,932	$ -	$ 5,884,932	14.19%	$ -	$ -	$ 5,884,932
MEDICAL CASE MGMT (Medical Care Coordination)	9,014,169	$ 656,963	$ 9,671,132	$ 9,014,169	$ 656,963	$ 9,671,132	23.33%	$ -	$ -	$ 9,671,132
ORAL HEALTH CARE	7,456,098	$ -	$ 7,456,098	$ 7,456,098	$ -	$ 7,456,098	17.98%	$ -	$ -	$ 7,456,098
MENTAL HEALTH	216,060	$ -	$ 216,060	$ 216,060	$ -	$ 216,060	0.52%	$ -	$ -	$ 216,060
EARLY INTERVENTION SERVICES	2,112,125	$ -	$ 2,112,125	$ 2,112,125	$ -	$ 2,112,125	5.09%	$ -	$ -	$ 2,112,125
HOME AND COMMUNITY BASED HEALTH SERVICES	2,758,499	$ -	$ 2,758,499	$ 2,758,499	$ -	$ 2,758,499	6.65%	$ -	$ -	$ 2,758,499
CHILD CARE SERVICES	0	$ -	$ -	$ -	$ -	$ -	0.00%	$ -	$ -	$ -
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	1,413,242	$ -	$ 1,413,242	$ 1,413,242	$ -	$ 1,413,242	3.41%	$ -	$ -	$ 1,413,242
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	0	$ 523,926	$ 523,926	$ -	$ 523,926	$ 523,926	1.26%	$ -	$ -	$ 523,926
HOUSING-RCFCI, TRCF	418,179	$ -	$ 418,179	$ 418,179	$ -	$ 418,179	1.01%	$ 4,264,161	$ 4,264,161	$ 4,682,340
HOUSING-Temporary and Permanent Supportive with Case Management	0	$ 3,283,615	$ 3,283,615	$ -	$ 3,283,615	$ 3,283,615	7.92%	$ -	$ -	$ 3,283,615

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

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

Expenditures reported by July 24, 2023

SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0	$ -	$ -	$ -	$ -	$ -	0.00%	$ 656,363	$ 656,363	$ 656,363
MEDICAL TRANSPORTATION	581,692	$ -	$ 581,692	$ 581,692	$ -	$ 581,692	1.40%	$ -	$ -	$ 581,692
LANGUAGE SERVICES	5,198	$ -	$ 5,198	$ 5,198	$ -	$ 5,198	0.01%	$ -	$ -	$ 5,198
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	3,740,480	$ -	$ 3,740,480	$ 3,740,480	$ -	$ 3,740,480	9.02%	$ -	$ -	$ 3,740,480
EMERGENCY FINANCIAL ASSISTANCE	1,741,442	$ -	$ 1,741,442	$ 1,741,442	$ -	$ 1,741,442	4.20%	$ -	$ -	$ 1,741,442
REFERRAL/OUTREACH (PARTNER SERVICES/LINKAGE AND REENGAGEMENT PROGRAM)	1,118,269	$ -	$ 1,118,269	$ 1,118,269	$ -	$ 1,118,269	2.70%	$ -	$ -	$ 1,118,269
LEGAL	537,618	$ -	$ 537,618	$ 537,618	$ -	$ 537,618	1.30%	$ -	$ -	$ 537,618
SUB-TOTAL DIRECT SERVICES	36,998,004	$ 4,464,504	$ 41,462,508	$ 36,998,004	$ 4,464,504	$ 41,462,508	100.00%	$ 4,920,524	$ 4,920,524	$ 46,383,032
YR 32 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	4,214,223	$ 378,020	$ 4,592,243	$ 4,214,223	$ 378,020	$ 4,592,243		$ 526,284	$ 526,284	$ 5,118,527
YR 32 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	930,003	$ -	$ 930,003	$ 930,003	$ -	$ 930,003		$ -	$ -	$ 930,003
TOTAL EXPENDITURES	42,142,230	$ 4,842,524	$ 46,984,754	$ 42,142,230	$ 4,842,524	$ 46,984,754		$ 5,446,808	$ 5,446,808	$ 52,431,562
TOTAL GRANT AWARD				**$ 42,142,230**	**$ 3,780,205**	**$ 45,922,435**			**$ 5,446,809**	
VARIANCE				$ 0	1,062,319				(1)	
MAI Carryover from YR 31 to YR 32	$	1,747,329								
MAI Carryover from YR32 to YR 33	**$**	**685,010**								

Ryan White Program Year 32

Care Utilization Data Summary

Part 1 - Ambulatory Outpatient Medical and Medical Care Coordination

Aug 15, 2023
COH Planning, Priorities, and Allocations Committee

Sona Oksuzyan, PhD, MD, MPH
Division of HIV and STD Programs

Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) Service Cluster

BACKGROUND

As a Ryan White Program (RWP) Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives grant funds from the Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB) to increase access to core medical and related support services for people living with HIV (PLWH)[1]. The amount of the award is based on the number of PLWH residing in LAC. DHSP receives additional funding from HRSA-HAB to reduce disparities in health outcomes among persons of color living with HIV through the Minority AIDS Initiative (MAI) and discretionary funds from the LAC Department of Public Health (net county costs [NCC]). DHSP received a total of $45.9 million from HRSA-HAB in fiscal year 2022 that included $42.1 million for Part A and $3.8 million for MAI.

HRSA-HAB and the Centers for Disease Control and Prevention (CDC) require that local HIV planning bodies develop integrated HIV prevention plans in collaboration with the health department to guide prevention and care efforts within the jurisdiction[2]. HIV surveillance and supplemental surveillance along with program service data and unmet need estimates are used to identify priority populations of focus. In LAC, the populations of focus overlap with priority populations identified in the local "Ending the HIV Epidemic" strategic plan and shown in bold[3]. These include:

1. **Latino Cisgender Men Who Have Sex with Men (MSM)**
2. **Black Cisgender MSM**
3. **Cisgender Women of Color**
4. **Transgender Persons**
5. **Youth Aged 13-29**
6. PLWH ≥ Age 50
7. **Persons Who Inject Drugs (PWID)**
8. Unhoused RWP Clients

Though not identified as priority populations in the integrated or Ending the HIV Epidemic (EHE) plans, we include RWP clients 50 years of age and older and those experiencing homelessness as an important subpopulation living with HIV with need for RWP services in LAC.

[1] Ryan White HIV/AIDS Programs Parts & Initiatives. (2022). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/about/parts-and-initiatives
[2] Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026.(2021). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf
[3] Ending the HIV Epidemic Plan for Los Angeles. (2021). In lacounty.hiv. Retrieved July 19, 2023 from https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

This report series summarizes utilization of medical and support services by RWP clients in Contract Year 32 (March 1, 2022-February 28, 2023) to inform the planning and allocation activities of the LAC Commission on HIV (COH). To inform focused discussion, we will present services in the following service clusters:

1. Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services
2. Mental Health and Substance Abuse (Residential) services
3. Housing, Emergency Financial Assistance and Nutrition services
4. General and Specialty Oral Health services
5. Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

The data presented is intended to provide priority highlights of who is accessing RWP services in LAC (demographic and socio-economic characteristics, priority populations), the types of services accessed, funding sources, and how these services are delivered (in-person or telehealth). The detailed source tables are included in the appendix for reference.

Outcomes and Indicators

The following information will be used to describe service utilization and estimate expenditures. Each of the five service clusters to be presented will include:

- HIV Care Continuum Outcomes (engagement in care, Retention in Care (RiC) and viral suppression (VS) among EHE priority and RWP priority populations
- RWP service utilization and expenditure indicators by service category:
    - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
    - Service units per client=Total service units/Number of clients
    - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
    - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

- HIV Casewatch (local RWP data reporting system)
    - Client characteristics and service utilization data reported by RWP contracted service agencies
    - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

WHAT DATA CAN AND CANNOT TELL US

This report will estimate for the current reporting year:

- How many unique RWP clients were served?
- What types of clients accessed RWP services?
  - How many clients?
  - Which clients are we serving?
  - Which services did they access?
- How did clients use services?
  - Which services did they use?
  - How were they utilized?
  - How much of the service did they receive?
  - Were there differences or disparities in how clients received services?
- Are we making progress toward targets for local and federal HIV care continuum (HCC) outcomes?
  - How are RWP clients doing compared to LAC overall?
  - How are clients doing within service categories?
  - Are there differences/disparities in outcomes?

What we cannot estimate using this report:

- What services clients need compared to what they receive (service gaps)
- Why the number of clients may change over time
- How many PLWH in LAC are uninsured
- Why there are disparities in utilization or outcomes
- Characteristics of or service use among PLWH outside of the RWP

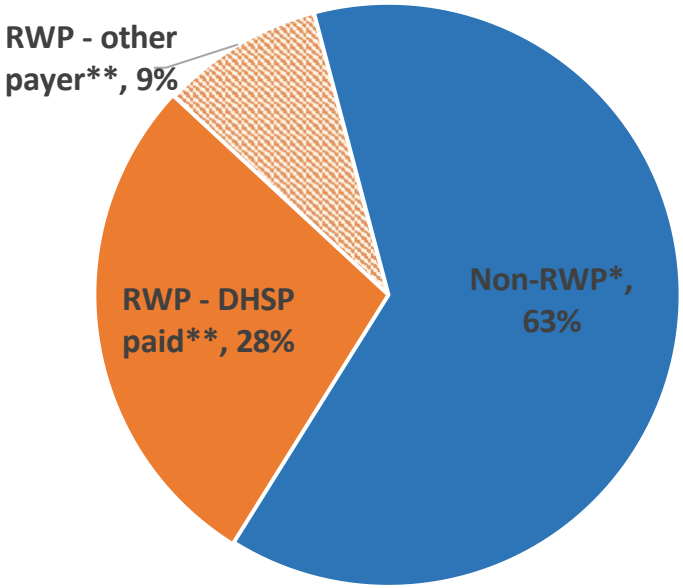
RYAN WHITE PROGRAM CLIENTS

Figure 1 below estimates RWP services use among people living with diagnosed HIV (PLWDH) in LAC in RWP Year 32 (March 1, 2022 - February 28, 2023).

- The orange section shows the percent of PLWDH who accessed RWP services that were paid for by DHSP RWP funds. This will be the population of focus for this report.
- The orange and white stripe section shows the percent of PLWDH who accessed RWP services that were ultimately paid for by another source such as Medi-Cal, Medi-Care, or other insurance
- The blue section shows the percent of PLWDH who did not use any RWP service. This means they receive medical care and other services through other systems of care.

In RWP Year 32, approximately 1 in 4 PLWDH received at least one RWP service paid by DHSP with RWP funds.

Figure 1. Use of RWP services among PLWDH in LAC (N=53,577), Year 32*



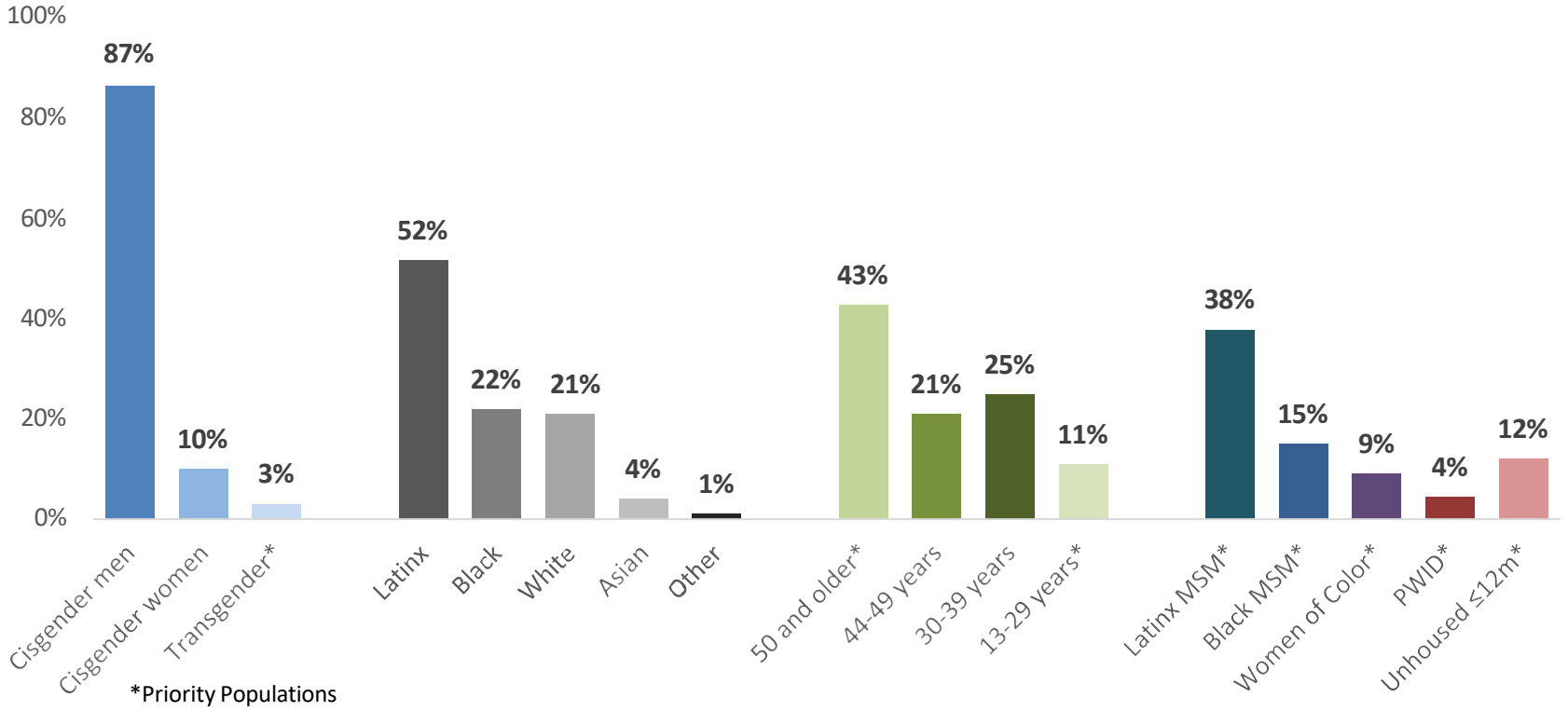
*LAC surveillance data for calendar year 2022 (Jan-Dec 2022)
**CaseWatch data for RWP year 32 (Mar 2022-Feb 2023)

Socio-Demographic Characteristics and Social Determinants of Health among RWP Clients

Of the 14,772 RWP clients **who** accessed RWP funded services in Year 32, 24% received at least one RWP-supported medical care visit in the reporting period.

In Year 32, the majority of RWP clients were Latinx or Black/African American (52% and 22%, respectively), cisgender male (87%), PLWH ≥ Age 50 (43%), living at or below the Federal Poverty Level (63%), MSM (71%) and residing in Hollywood-Wilshire Health District (19%). (Figure 2, Supplemental Table 1)

Figure 2. Demographic Characteristics and Priority Populations among RWP Clients in LAC, Year 32

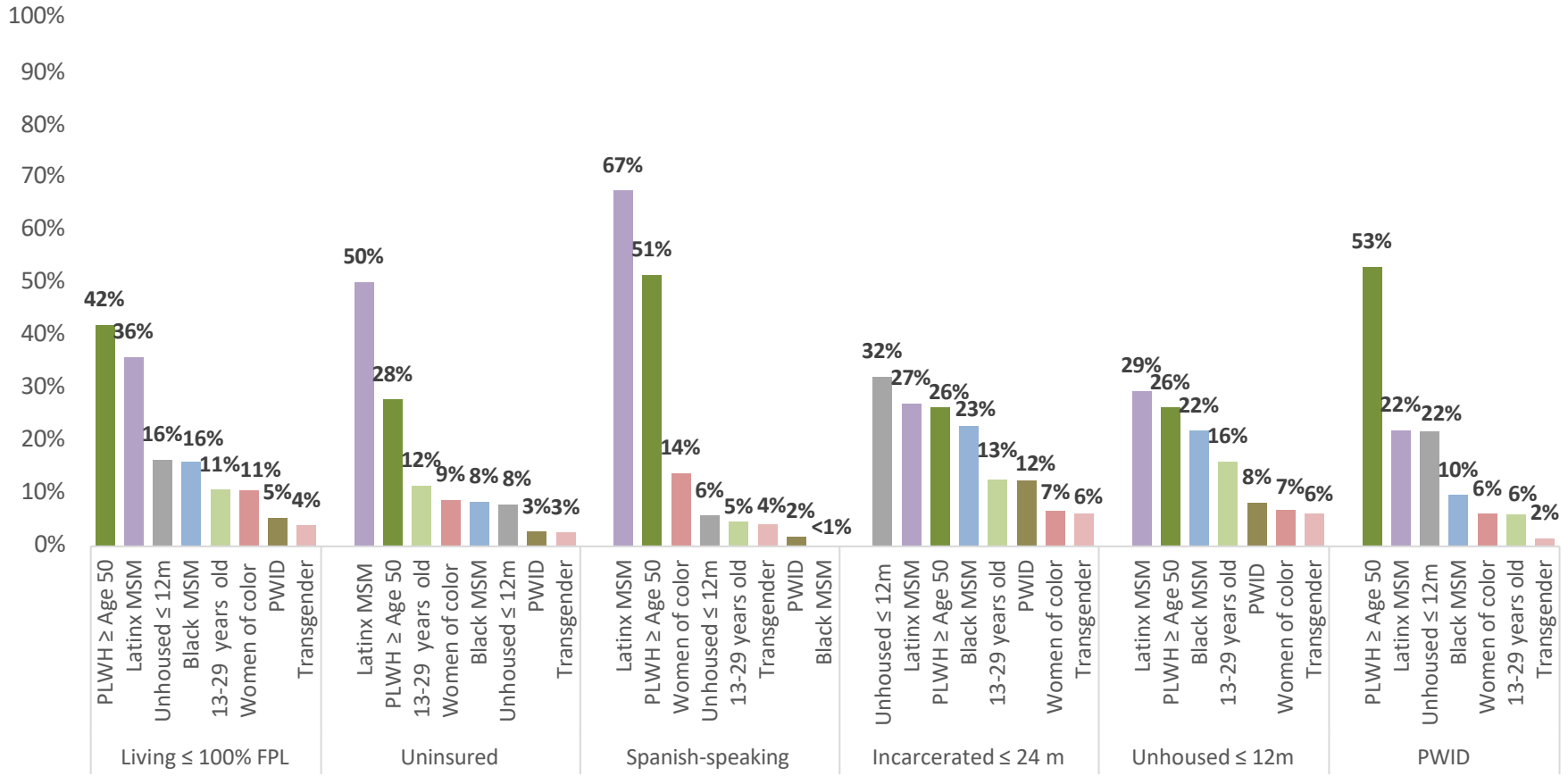


The demographic characteristics of RWP clients have remained stable over the past five RWP years *except for age*. The percent of clients aged 50 and older has increased overtime, reflecting the aging HIV epidemic locally and across the US. For more information about client characteristics over time, please refer to Supplemental Table 1.

Figure 3 presents key determinants of health by priority population:

- **Living at or below FPL**: highest among PLWH ≥ Age 50 (42%) followed by Latinx MSM (36%)
- **Uninsured**: highest among Latinx MSM (50%) followed by PLWH ≥ Age 50 (28%)
- **Primary Spanish-Speakers**: highest among Latinx MSM (67%) followed by PLWH ≥ Age 50 (51%)
- **Recent Incarceration**: highest among unhoused in past 12 m (325) followed by Latinx MSM (27%)
- **Unhoused in the Reporting Period**: highest among Latinx MSM (29%) followed by PLWH ≥ Age 50 (26%)
- **PWID**: highest among PLWH ≥ Age 50 (53%) followed by Latinx MSM and unhoused in past 12 m (22% each)

Figure 3. Social Determinants of Health by Priority Populations among RWP Clients in LAC, Year 32

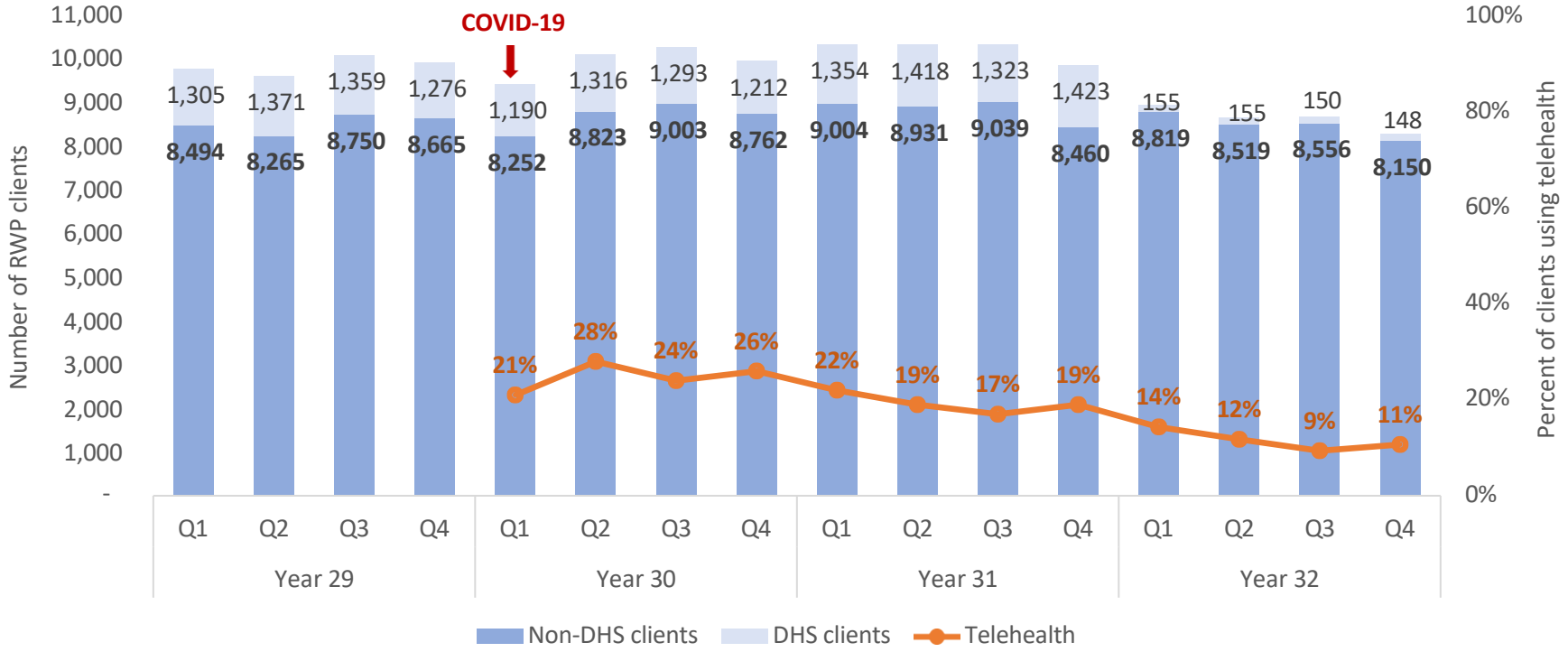


SERVICE UTILIZATION

Figure 4 below shows the number of RWP clients accessing services for RWP Years 29-32 (March 1, 2019 – February 28, 2023) by quarter to show the impact of the COVID-19 pandemic on utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. Each bar represents the total number of clients by quarter. The light blue part of the bar shows the number of DHS clients. The darker blue part of the bar shows the number of all other (non-DHS) clients. We can see that the total number of clients decreased starting in quarter 1 of Year 32 however we can see the utilization of RWP by non-DHS clients has remained stable.

The orange line shows the percent of RWP services that were utilized through telehealth modalities. Telehealth was a critical strategy to promote continuity of care for RWP clients during the COVID-19 pandemic. MCC, AOM, Non-Medical Case Management (NMCM), Mental Health (MH), and Home-Based Case Management (HBCM) continued to be offered to clients with a telehealth option through Year 32. About 25% of RWP clients received at least one of the RWP services via telehealth in Year 32 (43% in Year 31). RWP services with the highest usage of telehealth were MH (51%), MCC (35%), and AOM (23%). Supplemental Table 2 provides more detail about telehealth services.

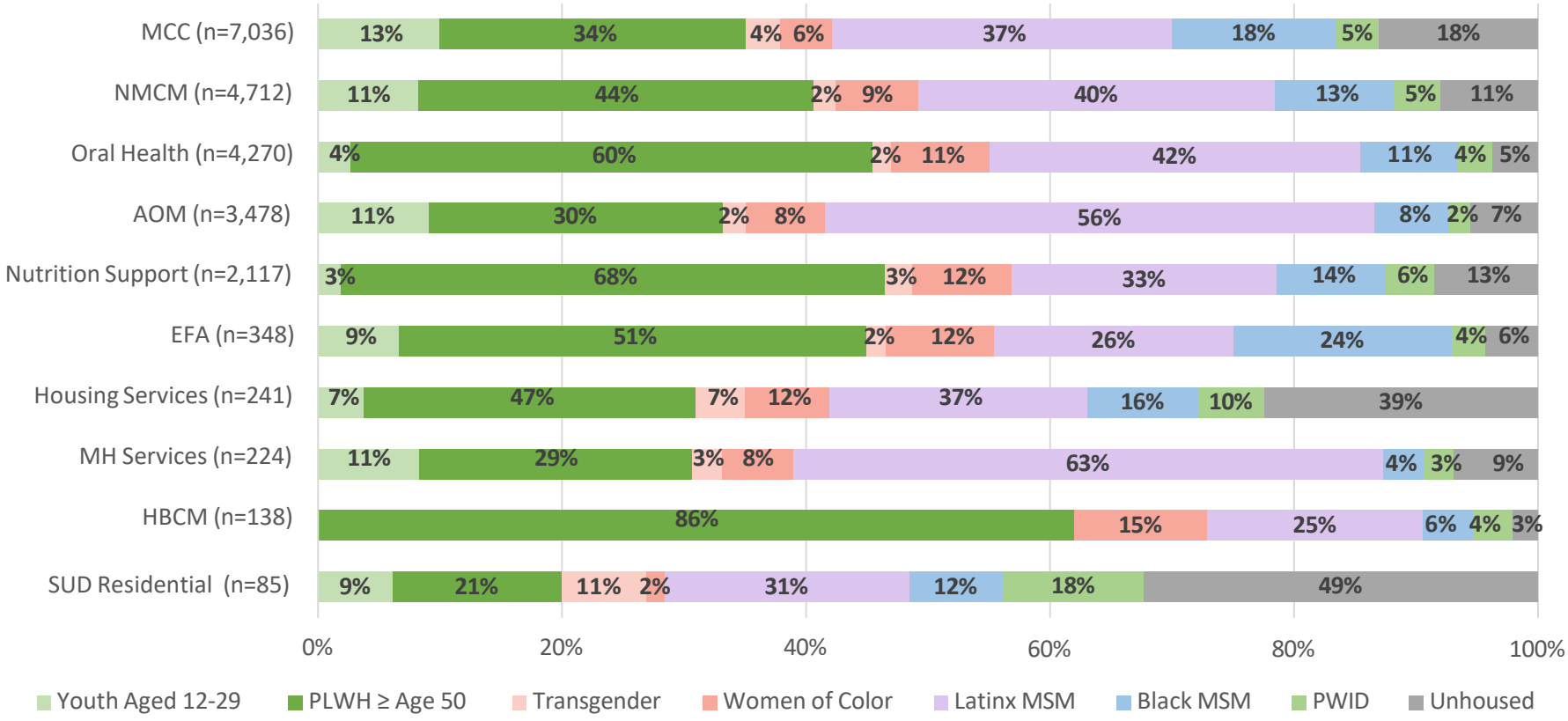
Figure 4. Service Usage and Telehealth Usage among RWP Clients, Years 29-32 by quarter



SERVICE UTILIZATION AMONG PRIORITY POPULATIONS

In Year 32, the MCC, Non-Medical Case Management (NMCM) and Oral Health services were used by the highest number of RWP clients. The figure below presents use of each service category by priority populations.

Figure 5. Utilization of RWP Services by Service Categories and by Priority Populations, LAC, Year 32

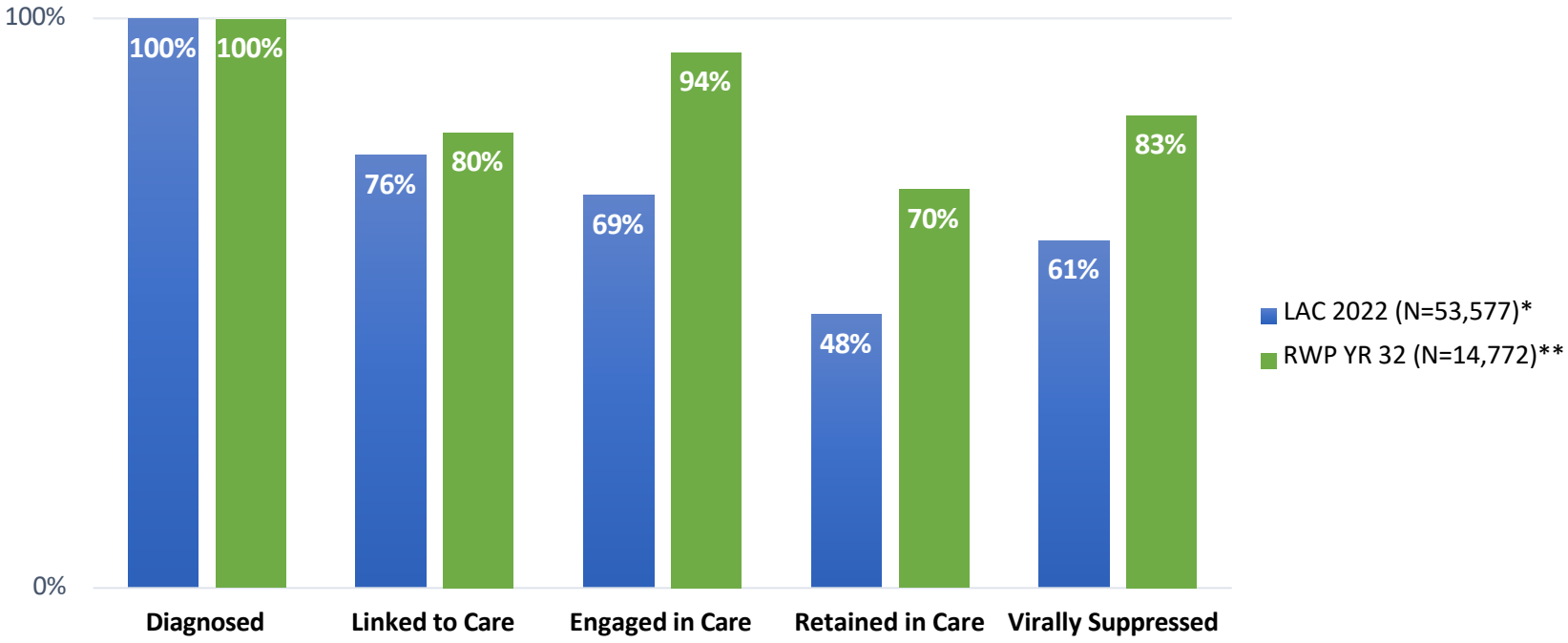


Among priority populations, the highest usage of all services was among Latinx MSM and/or PLWH ≥ Age 50, with the exception of Housing and SUD Residential services where the highest percentage of people utilizing these services was among unhoused people.

HIV CARE CONTINUUM FOR RWP CLIENTS

Figure 6 below shows Health Care Continuum (HCC) outcomes for RWP clients compared to all PLWH in LAC. Higher proportions of RWP clients were linked to care within 30 days of diagnoses, engaged in care, retained in care (RiC) and achieved viral suppression (VS) in RWP Year 32 compared to all PLWH in LAC. Of the 14,772 clients who received RWP services in Year 32, 94% were engaged in care, 70% were retained in care (RiC), and 83% achieved viral suppression (VS) in the past 12 months.

Figure 6: HIV Care Continuum Comparing People Living with Diagnosed HIV and Ryan White Program Clients in Year 32, Los Angeles County

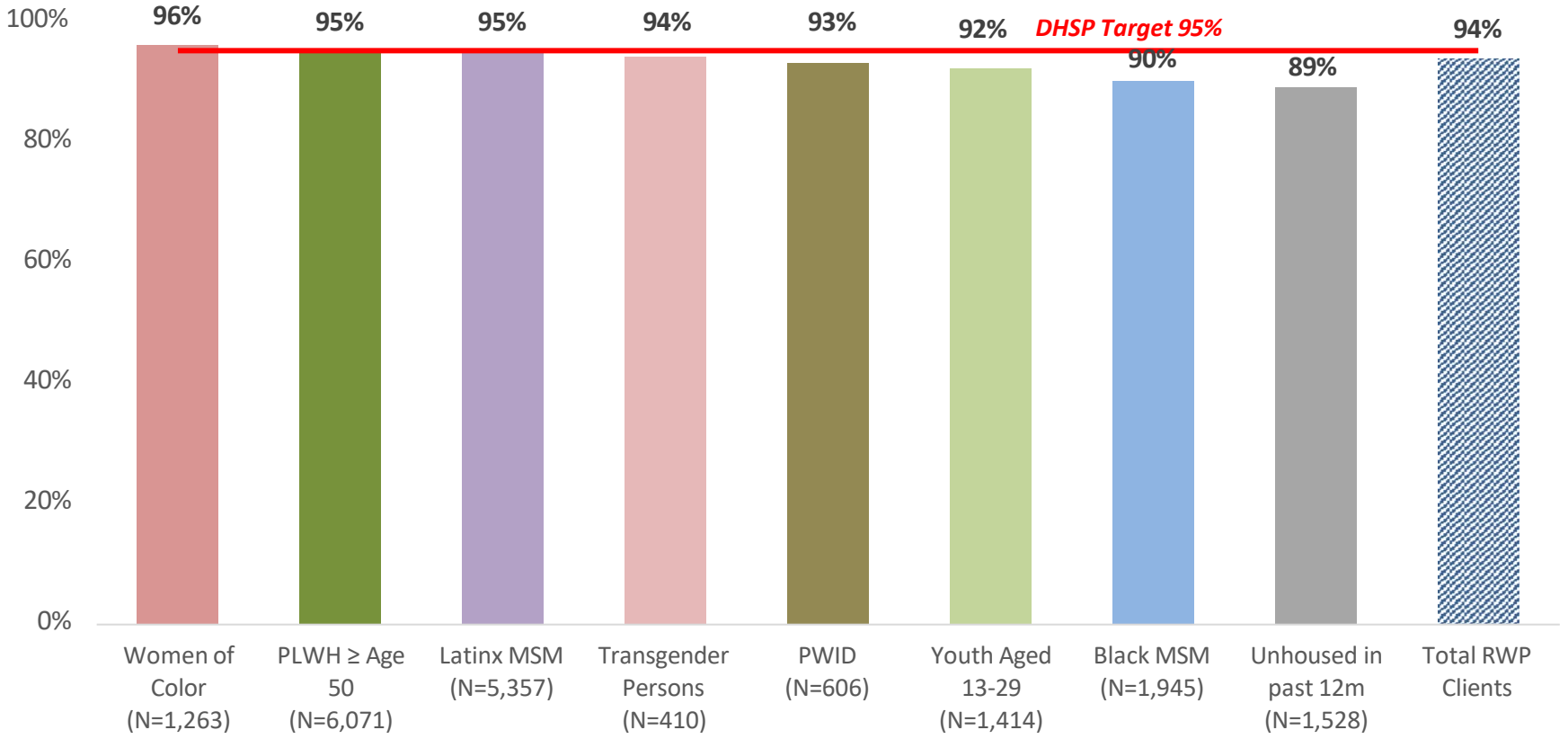


*LAC surveillance data for calendar year 2022 (Jan-Dec 2022)
**CaseWatch data for RWP year 32 (Mar 2022-Feb 2023)

- ***Engagement in HIV Care***

Figure 7 shows engagement in HIV care defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period among priority populations. Engagement in care for RWP clients was the highest among women of color (96%), following by PLWH ≥ 50 year of age and Latinx cisgender MSM (95% each). Engagement in care was lowest for Black cisgender MSM (90%) and unhoused in past 12 months (89%).

Figure 7: Engagement in HIV Care among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]

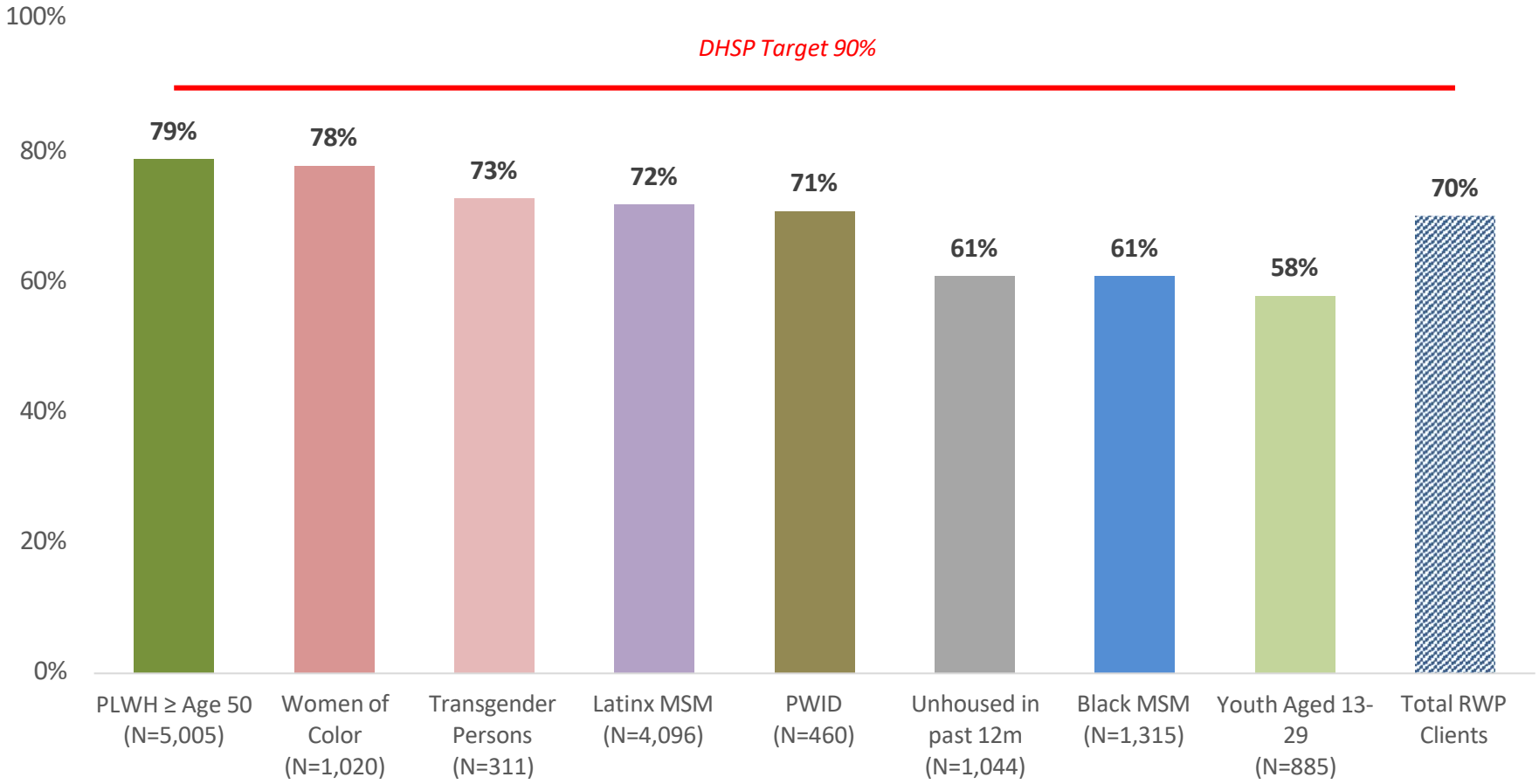


[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

- ***Retention in Care***

Figure 8 shows retention in care (having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period) among priority populations. The percent of RWP clients retained in care was the highest for PLWH aged 50 and older (79%) and cisgender women of color (78%). Retention in care was lowest among youth aged 13-29 (58%).

Figure 8: Retention in Care among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]

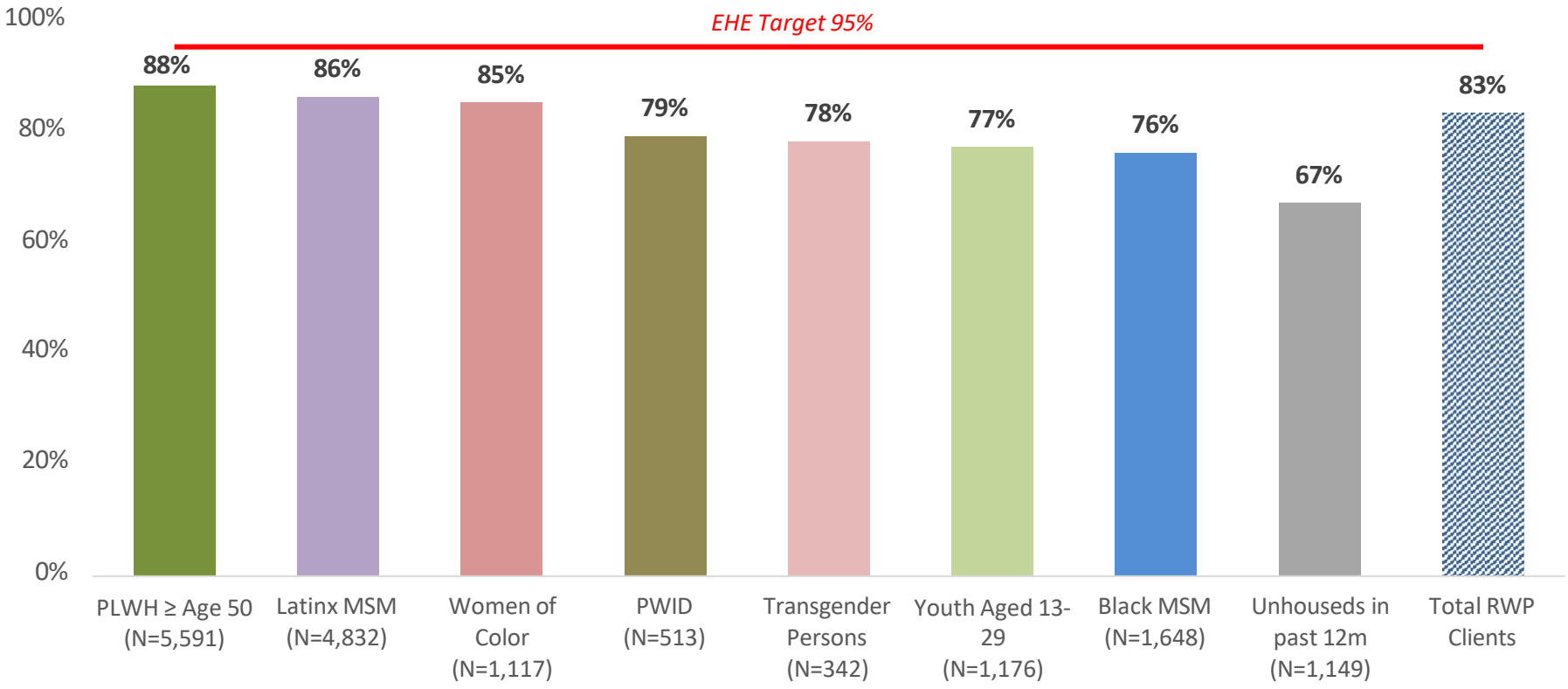


[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

- ***Viral Suppression***

Figure 9 shows viral suppression (viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period) among priority populations. Among priority populations, the percent of RWP clients who were virally suppressed was the highest for clients aged 50 and older (88%), and the lowest for people who were experiencing homelessness in past 12 months (67%).

Figure 9: Viral Suppression among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]



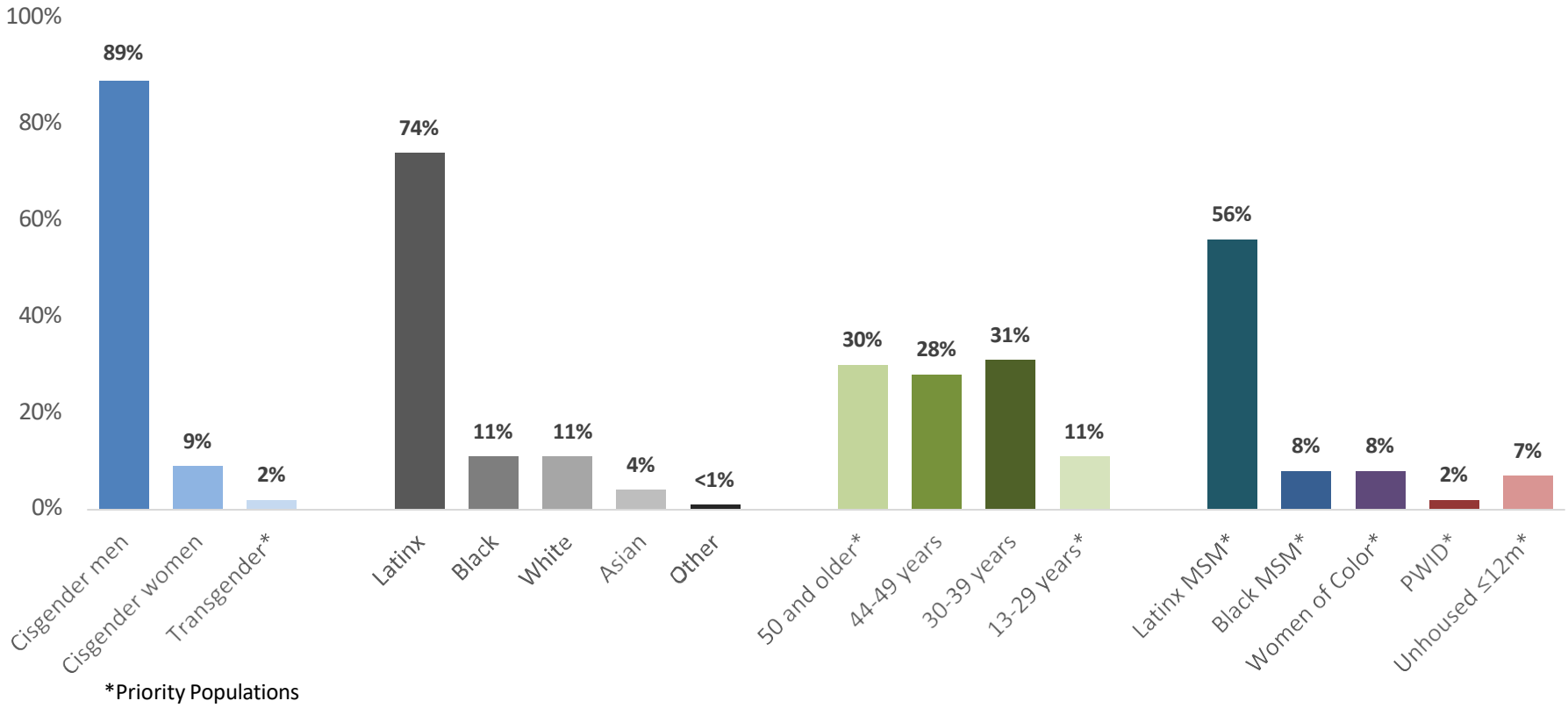
[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

Please see the supplemental tables for details on changes in HCC outcomes over time.

AMBULATORY OUTPATIENT MEDICAL (AOM)

- ***Population Served:***
  - 3,478 clients received AOM services in Year 32.
  - Among those the highest percentages of clients receiving AOM services were among cisgender men, Latinx, aged 30-39 years old and PLWH ≥ Age 50, MSM, and residing in Hollywood-Wilshire HD.
  - By priority populations the highest percentage receiving AOM services was among Latinx MSM (56%) followed by clients aged 50 years and older (30%). (Figure 10)

Figure 10. Demographic Characteristics and Priority Populations among AOM Clients in LAC, Year 32

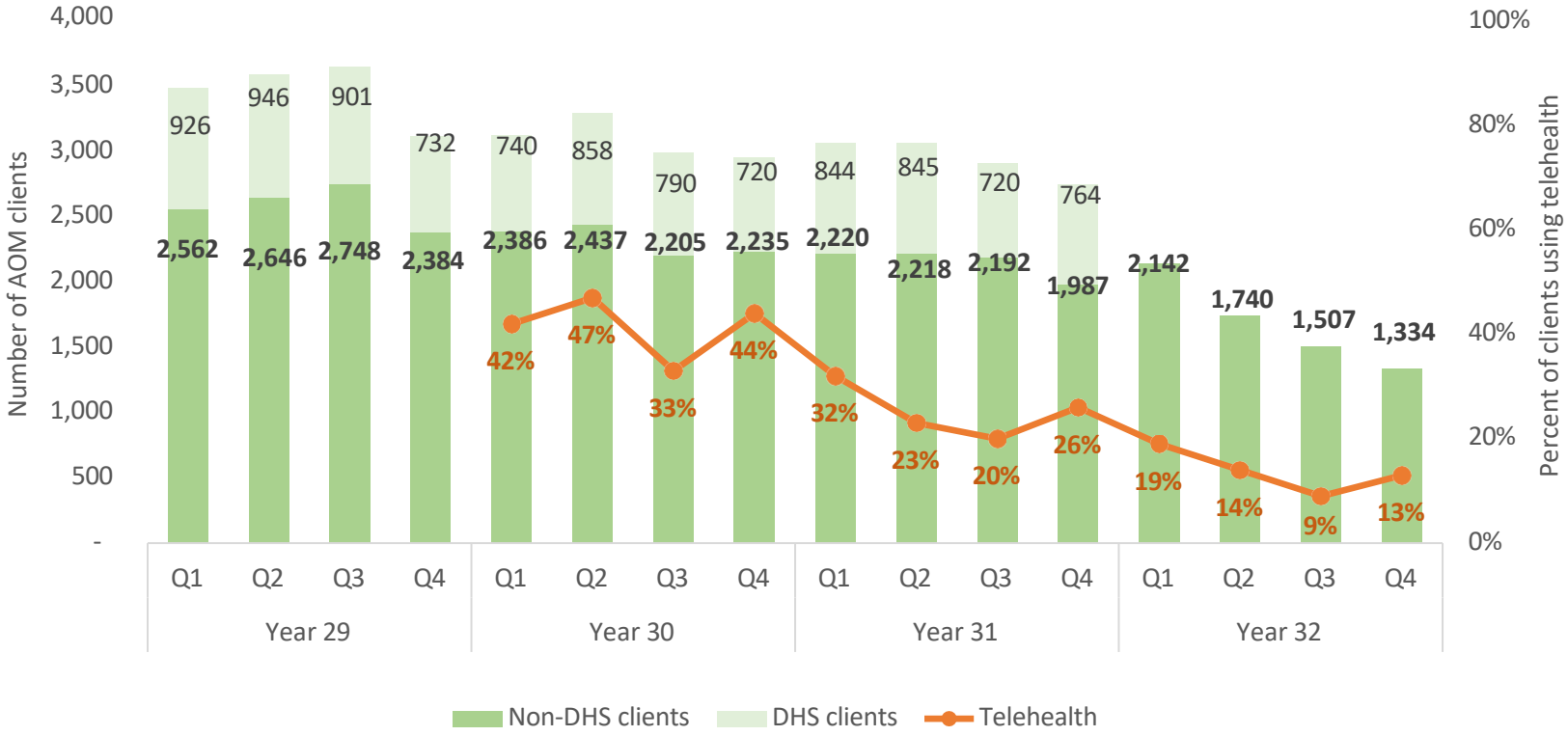


- ***Telehealth:***

Figure 11 below shows the number of RWP clients accessing AOM services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on AOM utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light green part of the bar shows the number of DHS clients. The darker green part of the bar shows the number of all other (non-DHS) clients. The total number of AOM clients decreased starting in quarter 1 of Year 32; however, we can see the utilization of AOM services by non-DHS clients has decreased.

The orange line shows the percent of AOM services that were utilized through telehealth modalities. About 23% of AOM visits were offered via telehealth in Year 32. This is lower than telehealth percentage in Year 31 (39%), however it remains an important mode of healthcare for certain populations, including White (27%), non-binary/non-conforming gender identity (50%), incarcerated ever (37%), people experiencing homelessness (22%), PWID (32%), and residing in Hollywood-Wilshire HD (27%).

Figure 11. Number of Department of Health Services (DHS) and Non-DHS AOM Clients by Quarter in LAC, RWP Years 30-32



- ***Service Utilization and Expenditures:***
  - Year 32 Funding Sources: **RWP Part A (100%)**
  - Percentage of RWP Clients Accessing AOM in Year 32: **24%**
  - Unit of Service: **Visits**

Table 1. AOM Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Unique Clients	% of Clients	Total Visits	% of Visits	Visits per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total AOM clients	*3,478*	*100%*	*8,891*	*100%*	*2.6*	*$1,692*	*$5,884,932 (Part A)*
Latinx MSM	1,961	**56%**	5,306	**60%**	**2.7**	**$1,791**	$3,511,936
PLWH ≥ Age 50	1,045	30%	2,622	29%	2.5	$1,661	$1,735,450
Youth Aged 12-29	397	11%	844	9%	2.1	$1,407	$558,627
Women of Color	282	8%	756	9%	**2.7**	**$1,774**	$500,381
Black MSM	263	8%	513	6%	2.0	$1,291	$339,544
Unhoused in past 12 m	241	7%	529	6%	2.2	$1,453	$350,135
Transgenders Persons	84	2%	202	2%	2.4	$1,592	$133,700
Persons who inject drugs (PWID)	75	2%	193	2%	2.6	**$1,703**	$127,743

Table 1 Highlights

- *Population Served:* Approximately two-thirds of clients accessing AOM services were MSM of color (64%): 56% Latinx MSM and 8% Black MSM.
- *Service Utilization:*
  - About two-thirds of the total AOM visits were attended by MSM of color (66%): 60% by Latinx MSM and 6% by Black MSM.
  - Visits per client were highest among Latinx MSM and women of color (2.7 visits per client each) and lowest among Black MSM (2.0 visits per client) compared to total AOM clients and other subpopulations.
  - The percent of AOM visits was higher relative to their population size among Latinx MSM and women of color represented (56% vs 60% and 8% vs 9%).
- *Expenditures:*
  - Latinx MSM, women of color, and PWID had higher expenditures per client than the average for all AOM clients ($1,692)
  - Compared to the percent out of total AOM clients, Latinx MSM, women of color, and PWID (1-2%) had disproportionally higher expenditures per client

- ***Health Care Continuum (HCC) Measures***

Table 2 below shows HCC outcomes for RWP clients receiving AOM services in Year 32. AOM clients had better HCC outcomes compared to RWP clients who did not receive AOM services.

Table 2. HIV Care Continuum Outcomes for AOM Clients and non-AOM Clients in LAC, Year 32

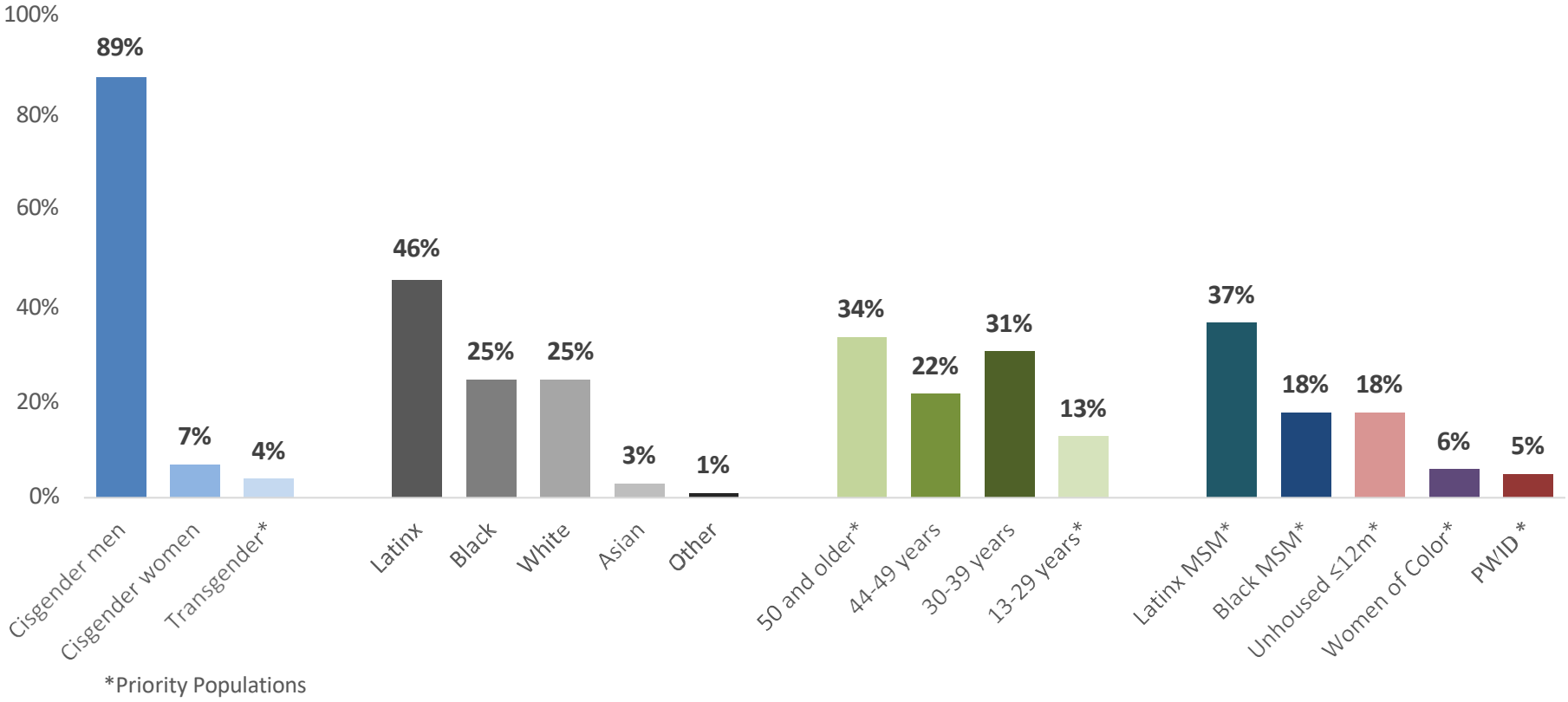
HCC Measures	AOM clients		Non-AOM clients	
	N	Percent	N	Percent
Engaged in HIV Care [a]	3,421	98%	10,425	92%
Retained in HIV Care[b]	2,586	74%	7,795	69%
Suppressed Viral Load at Recent Test[c]	2,164	89%	9,170	81%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

MEDICAL CARE COORDINATION (MCC)

- ***Population Served:***
  - 7,036 clients received MCC services in Year 32.
  - Among those the highest percentages of clients receiving MCC services were among cisgender men, Latinx, aged 50 and older, MSM, and residing in Hollywood-Wilshire HD.
  - By priority populations the highest percentage receiving MCC services was among Latinx MSM (37%) and PLWH ≥ Age 50 (34%). (Figure 12)

Figure 12. Demographic Characteristics and Priority Populations among MCC Clients in LAC, Year 32

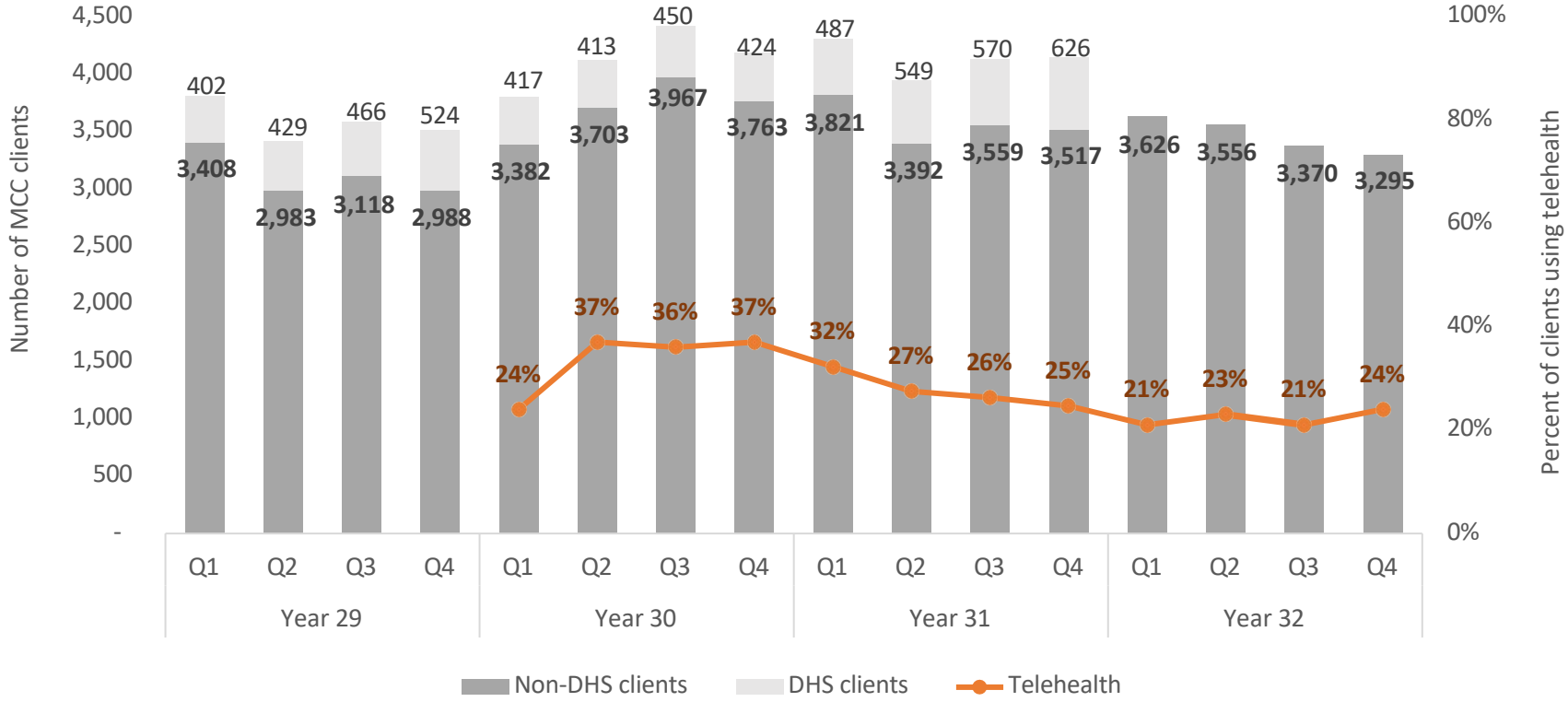


- ***Telehealth:***

Figure 12 below shows the number of RWP clients accessing MCC services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on MCC utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light grey part of the bar shows the number of DHS clients. The darker grey part of the bar shows the number of all other (non-DHS) clients. The total number of MCC clients decreased starting in quarter 1 of Year 32; however, we can see the utilization of MCC services by non-DHS clients has remained stable.

The orange line shows the percent of MCC services that were utilized through telehealth modalities. About 35% of MCC visits were offered via telehealth in Year 32. Although it is lower than the telehealth percentage in Year 31 (46%), it remains an important mode of healthcare for certain populations, such as Latinx (37%), transgender (48%), incarcerated over 2 years ago (38%), and unhoused in past 12 m (38%), PWID (74%), and residing in Hollywood-Wilshire HD (34%).

Figure 12. Telehealth Usage among MCC Clients, Years 30-32 by Quarter, LA County



- ***Service Utilization and Expenditures:***
  - Year 32 Funding Sources: **RWP Part A (92%), MAI (8%)**
  - Percentage of RWP Clients Accessing MCC in Year 32: **48%**
  - Unit of Service: **Hours**

Table 3. MCC Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Unique Clients	% of Clients	Total Hours	Hours per Client	Percent of Hours	Expenditures per Client	Estimated Expenditures by subpopulation
Total MCC clients	***7,036***	***100%***	***91,401***	***13.0***	***100%***	***$1,375***	***$8,918,584 (Part A), $752,548 (MAI)***
Latinx MSM	2,628	37%	33,835	12.9	37%	$1,361	$3,577,401
PLWH ≥ Age 50	2,369	34%	33,470	14.1	37%	$1,494	$3,538,809
Black MSM	1,276	18%	14,957	11.7	16%	$1,239	$1,581,415
Unhoused in past 12 m	1,234	**18%**	22,235	18.0	**24%**	**$1,905**	$2,350,924
Youth (29 years and younger)	942	13%	12,122	12.9	13%	$1,361	$1,281,668
Women of Color	403	6%	7,498	**18.6**	8%	**$1,967**	$792,769
Persons who inject drugs (PWID)	330	5%	6,674	**20.2**	7%	**$2,138**	$705,647
Transgender Persons	265	4%	4,131	15.6	5%	$1,648	$436,774

Table 3 Highlights

- *Population Served:* Over half of clients using MCC services in Year 30 were MSM of color - 37% were Latinx MSM and 18% were Black MSM.
- *Service Utilization:*
  - Over half of the total MCC hours were used by MSM of color (53%): 37% by Latinx MSM and 16% by Black MSM.
  - Hours per client were highest among PWID (20.2 hours per client) and women of color (18.6 hours per client), and the lowest among Black MSM (11.7 hours per client) compared to total MCC clients and other subpopulations.
  - Unhoused MCC clients representing 18% of all MCC clients used the higher number of MCC hours per client (24%).
  - The percent of MCC hours was higher relative to their population size among women of color, transgender, PLWH ≥ Age 50, and PWID
  - The percent of MCC hours was lower relative to their population size among Black MSM
- *Expenditures:*
  - PWID had the highest expenditures per client ($2,138), followed by women of color ($1,967) and unhoused ($1,905)
  - PWID, women of color, unhoused, transgender, PLWH ≥ Age 50 had higher expenditures per client than the average for all MCC clients
  - Compared to the population size, unhoused people, PLWH ≥ Age 50, women of color and PWID had disproportionally higher expenditures per client

- ***Health Care Continuum (HCC) Measures***

Table 4 below shows HCC outcomes for RWP clients receiving MCC services in Year 32. RWP clients receiving MCC services in Year 32 had worse HCC outcomes compared to RWP clients who were not enrolled in the MCC program.

Table 4. Health Care Continuum among MCC Clients and non-MCC Clients in LAC, Year 32

HCC Measures	MCC clients		Non-MCC clients	
	N	Percent	N	Percent
Engaged in HIV Care[a]	6,395	91%	7,451	96%
Retained in HIV Care[b]	4,380	62%	6,001	78%
Suppressed Viral Load at Recent Test [c]	6,836	77%	5,441	88%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. Main findings for service utilization are presented below in Table 5.

Table 5. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	AOM	MCC
Primary Populations Served	• Latinx and Black • Cisgender male • PLWH ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH aged 30-39 and ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH ≥ Age 50 • MSM
Utilization over time	• Decreased over time by 6% from Year 28 and 13% from Year 31 due to exit of DHS from RWP	• 35% lower number of RWP clients in Year 32 compared to Year 31 due to DHS exit from RWP	• 15% decrease in the number of MCC clients in Year 32 compared to Year 31, due to DHS exit from RWP
Telehealth	• Telehealth usage decreased to 25% compared to Year 31 (43%). The highest telehealth usage among: - Latinx - Non-binary and transgender clients - PWID - Unhoused	• 23% of AOM services provided via telehealth. The highest telehealth usage among: - Non-binary clients - Unhoused - PWID	• About 35% of MCC services were provided via telehealth in Year 32. The highest telehealth usage among: - Transgender people - Women of Color - Unhoused - PWID
HCC outcomes	• The lowest percentage of engagement in care was among unhoused people and Black MSM • The lowest percentage of RWP clients RiC was among youth aged 13-29, Black MSM and unhoused • The lowest percentage of VS was among unhoused	• AOM clients had higher engagement and RiC and VS compared to non-AOM clients	• MCC clients had lower engagement, RiC and VS compared to non-MCC clients
Service Units per Client	N/A (units vary)	3 visits per client	13 hours per client
Expenditures	$45.9 million: $42.1 million - Part A $3.8 million - MAI	Total $5,884,932 (Part A) $1,692 per client	$8,918,584 (Part A), $752,548 (MAI) $1,375 per client

Latinx MSM	• The largest populations receiving RWP services • About 25% of Latinx MSM received RWP services via telehealth • The 3rd highest percentage of engagement in HIV care • The 2nd highest percentage of VS • The highest percentage of Spanish-speakers • The highest percentage of uninsured	• Represented over a half of all AOM clients (56%) and accounted for about 60% percentage of services provided • Among priority populations average numbers of visits and expenditures were higher than respective average numbers for all AOM clients • The highest per client visits and expenditures among priority populations	• 37% MCC clients and accounted for the same percentage of services provided • Average number of visits and expenditures were slightly lower than respective average numbers for all MCC clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• 8% of all AOM clients and accounted for about 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• 18% of all MCC clients and accounted for about 16% of services provided • Average number of visits and expenditures were lower than respective average numbers for all MCC clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low MCC service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The 3rd highest percentage of uninsured among priority populations • The lowest percentage of RiC among priority populations	• 11% of all AOM clients but accounted for 9% of AOM services • Lower per client service units (visits) and expenditures than average for all AOM clients • Reasons for low AOM service utilization are unclear but may reflect	• 13% of all MCC clients and accounted for the same percentage of service hours provided • Lower per client service hours and expenditures than the average for all MCC clients

		poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• One of the lowest utilizers of MCC services as demonstrated by the percentage of total visits they received and average hours per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • The 2nd highest percentage of engagement in care among priority populations • The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • The 2nd highest percentage of uninsured, Spanish-speaking, and unhoused people	• 30% of all AOM clients and accounted for 29% of AOM services • One of the highest utilizers of AOM services as demonstrated by the percentage of total visit. • Moderately lower per client service units (visits) and expenditures than respective average for all AOM clients	• 34% of all MCC clients and accounted for 37% of services provided • One of the highest utilizers of MCC services as demonstrated by the percentage of total hours they received and average hours per client • Expenditures per client were above the average for all MCC clients
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • The 2nd highest percentage of RiC among priority populations	• 8% of all AOM clients and accounted for 9% of services provided • The second highest utilizers of AOM services as demonstrated by the number of visits per client. • The second highest per client expenditures for AOM services among priority populations	• 6% of all MCC clients and accounted for 8% of services provided • The highest utilizers of MCC services as demonstrated by the number of hours per client • The 2nd highest per client expenditures for MCC services among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • The highest percentage of unhoused people • The 2nd highest percentage of people living ≤ FPL	• 2% of all AOM clients and accounted for the same percentage of services provided • Lower per client visits and expenditures than respective averages for all AOM clients	• 4% of MCC clients and accounted for 5% of services provided • Average number of service hours and expenditures were considerably higher than respective average numbers for all MCC clients

		• Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• 7% of clients receiving AOM service and 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients	• 18% of clients receiving MCC service and accounted for 24% percentage of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • High utilization of MCC services by unhoused people may be reflective of complexity of social and behavioral issues in this subpopulation.
PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • The 2nd highest percentage of unhoused in past 12 m	• 2% of clients receiving AOM service and accounted for the same percentage of services provided • Average number of visits and expenditures were higher than respective average numbers for all AOM clients • The 2nd highest number of per client AOM visits among priority populations • The 3rd highest per client expenditures for AOM services among priority populations	• 5% of clients receiving MCC service and accounted for 7% of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • The highest number of per client hours of MCC service among priority populations • The highest per client expenditures for MCC services among priority populations

LOS ANGELES COUNTY
COMMISSION ON HIV

Consumer Discussion Prompts

This listening session is intended to collect important information from clients of HIV prevention and care services to better understand HIV/STD service gaps and explore opportunities for improvement in the community. We appreciate your willingness to participate. We value your input and want you to share your honest and open thoughts so that we can identify ways on how we can improve HIV services in Los Angeles County.

There are a few guidelines and rules to help facilitate today's discussion:

- We want you to do the talking. We encourage everyone to participate.
- There are no right or wrong answers. Every person's experience and opinion are important. Speak up whether you agree or disagree. We expect and want to hear a wide range of opinions and we do not anticipate consensus, just sharing.
- We emphasize that what is said in this room should remain here. Please don't' disparage another participant's remarks. Be sure to allow one speaker at a time.
- We will record this session as we want to capture everything that is said. We won't identify anyone by name in our findings - you will remain anonymous.
- The discussion will last for about one hour. Please silence your mobile phones and give everyone the chance to express his/her opinion during the conversation. You can address each other if you like. We are only here to assist in the discussion.

FACILITATION QUESTIONS

1. Where do you get your information on sexual health including information about HIV/STIs (sexually transmitted infections) prevention? Who do you talk to about your sexual health?
2. What is your relationship with your primary care doctor? Do you feel comfortable talking to them about HIV/STIs or drugs use? Do you feel comfortable talking to your HIV/STI service providers about your sexual health or drug use? Please explain.
3. What have been your experiences with obtaining HIV/STD specific services? Examples can include both positive and negative experiences; service, how people treat you, easy to make appointments, etc.)
4. What services do you use the most? What services do you need to are unable to access? What are some issues you may have faced when trying to access HIV/STD care or supportive services? Examples may include stigma around HIV status, fear of discrimination, not knowing about a service, long wait times, poor physical or mental health, hours of service are inconvenient, ineligibility etc.) Is there anything else that you would like to add about needs, gaps, and barriers you have experienced in accessing HIV/AIDS care and support services?

5. What types of support systems or programs do you need to ensure regular engagement in HIV/STD care and prevention? (Examples can include peer support networks, regular check-ins from provider, family, etc.)
6. How do you protect yourself and others from HIV or STIs? (Describe your sexual activity since acquiring HIV. If HIV negative, what do you to protect yourself?)
7. Can you provide some examples of where you experienced or have seen HIV/STD related stigma in your community? What can be done to reduce HIV/STD related stigma to increase the use of HIV and STI prevention and care services? What are some suggestions for changing people's perception and behaviors in dealing with HIV/STDs?
8. What is the best way to share information and resources on HIV and STIs with the public? (How do you prefer to receive information? Where are there gaps/opportunities for improvement? Examples include bus stops, Metro rail, billboards, social media, etc.)
9. What would you change to improve HIV/STD services? What can your primary care doctors and other providers do to better serve and support their clients?
10. What are the three greatest challenges in your life that you are struggling with right now? (Opportunity to identify other services that may not be available.)

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Consumer Demographic Questionnaire

This questionnaire is intended to collect important information on the general demographic characteristics of participants in the HIV/STI consumer listening sessions. Your responses are very important and are completely anonymous. Your answers will never be associated with you. This survey will take approximately 10 minutes to answer.

1. How old are you?
   - ☐ Under 18 years
   - ☐ 19-24 years
   - ☐ 25-29 years
   - ☐ 30-39 years
   - ☐ 40-49 years
   - ☐ 50-59 years
   - ☐ 60 years and older

2. Race/Ethnicity (check all that apply)
   - ☐ African American
   - ☐ American Indian/Alaska Native
   - ☐ Asian
   - ☐ Pacific Islander
   - ☐ Latinx/Hispanic
   - ☐ White (non-Hispanic)
   - ☐ Other: _____
   - ☐ Decline to state

3. What is your gender identity?
   - ☐ Male
   - ☐ Female
   - ☐ Non-binary
   - ☐ Transgender: male to female
   - ☐ Transgender: female to male
   - ☐ Other: _____

4. How do you identify?
   - ☐ Heterosexual/Straight
   - ☐ Gay, lesbian, same gender loving
   - ☐ Bisexual
   - ☐ Pansexual
   - ☐ Other: _____
   - ☐ Decline to state

5. What is your highest level of education?
   - ☐ Less than high school
   - ☐ Some high school
   - ☐ High school diploma/GED
   - ☐ Some college, but no degree
   - ☐ Vocational/Technical school diploma
   - ☐ Associates degree (e.g., AA, AS)
   - ☐ Bachelor's degree (e.g., BA, BS)
   - ☐ Advanced degree (Masters or higher)

6. What is your zip code? _____

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7. Have you ever been diagnosed with HIV? ☐ Yes ☐ No
   a. If so, what year you were diagnosed? If you are unsure of the exact year, please give your best guess. (enter 4-digit year) _____
   b. If you are not a person living with HIV (are HIV negative) how often do you get tested for HIV?
      - ☐ Once a year
      - ☐ Every 3 months
      - ☐ Every 6 months
      - ☐ Every month
      - ☐ After sexual activity with a new partner
      - ☐ When a partner asks me to
      - ☐ Never

8. Were you born in the United States? ☐ Yes ☐ No

9. Do you have health insurance? ☐ Yes ☐ No
   If yes, what kind of insurance? (Please check all that apply)
   - ☐ Medi-Cal
   - ☐ Health insurance or coverage bought directly by yourself or spouse/family member
   - ☐ Covered California
   - ☐ Indian or Tribal Health Service
   - ☐ Medicare
   - ☐ Health insurance or coverage through your employer or your spouse/ partner, parent, or someone else's employer
   - ☐ TRICARE or Veteran's benefits
   - ☐ Other: _____

10. What is your annual household income from all sources?
    - ☐ Less than $15,000
    - ☐ $15,000 - $23,000
    - ☐ $23,000 - $35,000
    - ☐ $35,000 - $45,000
    - ☐ $45,000 - $55,000
    - ☐ $55,000 - $65,000
    - ☐ $65,000 - $85,000
    - ☐ $85,000 or more

11. Including yourself, how many people depend on your annual household income?
    - ☐ 1 (just you)
    - ☐ 2 - 3 people
    - ☐ 3 – 6 people
    - ☐ 6 or more people

12. During the past 12 months, was there a time when you were not able to pay for…
    a. Mortgage/rent ☐ Yes ☐ No
    b. Utility bills ☐ Yes ☐ No
    c. Medical bills (including premium, co-pay, medication) ☐ Yes ☐ No
    d. Groceries ☐ Yes ☐ No
    e. Child care ☐ Yes ☐ No
    f. Phone ☐ Yes ☐ No

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13. What best describes your current housing?

- ☐ I own my own home
- ☐ I pay rent for my place
- ☐ I live in government subsidized housing
- ☐ I live with family or friends and pay rent
- ☐ I live with family or friend and *do not* pay rent
- ☐ I am couch hopping right now
- ☐ I am in a shelter
- ☐ I am in my car or on the street

14. Do you currently receive public assistance to help pay for your monthly mortgage or rent or utilities?
☐ Yes ☐ No

15. During the past 12 months, have you stayed in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay? ☐ Yes ☐ No
If yes, how often? _____

16. In the past 12 months, have you had any problems keeping your housing due to any of the following?

- ☐ I have not had any problems keeping my housing
- ☐ Difficulty paying rent, mortgage, or utilities
- ☐ Drug or alcohol use
- ☐ Unemployment/Job loss
- ☐ Credit problems
- ☐ Eviction
- ☐ Problems with my immigration status
- ☐ Legal problems
- ☐

Please continue to the next page.

LOS ANGELES COUNTY
COMMISSION ON HIV

These questions focus on services you received or may have needed during the past 12 months. Select the appropriate response for each services area by putting a check mark.

Services	Yes, I received this service	I needed but DID NOT know this service existed	I needed but DID NOT access this service	I did not need this service
Medical case management to coordinate HIV-related medical care and access to other services				
Treatment adherence services (education and counseling to help you routinely take HIV/AIDS medications and follow through on HIV/AIDS treatment)				
Emergency housing assistance (one month of rental or utility assistance)				
Short-term assistance to support temporary or transitional housing (more than one-month assistance but less than two years)				
Long-term assistance to support housing (more than two years)				
Emergency financial assistance to help pay for utilities (examples: gas, electric, water, phone)				
Emergency financial assistance to pay for rent				
Emergency financial assistance to help pay for food/groceries				
Assistance obtaining and paying for HIV medications				
Financial assistance to maintain continuity of health insurance or medical and pharmacy benefits				
Transportation assistance to health care services				
Food/groceries from a food pantry				
Home-delivered meals				
On-site meals in a community setting				
Mental health services (psychological or psychiatric treatment and counseling services) provided by a licensed professional in an individual or group setting				

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COMMISSION ON HIV

These questions focus on services you received or may have needed during the past 12 months. Select the appropriate response for each services area by putting a check mark.

Services	Yes, I received this service	I needed but DID NOT know this service existed	I needed but DID NOT access this service	I did not need this service
Emotional support group for people with HIV				
Help getting enrolled in health insurance				
PrEP (pre-exposure prophylaxis), PEP (post-exposure prophylaxis), or Doxy-PEP (doxycycline post-exposure prophylaxis)				
A medical visit for HIV-related medical care				
Counseling or information related to returning to or leaving the work force, health insurance and disability benefits, and public assistance programs				
Assistance in finding the health insurance option or benefit package that best suits my needs				
Oral health from a dentist, hygienist, or assistant				
Education or counseling about HIV transmission and how to reduce the risk of transmission				
Treatment counseling from non-medical personnel outside of a medical case management and/or clinical setting				
Outpatient substance abuse treatment or counseling				
Inpatient (residential) substance abuse treatment or counseling				
Home and community-based health care services including home health aide services and/or attendant care services				
Home health care services by a licensed health care worker (examples: nurse, home health care worker)				
Information or referrals for HIV services via telephone, online, or printed materials				
Nutritional counseling provided by a dietitian				

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COMMISSION ON HIV

HIV Provider Discussion Prompts

This listening session is intended to collect important information regarding unmet HIV/STD prevention and care needs, to help people from acquiring HIV, to assess people's satisfaction with services and to improve and make services more available to the public. We appreciate your willingness to participate. We value your input and want you to share your honest and open thoughts so that we can identify ways on how we can improve HIV services in Los Angeles County.

There are a few guidelines and rules to help facilitate today's discussion:

- We want you to do the talking. We encourage everyone to participate.
- There are no right or wrong answers. Every person's experience and opinion are important. Speak up whether you agree or disagree. We expect and want to hear a wide range of opinions and we do not anticipate consensus, just sharing.
- We emphasize that what is said in this room should remain here. Please don't' disparage another participant's remarks. Be sure to allow one speaker at a time.
- We will record this session as we want to capture everything that is said. We won't identify anyone by name in our findings - you will remain anonymous.
- The discussion will last for about one hour. Please silence your mobile phones and give everyone the chance to express his/her opinion during the conversation. You can address each other if you like. We are only here to assist in the discussion.

Facilitation Questions - HIV Workforce

1. What encourages you to work in this field?
2. What do you think is important in helping people prevent HIV and STDs? What kind of supports and services do people need to help prevent HIV and STDs?
3. What are trends in the risk activities, behaviors or conditions for HIV/STD acquisition and transmission that you are seeing in the community?
4. What services do clients utilize the most? What services are critical for addressing the needs of these clients and why? How do you retain clients in care?
5. What are common concerns that clients diagnosed with HIV have about services? Examples include appointment times, insurance coverage, paperwork, LGBTQ+ sensitivity, stigma, etc.
6. What services do high-risk HIV negative clients utilize the most? How do you retain clients in care?
7. What services do your clients (clients diagnosed with HIV and high-risk HIV negative) need but are unable to access? What are the reasons they can't access them? (Can be ineligibility, paper

burden, lack of timely follow through, substance use disorder, mental health needs, etc.) What can be done to help address the barriers?

8. How do you engage clients? How do they receive information about you? How do you promote your services?
9. Please describe the training you have received for your job. What tools and resources do you have to do your job? Describe any supports that help you maintain and improve your knowledge and skills.
10. What are the barriers that prevent you from providing care and supportive services to clients? Examples include billing/lack of reimbursement for services, administrative obstacles, staffing (not enough or lack of knowledge), siloed funding, legal challenges, etc. What changes can be made to help address these barriers?
11. What works at your agency? What are some effective practices or policies can be recommended to other agencies or care systems?
12. What does your agency do to support the health and well-being of staff to minimize staff burnout?
13. Is there anything else that you would like to share that wasn't discussed?

Non-HIV specific clinics

1. How comfortable are you taking a sexual history and providing sexual health counseling? Who do you provide sexual health counseling to?
2. How comfortable are you talking to patients about HIV and STI screening and answering their questions? What keeps you from feeling more comfortable discussing HIV screening with patients?
3. In the context of all the care you provide to your patients, how big a priority is HIV/STI screening? What are barriers to offering routine HIV/STI testing to your patients?
4. What would you do if you received a patient at your clinic today with a new HIV diagnosis? What does your organization do to link people who test positive for an HIV or STI? (How prepared are your providers to care for and treat a patient living with HIV? Does your organization offer treatment services or do they refer the patient elsewhere? What issues would need to be addressed?)
5. Are there any barriers within your organization that prevent you from providing care to patients diagnosed with HIV?

HIV Provider Demographic Questionnaire

This questionnaire is intended to collect important information on the general demographic characteristics of participants in the HIV workforce listening sessions. Your responses are very important and are completely anonymous. Your answers will never be associated with you. This survey will take approximately 10 minutes to answer.

1. How old are you?
   - ☐ Under 18 years
   - ☐ 19-24 years
   - ☐ 25-29 years
   - ☐ 30-39 years
   - ☐ 40-49 years
   - ☐ 50-59 years
   - ☐ 60 years and older

2. What is your gender?
   - ☐ Male
   - ☐ Female
   - ☐ Other: _____
   - ☐ Transgender: male to female
   - ☐ Transgender: female to male

3. Race/Ethnicity (check all that apply)
   - ☐ African American
   - ☐ American Indian/Alaska Native
   - ☐ Asian
   - ☐ Pacific Islander
   - ☐ Latinx/Hispanic
   - ☐ White (non-Hispanic)
   - ☐ Other: _____
   - ☐ Decline to state

4. Gender Identity
   - ☐ Heterosexual/Straight
   - ☐ Gay, lesbian, same gender loving
   - ☐ Bisexual
   - ☐ Genderqueer/Gender non-conforming
   - ☐ Other: _____
   - ☐ Decline to state

5. Sexual Identity
   - ☐ Heterosexual/Straight
   - ☐ Gay, lesbian, same gender loving
   - ☐ Bisexual
   - ☐ Pansexual
   - ☐ Other: _____
   - ☐ Decline to state

6. What is your highest level of education?
   - ☐ Less than high school
   - ☐ Some high school
   - ☐ High school diploma/GED
   - ☐ Some college, but no degree
   - ☐ Vocational/Technical school diploma
   - ☐ Associates degree (e.g., AA, AS)
   - ☐ Bachelor's degree (e.g., BA, BS)
   - ☐ Advanced degree (Masters or higher)

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7. What is your primary profession or role?
   - ☐ Case Manager
   - ☐ Manager/Administrator
   - ☐ Front Desk Clerk/ Receptionist
   - ☐ HIV Testing Counselor
   - ☐ Infectious Disease board-certified physician
   - ☐ Other _____
   - ☐ Outreach Worker
   - ☐ Nurse Practitioner
   - ☐ Health Educator
   - ☐ Supervisor
   - ☐ Other board-certified physician

8. How many years of experience do you have working in the HIV/STI field?
   - ☐ Less than 2 years
   - ☐ 2 to 5 years
   - ☐ 5 to 10 years
   - ☐ 10 to 15 years
   - ☐ 15 to 20 years
   - ☐ 20 to 25 years
   - ☐ Over 25 years

9. What is your role in routine HIV/STI testing? (Check all that apply)
   - ☐ Management or administrative role in routine HIV/STI testing
   - ☐ Supervise staff conducting HIV/STI testing
   - ☐ Conduct HIV/STI testing
   - ☐ Provide health care services for patients who have received routine HIV/STI testing/screening
   - ☐ Teach other health care providers or students about routine HIV/STI testing
   - ☐ No role in routine HIV/STI testing
   - ☐ Other (Specify) _____

10. Briefly describe the general characteristics of your patient/client population. (For example, race, ethnicity, gender, age, socioeconomic status, cultural identities, etc.)

    _____
    _____
    _____
    _____

11. Type of Agency
    - ☐ Federally Qualified Health Center
    - ☐ Community-based Clinic (non-FQHC)
    - ☐ AIDS Serving Organization
    - ☐ University Hospital
    - ☐ Other Hospital
    - ☐ Other (Specify) _____

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COMMISSION ON HIV

12. What zip code(s) does your agency currently provide services?

_____

_____

_____

13. Funding Source(s)

- ☐ Part A
- ☐ Part B
- ☐ Part C
- ☐ Part D
- ☐ Other: _____
- ☐ AETC
- ☐ Part F
- ☐ Ending the HIV Epidemic (EHE)
- ☐ Non-RWP State Grants

Professional Satisfaction: Please rate the following based on your current employment.

Please circle one:					
Salary and reimbursement	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Amount of time required and available for documentation/administrative work.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Work schedule/on-call responsibilities.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Support services to assist patient/client management.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Support and coverage from other HIV service providers (care and prevention)	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Availability of specialists for consultation and referrals.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Effort required to keep up with the new medical, prevention, and scientific advances.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Support for training and professional development.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied
Support to address burnout and/or vicarious trauma.	Very satisfied	Satisfied	OK	Dissatisfied	Very dissatisfied

Please continue to the next page.

LOS ANGELES COUNTY
COMMISSION ON HIV

What type of services does your agency currently provide? Check all that apply.

Type of service	Check if agency provides service
Health insurance enrollment assistance	
PrEP (pre-exposure prophylaxis)/ PEP (post exposure prophylaxis)	
HIV prevention education (classes, workshops, etc.)	
STI prevention education (classes, workshops, etc.)	
Free condom distribution	
HIV/STD testing	
STI treatment	
Partner Services	
Social marketing, media and community mobilization	
Comprehensive prevention with HIV-positive individuals	
Evidence-based interventions for high-risk population. Please name of evidence-based intervention:	
Capacity building and technical assistance	
HIV medical care	
General oral health services (regular check-up, cleaning, root canals, braces)	
Psychiatry mental health services (diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders)	
Psychotherapy mental health services (treating mental health problems by talking with a psychiatrist, psychologist, or other mental health provider; helps you learn how to take control of your life and respond to challenging situations with healthy coping skills).	
Medical case management services	
Home and community-based services	
Medical nutrition therapy	
Non-medical case management (assistance in accessing medical, social, community, legal, financial, and other needed services)	
Medical transportation services	
Food bank/home-delivered meals	
Housing services	
Housing Opportunities for People with AIDS (HOPWA) program services	
Language services (interpretation, translation)	
Residential substance abuse treatment (Long-term residential treatment provides care 24 hours a day, generally in non-hospital settings)	
Outpatient substance abuse treatment (group counseling; treatment for patients with medical or other mental health problems in addition to their drug disorders.)	
Outreach (basic education; get people into needed services)	
Referrals for services	
Legal services	
Other: (specify):	

Overview of HIV among the AIAN population in LAC

Impact of alternative race/ethnicity classification approaches on case numbers and rates

Division of HIV and STD Programs
HIV Case Surveillance
(HCS)

Commission on HIV Meeting
August 10, 2023

Ekow Kwa Sey, PhD, MPH

Chief, HIV and STD Surveillance

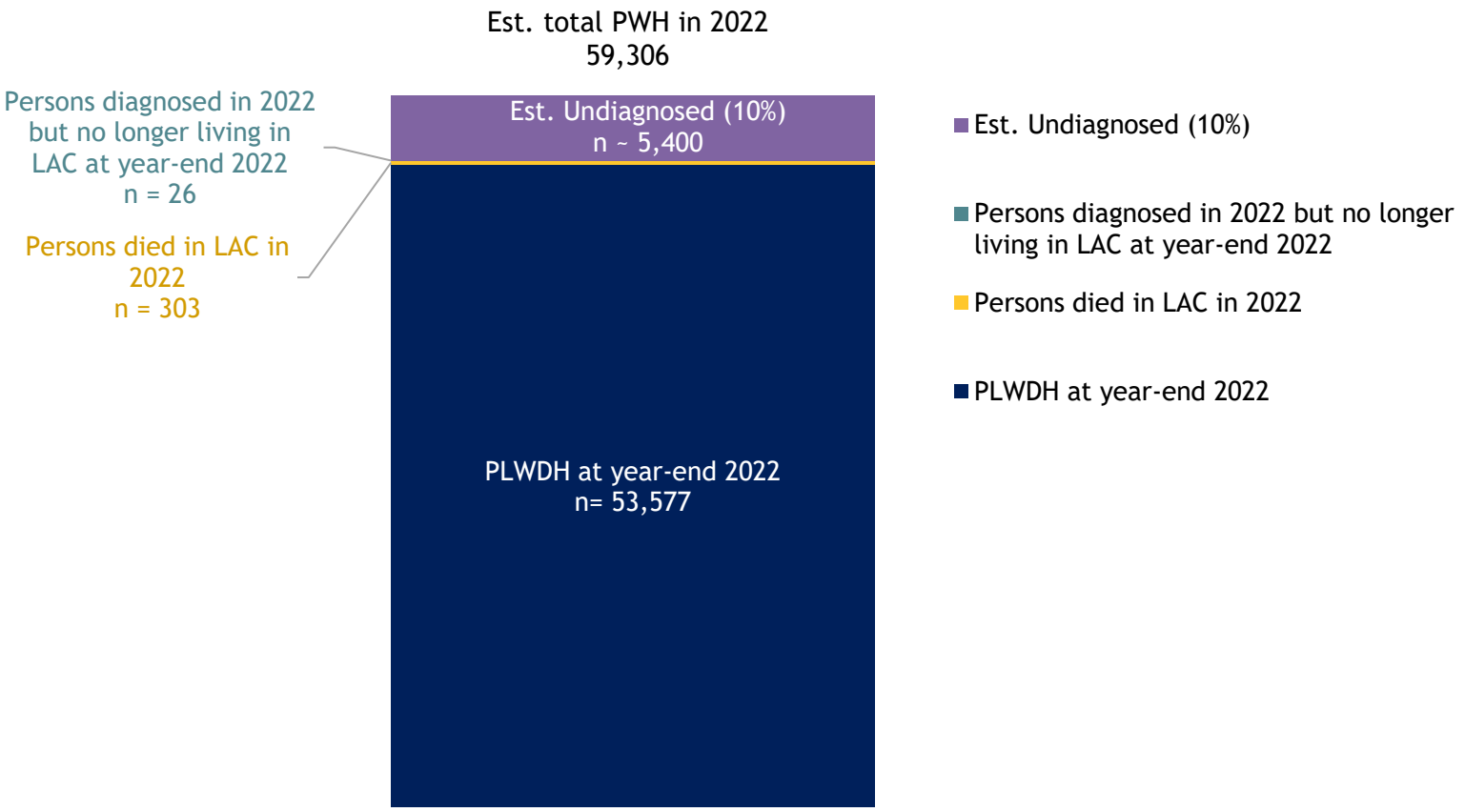
Division of HIV and STD Programs

Los Angeles County Department of Public Health

Outline

- Overview of HIV among AIAN population in LAC
- Alternative approaches to classifying AIAN
- Impact of classification approaches on resulting case counts, prevalence, and rates

Estimated Number of Persons with HIV in Los Angeles County in 2022 (13+y)



Source: HIV Surveillance data as of December 2022

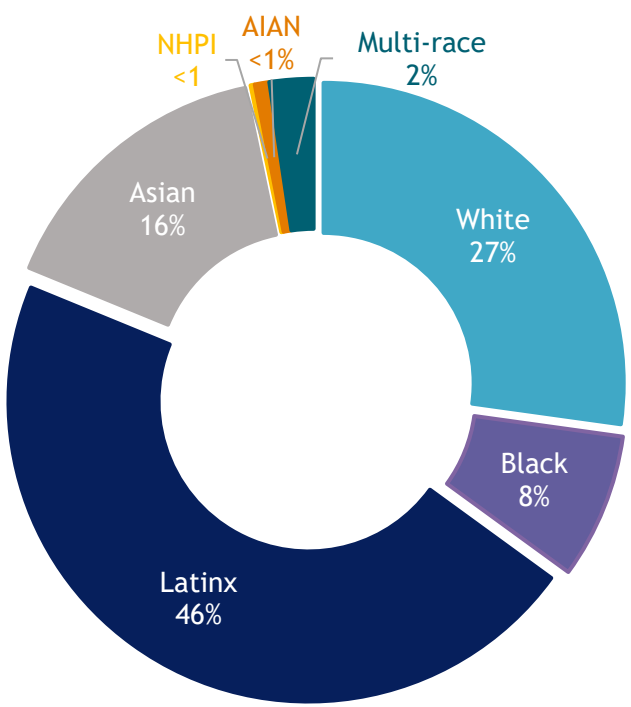
Estimated number of AIAN[1] persons with HIV in Los Angeles County in 2022 (13+y)

1.Includes non-Hispanic AIAN alone or in combination with one or more other race/s aged ≥13 years

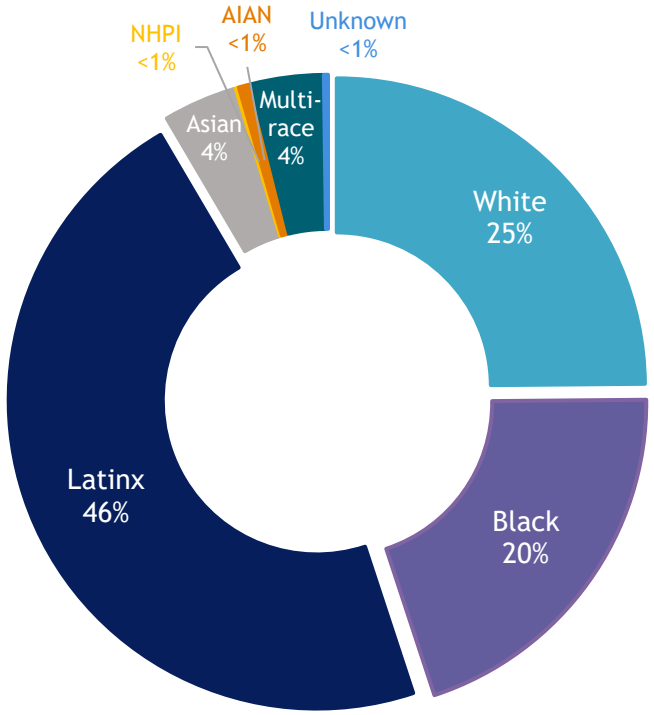
Source: HIV Surveillance data as of December 2022

LAC Population[1] Vs. PLWDH [2] by Race/Ethnicity, LAC 2022 (13+y)

Est. Population , LAC 2021
(n=8,549,321)



PWLDH, LAC 2022
(n=53,577)



Abbreviations: AIAN = non-Hispanic American Indian/Alaskan Native alone or in combination with one or more other races

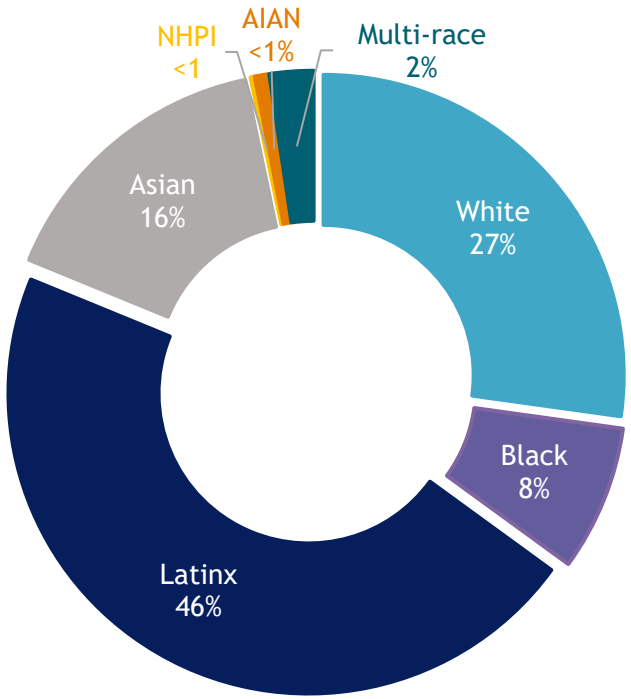
[1] Based on the 2021 adjusted population estimates produced by LAC DPH OHAE, Vital Records and Demography Unit.to account for non-Hispanic AIAN alone or in combination with one or more races, versus non-Hispanic AIAN alone.

[2] Data are provisional due to reporting delay.

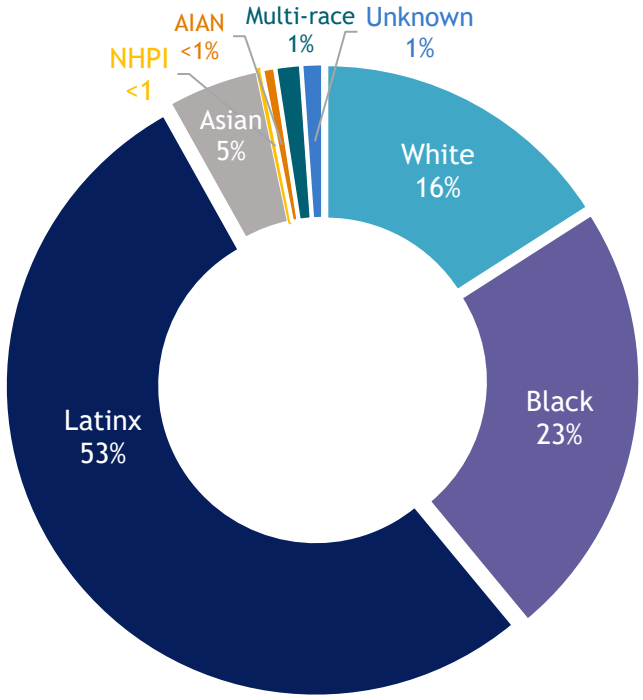
Source:
LAC DPH OHAE, Vital Records and Demography Unit
HIV Surveillance data as of December 2022

LAC Population[1] Vs. New HIV Diagnoses[2] by Race/Ethnicity, LAC 2021 (13+y)

Est. Population , LAC 2021
(n=8,549,321)



HIV Diagnoses, LAC 2021
(n=1,518)



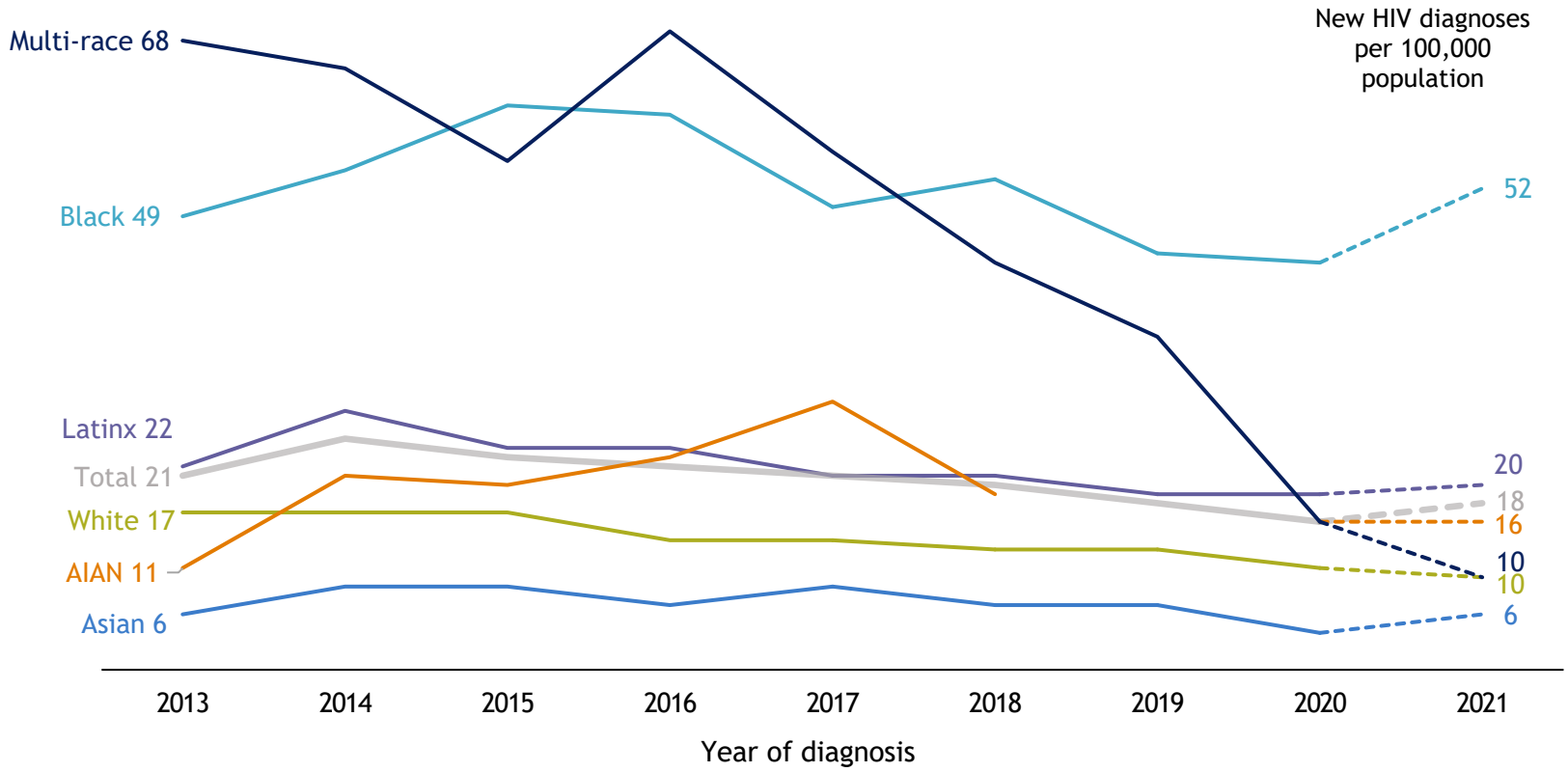
Abbreviations: AIAN = non-Hispanic American Indian/Alaskan Native alone or in combination with one or more other races

[1] Based on the 2021 adjusted population estimates produced by LAC DPH OHAE, Vital Records and Demography Unit.to account for non-Hispanic AIAN alone or in combination with one or more races, versus non-Hispanic AIAN alone.

[2] Data are provisional due to reporting delay.

Source:
LAC DPH OHAE, Vital Records and Demography Unit
HIV Surveillance data as of December 2022

HIV diagnoses rates by race/ethnicity among persons aged ≥ 13 years, LAC 2013-2021[1]

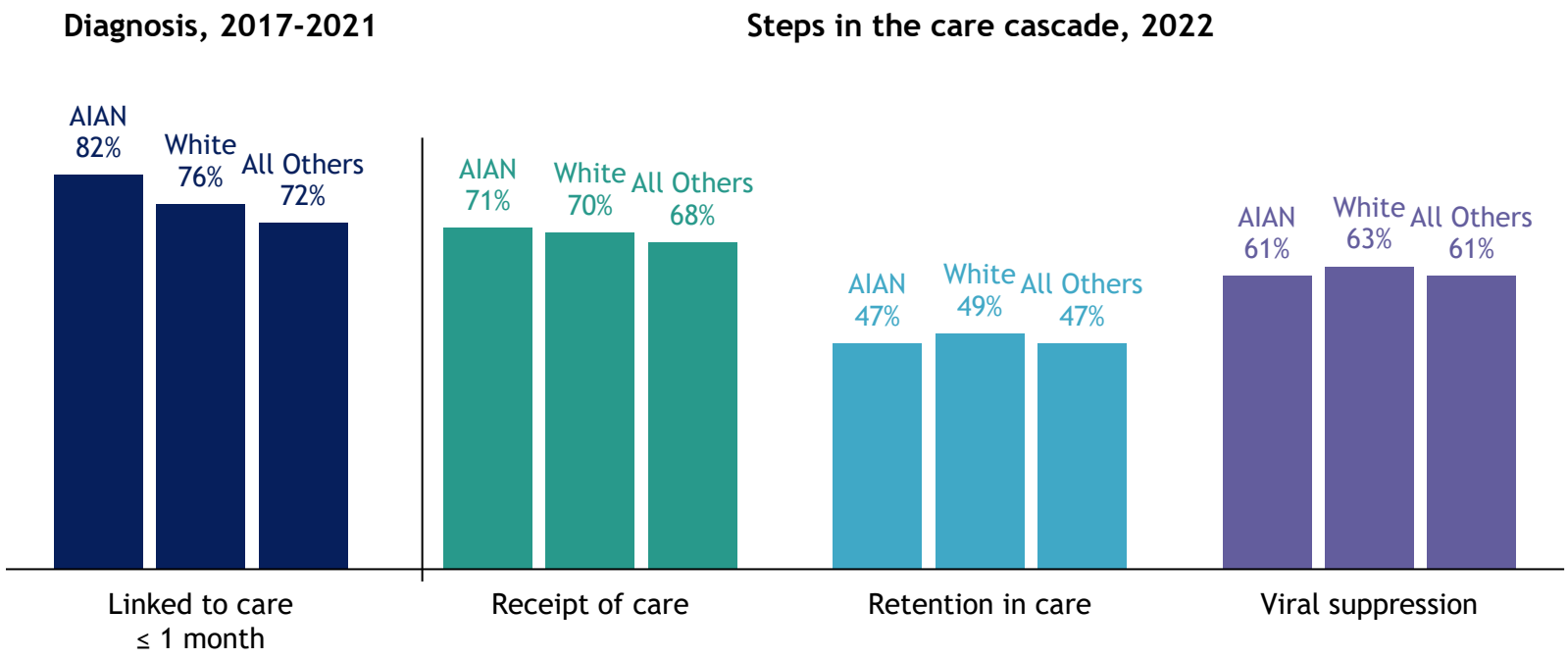


AIAN = non-Hispanic American Indian/Alaskan Native alone or in combination with one or more other races

[1]Based on the 2021 adjusted population estimates produced by LAC DPH OHAE, Vital Records and Demography Unit. Data for 2021 are provisional due to reporting delay., AIAN rare for 2019 is not shown due to small numbers (n<5)

Source:
LAC DPH OHAE, Vital Records and Demography Unit
HIV Surveillance data as of December 2022

Comparison of HIV care continuum[1] among persons aged ≥ 13 years, LAC 2017-2021 and 2022[2]



[1] The HIV care continuum includes the following steps in the care cascade: 1) the percentage of persons receiving a diagnosis of HIV in given calendar years who were linked to HIV care within 1 month of diagnosis (defined as ≥ 1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis) ; and the percentage of all persons living with diagnosed HIV who (1) received HIV care (defined as ≥ 1 CD4/VL/Genotype test per year, (2) were retained in HIV care (defined as ≥ 2 CD4/VL/Genotype tests at least three months apart, per year), and (3) were virally suppressed (defined using most recent viral load, per year). PLWDH without a VL test in the measurement year were categorized as having unsuppressed viral load.

[2] The HIV care continuum denominator includes persons diagnosed in 2017-2021 to calculate linkage to care ≤ 1 month of diagnosis, and all PLWDH diagnosed through 2021 and living in LAC at year-end 2022 to calculate receipt of care, retention in care, and viral suppression.

AIAN = non-Hispanic American Indian/Alaska Native alone or in combination with one or more other races.

Source: HIV Surveillance data as of December 2022

Alternative Approaches to Classifying AIAN Race

- A 2007 comparison between the HIV and AIDS Reporting System (HARS) and the National Patient Information and Reporting System (NPIRS) of the National Indian Health Service, estimated that American Indian/Alaska Natives (AIAN) living with HIV were undercounted by >50%.

- Since 2010, for HIV surveillance summary reports in LAC, DHSP has classified any non-Hispanic/non-Latinx person who mentions AIAN in response to the question "What is your race/ethnicity" as AIAN.

- By contrast, CDC's current approach is to classify persons who mention AIAN only in response to the question "What is your race/ethnicity" into the AIAN category. Those who mention more than one racial/ethnic group, including AIAN, are classified as 'Multi-racial".

County of Los Angeles
Confidential Provider HIV/AIDS Adult Case Report Form

Race (check all that apply): ☐ White ☐ Black

☐ American Indian/Alaskan Native

☐ Asian

- ☐ Chinese
- ☐ Japanese
- ☐ Filipino
- ☐ Korean
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Laotian
- ☐ Cambodian

☐ Pacific Islander

- ☐ Hawaiian
- ☐ Guamanian
- ☐ Samoan

☐ Other *(specify)*: _____

Ethnicity:

☐ Hispanic/Latinx

☐ Not Hispanic/Non-Latinx

☐ Unknown

Expanded Race/Ethnicity:

Source:HIV-AIDS-AdultCaseReportFormRev-8.2020_website.pdf (lacounty.gov)
Revised 08/25/2020

Alternative Approaches to Classifying AI/AN Race

- **Only-mention of AI/AN:** In CDC's report, AI/AN is defined for persons with AI/AN race alone. AI/AN persons reported with other race(s) are grouped into the "Multi-racial" category.
- **Any-mention of AI/AN with the exception of Hispanic/Latinx:** Persons with any mention of AI/AN tribe or race are classified as AI/AN. All persons with Hispanic/Latinx ethnicity are grouped into a separate group (Latinx), regardless of the racial information. Current approach for LAC HIV surveillance summary reports and presentations.
- **Any-mention of AI/AN including Hispanic/Latinx:** Persons with any mention of AI/AN tribe or race are classified as AI/AN

HIV Among AIAN in LAC

Comparing Rates for American Indian/Alaska Natives in LAC, ≥ 13 years of age

	AIAN alone, NH (CDC)		AIAN any Mention, NH (excluding Latinx, see LAC reports)		AIAN all inclusive including Latinx	
	N	Rate	N	Rate	N	Rate
Population Size	16,976	n/a	61,129	n/a	230,013	n/a
2021 New Diagnoses	6	34/100,000	10	16/100,000	15	7/100,000
2022 PLWDH*	69	396/100,000	316	517/100,000	643	280/100,000

Conclusion

- Although AIAN account for less than 1% of LAC HIV cases, with diagnosis rates* second only to Black and Latinx, AIAN represent an important population for targeted HIV interventions.
- A more inclusive approach to categorizing persons as AIAN may result in an increase in number of LAC HIV cases who are classified as AIAN HIV, but any such increase may be accompanied by a much larger increase in the number of LAC residents who are classified as AIAN.
- Consequently, a more inclusive approach to categorizing persons as AIAN is likely to result in decreases in the rates

1.2021 HIV diagnosis rates

Questions and Discussion

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Division of HIV and STD Programs
HIV Case Surveillance
(HCS)