LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Virtual Meeting

Tuesday, March 16, 2021

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

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

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https://tinyurl.com/4ke8yrwe
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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

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

To Join by Computer: https://tinyurl.com/4ke8yrwe
**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001
Access code: 145 084 2213

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

AGENDA POSTED March 12, 2021

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

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

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

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

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting

agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.
If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

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

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

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

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

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

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

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

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

IV. REPORTS 1:10 P.M. – 1:30 P.M.

5. **EXECUTIVE DIRECTOR'S/STAFF REPORT**

6. **CO-CHAIR REPORT** 1:30 P.M. – 2:20 P.M.

a. Priority Setting and Resource Allocation (PSRA) Training Decision Making Process
b. "So, You Want to Talk about Race" by I. Oluo Reading Activity"
   - Excerpt selected by Co-Chairs from Chapter 1.

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

a. Fiscal Update
b. Contracts and Procurement Update

8. PREVENTION PLANNING WORKGROUP 2:30 P.M. – 2:35 P.M.

a. Update

V. DISCUSSION 2:35 P.M. – 2:55 P.M.

a. Taskforce and Caucus Recommendations and Planning

VI. NEXT STEPS 2:55 P.M. – 2:58 P.M.

a. Task/Assignments Recap
b. Agenda Development for the Next Meeting
    i. Multi-Year Planning Review (PY 31 & 32)

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

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

VIII. ADJOURNMENT 3:00 P.M.

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

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/4/21

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CATALDO	**Raquel**	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Home-Based
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Mental Health
			Substance Abuse, Transitional Housing (meth)
			Transitional Case Management-Jails
			Transportation Services
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng 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
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
JOHNSON	**Diamante**	Unaffiliated consumer	No Ryan White or prevention contracts
KAMURIGI	**Nestor**	No Affiliation	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

Priority Setting and Resource Allocations Process Summary (A.K.A. "What do you all do with that money?)

LOS ANGELES COUNTY
COMMISSION ON HIV

Created 10/1/20

Revised 03/16/21

Acronyms

- DHSP – Division of HIV and STD Programs
- PSRA – priority setting and resource allocation
- HRSA – Health Resources Services Administration
- RW- Ryan White
- PY- Program Year
- FY- Fiscal Year
- NCC- Net County Cost (Los Angeles County funds; non grants)
- MAI- Minority AIDS Initiative
- COH – Commission on HIV
- PLWHA- people living with HIV/AIDS

Order of Decision-Making

1 Rank Service Categories

2 Allocate Funds by Service Categories

3 Develop Instructions to DHSP (Directives)

4 Reallocation

Ranking DOES NOT equal Level of Allocation by Percentage

Directives are informed by COH Committees, Caucuses, Task Forces, data, PLWH and provider input.

Steps in the Priority Setting and Resource Allocations Process

1

- Review core medical and support service categories, including HRSA service definitions

2

- Review data/information from DHSP

3

- Agree on how decisions will be made; what values will be used to drive decisions.

Steps in the Priority Setting and Resource Allocations Process

4

- Rank services by priority

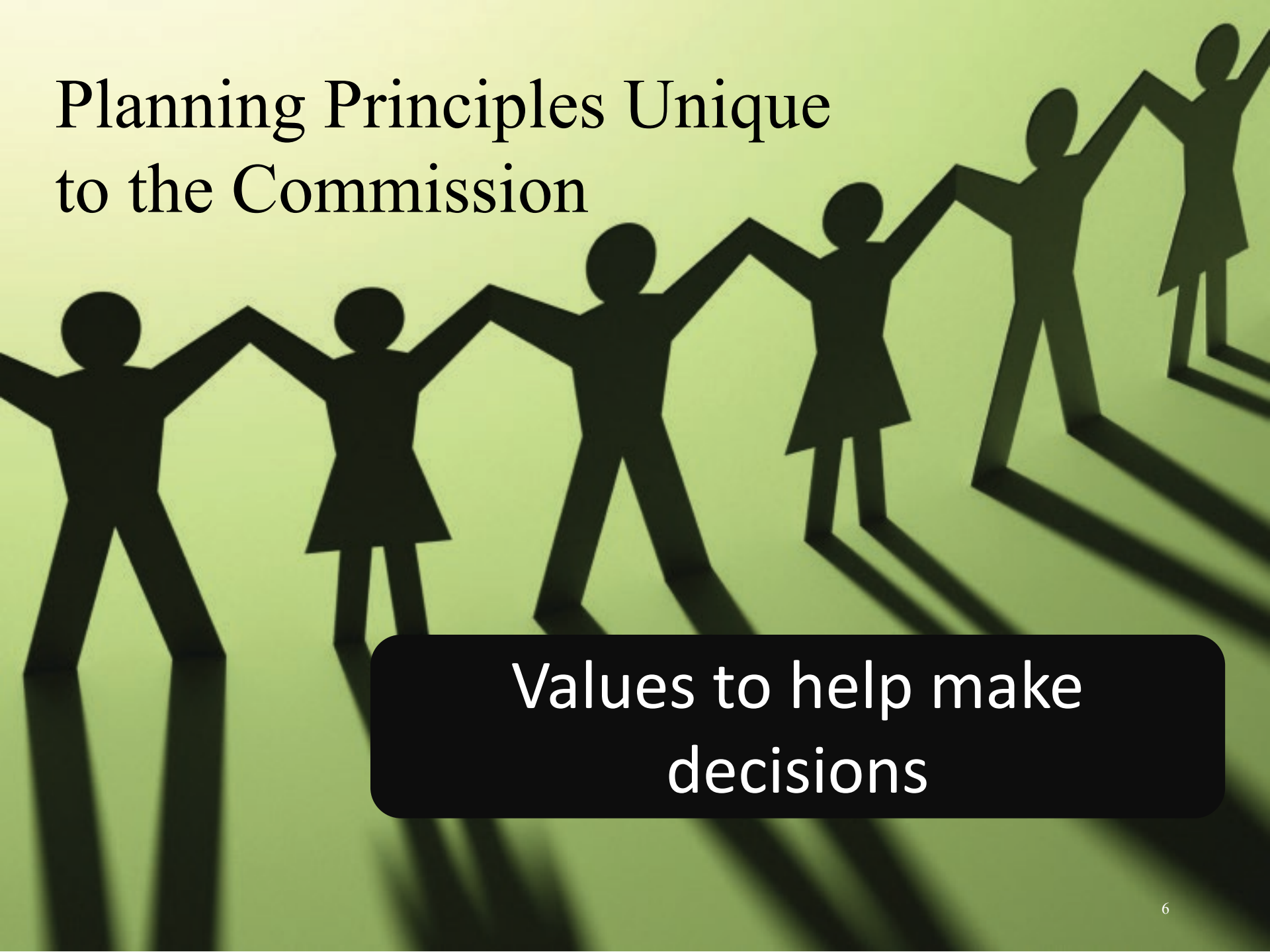
5

- Allocate funding resources to services by percentage

6

- Provide instructions to DHSP on how to best meet the priorities (Directives)

Planning Principles Unique to the Commission



Values to help make decisions

Main Values for Decision-Making

- Compassion: response to suffering of others that motivates a desire to help

- Equity: The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. (1)

Footnote:
(1) the World Health Organization's (WHO) definition of equity.

Operating Values

- Efficiency: accomplishing the desired operational outcomes with the least use of resources
- Quality: the highest level of competence in the decision-making process
- Advocacy: addressing the asymmetrical power relationships of stakeholders in the process
- Representation: ensuring that all relevant stake-holders/constituencies are adequately represented in the decision-making process
- Humility: Acknowledging that we do not know everything and being open to learning and listening carefully to others.

Expense Report—Example from Program Year 29

	Service Category	YR 29 (2019) Allocations		YR 29 (2019) Final Expenditures				2020 Allocations		
		Part A	MAI	Part A	MAI	Part B	HIV NCC	CDC EHE	HRSA CARES	HRSA 078
CORE SERVICES	Outpatient/Ambulatory Outpatient (AOM)	$ 9,810,822	$ -	$ 9,633,451	$ -	$ -	$ -	$ -	$ -	$ -
	Oral Health	$ 6,300,000	$ -	$ 5,821,872	$ -	$ -	$ 1,719	$ -	$ 15,000	$ 120,000
	Early Intervention Services (EIS)	$ 500,000	$ -	$ 1,088,738	$ -	$ -	$ -	$ -	$ -	$ -
	Mental Health	$ 300,000	$ -	$ 297,720	$ -	$ -	$ -	$ -	$ -	$ -
	Home and Community Based Health Services	$ 2,390,352	$ -	$ 2,581,793	$ -	$ -	$ -	$ -	$ -	$ -
	Medical Nutritional Therapy	$ 21,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Medical Case Management/ Medical Care Coordination (MCC)	$ 10,569,206	$ -	$ 8,888,809	$ 2,042,205	$ -	$ 230,131	$ -	$ -	$ -
SUPPORT SERVICES	Non-medical Case Management	$ 1,753,458	$ 752,024	$ 1,564,020	$ 830,408	$ -	$ 4,819	$ -	$ -	$ -
	Nutritional Support and Home Delivered Meals	$ 1,299,557	$ -	$ 2,117,073	$ -	$ -	$ -	$ -	$ 130,000	$ -
	Housing	$ 500,000	$ 1,455,000	$ 1,042,161	$ 2,238,934	$ 3,714,800	$ -	$ -	$ -	$ -
	Legal Services	$ 137,436	$ -	$ 115,567	$ -		$ -	$ -	$ -	$ -
	Linguistic Services	$ 17,976	$ -	$ -	$ -		$ -	$ -	$ -	$ -
	Medical Transportation	$ 1,148,938	$ -	$ 643,950	$ -		$ -	$ -	$ -	$ -
	Emergency Financial Assistance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,500,000
	Substance Use Residential Transitional	$ -	$ -	$ -	$ -	$ 785,200	$ -	$ -	$ -	$ -
	Outreach	$ -	$ 1,000,000	$ 1,193,902	$ -	$ -	$ -	$ -	$ -	$ -
OTHER SERVICES	Electronic Panel Management Tool						$ -	$ 200,000	$ -	$ -
	Community Mobilization						$ -	$ 1,000,000	$ -	$ -
	Community Engagement (COH)						$ -	$ 250,000	$ -	$ -
	Social Marketing/Media						$ -	$ 274,592	$ -	$ -
	DHSP Staff to implement Pillar 1 and 3 EHE Activities						$ -	$ 700,000	$ -	$ -
	Home Test Kits						$ -	$ 600,000	$ -	$ -
	PPE (for consumers)						$ -	$ -	$ 735,000	$ -
	DHSP Staff to implement Pillar 2 EHE Activities						$ -	$ -	$ -	$ 200,000
	Street Medicine Program						$ -	$ -	$ -	$ 825,427
	Re-engagement Incentives ($50 Gift Cards)						$ -	$ -	$ -	$ 250,000
	Vulnerable Populations						$ 1,982,735	$ -	$ -	$ -
	Heath Education/Risk Reduction						$ 721,690	$ -	$ -	$ -
	Biomedical HIV Prevention						$ 1,000,620	$ -	$ -	$ -
	HIV Testing Services						$ 1,311,523	$ -	$ -	$ -
	STD Services						$ 11,775	$ -	$ -	$ -
	NCC 2nd District/UUT						$ 532,555	$ -	$ -	$ -
	Other						$ 6,070	$ -	$ -	$ -
	Direct Services Total	$ 34,748,745	$ 3,207,024	$ 34,989,056	$ 5,111,547	$ 4,500,000	$ 5,803,637	$ 3,024,592	$ 880,000	$ 2,775,427
	DHSP Direct Services, CQM, Planning, Evaluation and Administration			$ 5,416,463	$ 356,336	$ 500,000	$ 12,398,621	$ 336,066	$ 120,000	$ 308,381
	Total			$ 40,405,519	$ 5,467,883	$ 5,000,000	$ 18,202,258	$ 3,360,658	$ 1,000,000	$ 3,083,808

Actual dollar amounts are shown in expense reports once the program year has ended. In this case, program year 29 ended on Feb. 28, 2020. Ryan White Program Year is March 1 through February.

Multi-Year Service Ranking- Example

Planning, Priorities and Allocations Committee
Service Category Rankings PY 30, 31, 32
Approved 9/10/20

Approved PY 30	PY 31	PY 32	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1	2	2	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
			Medical Subspecialty Services		
			Therapeutic Monitoring Program		
2	1	1	Housing	S	Housing
			Permanent Support Housing		
			Transitional Housing		
			Emergency Shelters		
			Transitional Residential Care Facilities (TRCF)		
			Residential Care Facilities for the Chronically Ill (RCFCI)		
3	7	7	Mental Health Services	C	Mental Health Services
			MH, Psychiatry		
			MH, Psychotherapy		
4	6	6	Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
5	10	10	Outreach Services	S	Outreach Services

Multi-Year Allocations Table – Example

	RW Service Allocation Descriptions	FY 2020 PY 30		FY 2021 PY 31		FY 2022 (PY 32)
PY 30 Priority #	Service Category	Part A %	MAI %	Part A %	MAI %	Total Part A/MAI %
1	Outpatient/Ambulatory Health Services (AOM)	27.24%	0.00%	27.21%	0.00%	28.30%
NP	AIDS Drug Assistance Program (ADAP) Treatments	0.0%	0.00%	0.00%	0.00%	0.00%
26	AIDS Pharmaceutical Assistance (local)	0.00%	0.00%	0.00%	0.00%	0.00%
11	Oral Health	14.10%	0.00%	13.04%	0.00%	12.00%
7	Early Intervention Services	0.59%	0.00%	0.59%	0.00%	1.25%
20	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	0.00%	0.00%	0.00%
17	Home Health Care	0.00%	0.00%	0.00%	0.00%	0.00%
16	Home and Community Based Health Services	6.67%	0.00%	6.70%	0.00%	5.91%
27	Hospice Services	0.00%	0.00%	0.00%	0.00%	0.00%

Percentages are used during a current Program Year (in this case PY 30) because the full funding amount is not yet known and/or the year has not closed. Similarly, future funding for years 21 and 22 are not yet known, that is why only percentages are used.

Multi-Year Allocations Table – Example (continued)

8	Emergency Financial Assistance		0.00%	0.00%	0.00%	2.50%
13	Food Bank/Home-delivered Meals	5.95%	0.00%	5.94%	0.00%	5.27%
6	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%	0.00%
2	Housing Services RCFCI/TRCF/Rental Subsidies with CM	1.42%	93.86%	1.56%	89.47%	5.00%
21	Legal Services	0.16%	0.00%	0.16%	0.00%	1.00%
22	Linguistic Services	0.00%	0.00%	0.00%	0.00%	0.00%
9	Medical Transportation	1.89%	0.00%	1.89%	0.00%	1.52%
5	Outreach Services (LRP)	5.57%	0.00%	5.56%	0.00%	0.00%
12	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%	2.00%
19	Referral	0.00%	0.00%	0.00%	0.00%	0.00%
24	Rehabilitation	0.00%	0.00%	0.00%	0.00%	0.00%
25	Respite Care	0.00%	0.00%	0.00%	0.00%	0.00%
15	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%	0.00%
	Overall Total	**100.0%**	**100.00%**	**100.0%**	**100.0%**	**100.00%**

Percentages are used during a current Program Year (in this case PY 30) because the full funding amount is not yet known and/or the year has not closed. Similarly, future funding for years 21 and 22 are not yet known, that is why only percentages are used.

LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
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HIV PREVENTION PLANNING WORKGROUP
Virtual Meeting

Make A Difference in Your Community. Join Us to End HIV!

Agenda and prevention resources can be found at the following link
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

Monday, March 22, 2021
5:30PM-7:00PM (PST)

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://tinyurl.com/4blt5uxc

JOIN VIA WEBEX ON YOUR PHONE:
1-415-655-0001 US Toll
Access code: 145 514 2959

*Link is for members of the public only. Commission members, please contact staff for specific log-in information if not already received.

Help prevent the spread of STDs and HIV. Let your voice be heard.

Your Input will inform the planning of prevention services in your community.

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PREVENTION PLANNING WORKGROUP
Virtual Meeting Agenda

Monday, March 22, 2021 @ 5:30 – 7:00pm

To Register + Join by Computer: https://tinyurl.com/4blt5uxc
To Join by Phone: +1-415-655-0001 | Access code: 145 514 2959

1. Welcome and Introductions	5:30pm – 5:40pm
2. Executive Director Comments	5:40pm – 5:50pm
3. Ending the HIV Epidemic Plan Overview	5:50pm – 6:05pm
4. Overview of Planning, Priorities and Allocations Committee Prevention Planning Activities	6:05pm – 6:15pm
5. Division of HIV and STD Programs (DHSP) Prevention Programs Overview	6:15pm – 6:45pm
6. Meeting Recap and Agenda Development for Next Meeting Case Study: Using Data to Assess Prevention Opportunities (Oasis Clinic)	6:45pm – 6:58pm
7. Public Comment + Announcements	6:58pm – 7:00pm
8. Adjournment	7:00pm

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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

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

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

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

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

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

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

Black/African American Trans Women:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

Endnotes

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

Women's Caucus-Key Highlights and Ideas for Directives

Top services identified by MCA and UCLA Clients: 1) family housing; 2) transportation; 3) benefits specialty; 4) mental health and substance use services

Directives ideas:

1. Augment contracts to add childcare and transportation to facilitate consistent engagement in care; this strategy would avoid releasing a stand alone RFP for childcare and transportation; service providers should be given the flexibility to provide these services to all female or (or male clients with children) and get reimbursed for the services; could be a budget line item.

2. Fund more family housing for women and men with children.

3. Expand flexibility to provide emergency financial support for women and families. This too could be a contract augmentation. This is a strategy to keep people housed and prevent homelessness.

4. Fund women and family focused housing specialist

5. Advertise services; create resource directories for women. Women simply do not know where to go for services; make it available in print, online, and apps.

6. Provide comprehensive care including mental health at women-friendly clinics so that they don't have to travel to another location.

7. Fee for service is a barrier for agencies—assess the impact of the fee for service structure service delivery and quality of care

8. Fund mobile teams or mobile care units to serve women. Mobile teams would be available for all agencies and can link women to services; mobile teams would go to where women are at instead of expecting them to travel to multiple sites. Study Max-Plus model from Seattle

9. Support one stop care sites for women and families.

10. Fund psychosocial services and support groups for women

11. Prevention services are typically male centric; need to create women-centered prevention services; many do not see them as "at-risk"

12. Have DHSP assess how funded agencies are addressing the needs of women; offer training for those requiring support and coaching.

13. Require that all contracted agencies create community advisory boards with women and/or give them meaningful roles in quality improvement committees.

14. Embed women-centered prevention services outside of usual HIV service agencies, such as domestic violence shelters and family planning clinics.

15. DHSP work with AETC to build upon public health detailing and train providers on what women-centered services look like (specific skill sets and service outcomes)

Other issues:
Some providers do not refer clients to other agencies for fear of losing that client/revenue. Address territorialism.