LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, April 20, 2021
1:00PM-3:00PM (PST)

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, April 20, 2021|1:00 PM – 3:00 PM

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

To Join by Phone: 1-415-655-0001
Access code: 145 446 8231

Planning, Priorities and Allocations Committee Members:			
Raquel Cataldo, Co-Chair	Frankie Darling Palacios, Co-Chair	Alexander Luckie Fuller	Everardo Alvizo, LCSW
Al Ballesteros, MBA	Kevin Donnelly	Felipe Gonzalez	Joseph Green
Karl T. Halfman, MS	Damontae Hack, Alternate	William King, MD, JD (LOA*)	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD	Maribel Ulloa
Guadalupe Velasquez	DHSP Staff		
QUORUM:	9		

AGENDA POSTED April 15, 2021 * Leave of Absence

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.

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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 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**

a. Commission and Committee Updates
b. Ending the HIV Epidemic Activities

6. **CO-CHAIR REPORT** 1:30 P.M. – 1:45 P.M.

a. "So, You Want to Talk about Race" by I. Oluo Reading Activity Chapters 2 and 3

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP)** 1:45 P.M. – 2:00 P.M.

a. Fiscal Update
b. Contracts and Procurement Update

8. **PREVENTION PLANNING WORKGROUP** 2:00 P.M. – 2:20 P.M.

a. Update

9. **V. DISCUSSION** 2:20 P.M. – 2:55 P.M.

a. Paradigms and Operating Values
b. Multi-Year Allocations Review
c. DHSP Directives PY 30, 31, & 32

10. **VI. NEXT STEPS** 2:55 P.M. – 2:58 P.M.

a. Task/Assignments Recap
b. Agenda Development for the Next Meeting

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

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

12. **VIII. ADJOURNMENT** 3:00 P.M.

a . Adjournment for the Meeting of April 20, 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

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

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

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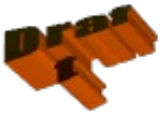
Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are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

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



February 16, 2021

PP&A MEMBERS PRESENT	PP&A MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/CONSULTANTS
Raquel Cataldo, *Co-Chair*	LaShonda Spencer, MD	Alasdair Burton	Cheryl Barrit, MPIA
Everardo Alvizo	Maribel Ulloa	Katja Nelson, MPP	Carolyn Echols-Watson, MPA
Kevin Donnelly		LCDR Jose Antonio Ortiz, MPH	Catherine Lapointe
Felipe Gonzalez	**PP&A MEMBERS ABSENT**		Jane Nachazel
Joseph Green	Frankie Darling Palacios, *Acting Co-Chair*		
Michael Green, PhD, MHSA			**DHSP/DPH STAFF**
Damontae Hack *(Alt.)*	Al Ballesteros, MBA		Jane Bowers, MPH
Karl Halfman, MS	Alexander Luckie Fuller		Pamela Ogata, MPH
William King, MD, JD	Diamante Johnson		Victor Scott
Miguel Martinez, MPH, MSW	Kayla Walker-Heltzel		Julie Tolentino, MPH
Anthony Mills, MD	Guadalupe Velasquez		Paulina Zamudio
Derek Murray			

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

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Planning, Priorities & Allocations Committee Virtual Meeting, *2/16/2021*
2) **Agenda**: Planning, Priorities & Allocations Committee Meeting Agenda, *2/16/2021*
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *12/15/2020*
4) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *1/19/2021*
5) **Table**: 2021 Work Plan – Planning, Priorities and Allocations Committee, *Draft 2/16/2021*
6) **Executive Summary**: Ending the HIV Epidemic in Los Angeles County, Executive Summary, *12/1/2020*
7) **Guidance**: COVID-19: Considerations for People with HIV, *Version 12/22/2020*

CALL TO ORDER - INTRODUCTIONS - CONFLICT OF INTEREST: Ms. Cataldo called the meeting to order at 1:02 pm. Attendees introduced themselves and identified conflicts of interest.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
MOTION 1: Approve the Agenda Order, as presented **(*Passed by Consensus*)**.

2. APPROVAL OF MEETING MINUTES
MOTION 2: Approve the 12/15/2020 and 1/19/2021 Planning, Priorities and Allocations (PP&A) Committee Meeting Minutes, as presented **(*Passed by Consensus*)**.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA

- Dr. King noted eligibility to receive COVID-19 vaccine was shifting from risk-based to age- and occupation-based criteria. He asked about vaccine eligibility and equity for PLWH.
- Ms. Barrit replied that at the 2/11/2021 Commission Meeting the Co-Chairs asked her to draft a letter to the Board of Supervisors (Board) and Department of Public Health (DPH) to elevate the priority of vaccinating PLWH. She was in the process of drafting the letter for review at the 2/25/2021 Executive Committee Meeting.
- ➲ Add state as addressee. Refer any additional feedback on the letter to Ms. Barrit.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- Ms. Barrit reminded all Commissioners that the HealthHIV survey to assess Commission effectiveness has been distributed. It is very important to garner a 100% response rate to accurately evaluate how well the Commission is doing in meeting its charge as the Los Angeles County (LAC) Planning Council (PC).
- Ms. Barrit congratulated Raquel Cataldo and Frankie Darling-Palacios on being elected Co-Chairs. She thanked them for stepping up. She thanked Al Ballesteros for serving multiple times as Co-Chair and offering his mentorship.
- February 2021 is Ms. Nachazel-Ruck's last cycle of covering meetings. Ms. Barrit thanked her for her service.

a. New Committee Members

- Ms. Barrit welcomed Unaffiliated Consumers (UCs) Damontae Hack, on an Alternate seat, and Guadalupe Velasquez.
- The Commission was working to orient all the new members to help them understand the process. She encouraged current PP&A members to help welcome them. UCs are being prioritized for placement in PP&A to ensure their voice is represented in the Priority Setting and Resource Allocations (PSRA) process.

b. Committee Updates

- Ms. Barrit noted the 2021 Paradigms and Operating Values were approved at the 2/11/2021 Commission Meeting. She congratulated PP&A for accomplishing that early in the year.
- The Commission also approved the Universal Standards of Care (SOC) presented by the Standards and Best Practices (SBP) Committee. It has been updated to address telehealth services and is posted on the Commission website.
- SBP identified the following SOCs to address in 2021: Home-Based Case Management, Benefits Specialty Services (BSS), and Substance Abuse Treatment – Residential. They will continue to work with Dr. Green and Ms. Ogata regarding any updates to the DHSP solicitation schedule that may indicate the need to review any other SOCs. Likewise, SBP will work with PP&A on any PSRA decisions that may impact the need to review other SOCs.

6. CO-CHAIR REPORT

a. Draft 2021 Committee Work Plan

- Ms. Echols-Watson noted the "Committee Responsibilities" section is drawn from the PP&A charge in the Bylaws.
- Ms. Cataldo reviewed the draft Work Plan.
- Regarding DHSP staff availability to assist in the PSRA process, Dr. Green reported no staff currently redeployed as Disaster Service Workers (DSWs) were being allowed to return to their usual duties as yet. He expected that, at minimum, major redeployment would continue through March 2021 since many staff are helping with the COVID-19 vaccination Point of Distribution (POD) sites which are already scheduled through March and may continue after that.
- DHSP will work to continue to prioritize the Utilization Report before the next term since that data is the most useful.
- The Work Plan indicates Expenditure Reports are monthly, but that is inaccurate. The last was around December 2020. The first Report on a grant term is usually not available for four or five months. That provides time to close the grant and ensure expenditures are shifted among grants to maximize each one. The next Report will most likely be in April.
- Mr. Donnelly asked about the status of the Comprehensive HIV Plan (CHP). Ms. Barrit elaborated that a great deal of work went into development of the CHP, but it was then superseded with the launch of the Los Angeles County HIV/AIDS Strategy (LACHAS). That, in turn, has been superseded by the Ending the HIV Epidemic (EHE) Plan.

- The one caveat is that the CHP has also been referred to as the "Integrated Plan" by the federal government. There has, as yet, been no guidance from the Health Resources and Services Administration (HRSA) or the Centers for Disease Control and Prevention (CDC) on whether they will request another "Integrated Plan." Until then, however, the goals and activities are similar so she recommended focusing on the current EHE Plan.
- Dr. Green commented that the CHP is no longer referenced by the federal government, but the EHE includes prevention in the pillars so it serves much the same purpose. Nevertheless, Mr. Halfman said that as a Part B provider grantee, the Office of AIDS (OA) has also asked HRSA about the "Integrated Plan" periodically and has been asked to wait for guidance. At the Ryan White Conference in August 2020, he asked Laura Cheever, MD, ScM, Associate Administrator, HIV/AIDS Bureau (HAB) if they planned to roll the "Integrated Plan" into EHE. At that time, she said no.
- ➲ Add Aging and Black African American Community (BAAC) Task Force Recommendations as standing agenda items.
- ➲ New member orientation includes PSRA review and it will also be reviewed at the start of the annual process.
- ➲ Item 6: Data Review – In consideration of the large number of DHSP redeployed as COVID-19 DSWs, ensure that data requests are coordinated with DHSP and submitted as early as possible.
- ➲ Item 12: Prevention Planning– Also incorporate into all items to underline the work towards full service integration.
- ➲ Staff will review the Work Plan to ensure descriptions are clarified per the day's discussion.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

- Ms. Nelson reported the California Department of Public Health (CDPH) issued new guidance on COVID-19 vaccination schedule Phase 1B on at risk people. HIV is not on the list, but there is a bullet on life-threatening illnesses that might apply.
- Dr. Green said, as far as he knew, it would be up to providers to look at other people if they have enough vaccine after vaccinating scheduled 1A and 1B. LAC has demonstrated it can vaccinate more people if it receives more vaccine.

a. Fiscal Update

- Dr. Green reported there will be no new information until April 2021. DHSP anticipates expending all Ryan White Part A, Part B, Minority AIDS Inititive (MAI) carryover, and a good portion of this year's MAI.
- This is a very good result for so challenging year, especially compared to other jurisdictions.

b. Contracts and Procurement Update

- Dr. Green said DHSP was in the process of extending many contracts, primarily because it lacks the staff to put together solicitation documents. Neither DHSP nor DPH Contracts and Grants has staff available due to DSW assignments.
- DHSP was asked at the 2/11/2021 Commission meeting why it might not bring on staff to help. DHSP has been told, however, that the LAC Chief Executive Office and Human Resources will only allow DHSP to hire epidemiologists and related classifications even though DHSP has vacancies and funding. DHSP cannot hire temporary workers either.
- He acknowledged that the Commission has asked if there was a way to help. That has been discussed in the office, but there was really nothing. He felt LAC should hire staff for COVID-19 so DHSP staff could return to their usual work.
- Ms. Cataldo was concerned that HIV funding was being used for COVID-19. Dr. Green said, though his staff was redeployed to COVID-19, they were being paid for out of COVID-19 funds rather than HIV funds. Ryan White Program (RWP) funding only allows for 10% administrative costs and services are expending their funding. Program managers are unavailable to assess work so DHSP is relying on monthly progress reports provided by agencies with their invoices.

c. Emergency Financial Assistance (EFA) Update: There was no more information past the 2/11/20221 Commission report.

8. PREVENTION PLANNING WORK GROUP UPDATE

- Mr. Martinez reported the next meeting will be 3/22/2021 from 5:30 to 7:00 pm. This is intentionally scheduled to facilitate voices that might not otherwise be able to attend. The agenda is being carefully drafted to ensure best use of time.
- Ms. Barrit has emailed a request to DHSP to provide: a general overview of DHSP-funded programs; prevention indicators such as on PrEP for priority populations; testing data by priority populations; and, a summary local resource inventory.
- Dr. Green said DHSP can provide the prevention portfolio. DHSP has no reliable HIV Testing System (HTS) data to present at this time. The HTS was so unreliable that it could not be repaired and was being replaced. Staff are trying to clean data so that data entered into the new system will be as accurate as possible. The new HTS was not expected to be available until August 2021. The DHSP PrEP database only shows DHSP-funded services. He was unaware of a state database, but can ask. Likewise, DHSP was only aware of resources it funds. One new CDC assignee was attempting to create a resource list.
- He noted how many topics could reasonably be explored would depend in large part on how experienced attendees are. Ms. Barrit noted the distribution list is some 15,000 so the range of experience will be broad. Dr. Green suggested, in that case, first laying the foundation of HIV prevention in LAC. He found case studies helpful, but Mr. Martinez preferred data.

- Ms. Barrit asked about PrEP update data on the CDC's EHE dashboard. Dr. Green cannot speak to the reliability of that data because he was unaware of the source, e.g., the state or pharmaceutical data.
- Dr. Green noted there were resource maps developed in 2017 as part of the preparation for LACHAS development. He noted that Substance Abuse Prevention and Control (SAPC) and Substance Abuse and Mental Health Services Administration (SAMHSA) also have much larger budgets than DHSP and likely have considerable data.
- Dr. Spencer said at OASIS they have been comparing PrEP clients and those newly diagnosed with HIV to identify criteria.
- Staff will include with the meeting notification the Executive Summary of the local EHE Plan and the CDC's recent letter with a compendium of interventions and strategies for prevention initiative.
- ➲ Dr. Spencer will share the OASIS data.
- ➲ Agreed that the first meeting should be foundational including the DHSP prevention portfolio, EHE, PrEP, and next steps.

V. NEXT STEPS

9. **TASK/ASSIGNMENTS RECAP**: There were no additional items.
10. **AGENDA DEVELOPMENT FOR NEXT MEETING**: There were no additional items.

VI. ANNOUNCEMENTS

11. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: There were no announcements.

VII. ADJOURNMENT

12. **ADJOURNMENT**: The meeting adjourned at 2:37 pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG • *VIRTUAL WEBEX MEETING*

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

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

Draft

March 16, 2021

PP&A MEMBERS PRESENT	PP&A MEMBERS PRESENT (CONTINUED)	PUBLIC	COMM STAFF/CONSULTANTS
Raquel Cataldo, *Co-Chair*	Maribel Ulloa	Katja Nelson, MPP	Cheryl Barrit, MPIA
Frankie Darling Palacios, *Co-Chair*		Victor Scott	Carolyn Echols-Watson, MPA
Everardo Alvizo, MSW, LCSW	**PP&A MEMBERS ABSENT**		Catherine Lapointe, Intern
Kevin Donnelly	Luckie Alexander		Abdul-Malik Ogunlade, Intern
Felipe Gonzalez	Al Ballesteros		
Bridget Gordon	(Alt. Damontae Hack)		
Joseph Green	Anthony Mills, MD		**DHSP/DPH STAFF**
Michael Green, PhD, MHSA	LaShonda Spencer, MD		Pamela Ogata, MPH
Karl T. Halfman, MS	Guadalupe Velasquez		
William King, MD, JD			
Miguel Martinez, MPH, MSW			
Derek Murray			

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

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Planning, Priorities & Allocations Committee Virtual Meeting,
2) **Agenda**: Planning, Priorities & Allocations Committee Meeting Agenda,
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes,
4) **List:** Commissioner Agency Category Conflicts Updated, *03/04/2021*
5) **PowerPoint**: Priority Setting and Resource Allocation (PSRA) Training, *Updated* 03*/16/2021*
6) **Flyer**: Prevention Planning Workgroup, 03*/16/2021*
7) **Document:** Black/African American Community Task Force, *Revised 10/10/2019*
8) **Document**: Women Caucus Key Highlights and Ideas for Directives

CALL TO ORDER - INTRODUCTIONS - CONFLICT OF INTEREST: Ms. Cataldo called the meeting to order at 1:00 pm.

I. ADMINISTRATIVE MATTERS

1. **APPROVAL OF AGENDA**
MOTION 1: Approve the Agenda Order, as presented **(*Passed by Consensus*)**.

2. **APPROVAL OF MEETING MINUTES**
MOTION 2: Approve the 02/16/2021 Planning, Priorities and Allocations (PP&A) Committee Meeting Minutes, as presented **(*Postponed*)**.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION:

There were no comments.

III. COMMITTEE NEW BUSINESS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA: There were no items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

Executive Director reviewed current activities of caucuses and task forces efforts.

The **Women's Caucus** hosted the director of the Positive Women's Network (PWN) on March 15, 2021. The director discussed Meaningful Involvement for People Living with HIV/AIDS (MIPA). MIPA is a form of advocacy. In addition, a panel of women living with HIV discussed their life experiences. The event was recorded and will be posted on the Commission website. Committee members were encouraged to view the recording which ways to engage people living with HIV/AIDS (PLWH/A) in meaningful and intentional advocacy.

The **Consumer Caucus** has focused its efforts on fostering leadership for people living with HIV/AIDS (PLWH/A) and supporting within the Commission, in community advisory boards (CABs) and other roles of leadership within the HIV movement. The Caucus is working with the National Minority AIDS Council (NMAC)to bring Building Leaders of Color (BLOC) training to the Commission. The training is tentatively scheduled for May 17-20th of 2021. Logistics to be clarified. The training will be expanded beyond Commission and Consumer Caucus members to the community at large. The training will be virtual. Once logistics are finalized the information will be disseminated. Committee members were encouraged to share the information throughout the community.

The Co-Chairs of the **Transgender Caucus** are working to strengthen and increase representation on the Commission. Of particular focus to the caucus is ensuring a strong partnership with the Public Policy Committee support legislation for the Transgender Wellness Fund and overall community wellness.

The **Black/African American Community (BAAC) Task Force (TF)** will meet with the Division on HIV/STD Programs (DHSP) on March 22, 2021 from 1 to 3PM. The meeting is dedicated to reviewing task force recommendations and clarifying DHSP's role and accountability in implementing the recommendations. DHSP will identify County resources associated with recommendations.

The **Aging Task Force** is monitoring DHSP's response to their recommendations presented. The TF next meeting is scheduled for April 6, 2021 from 1 to 3PM. The Task Force is reviewing models of care for PLWH who are over 50 to articulate some best practices to use within the Ryan right care system. The TF will sponsor community training on implicit bias with a focus on aging. The TF felt it important to understand the needs of the aging population. They are working with the SCAN Foundation to provide training sometime in May 2021. A flyer is forthcoming.

6. CO-CHAIR REPORT

a. Priority Setting and Resource Allocation (PSRA) Training – Decision Making Process

Co-Chair Raquel Cataldo reviewed the PSRA process using the PowerPoint included in the meeting packet, as a refresher for the committee.

- Common acronyms were reviewed.
- Program year versus fiscal year were clarified. A program year was defined as the Ryan White funding year which is March 1 to February 28 or 29th. The fiscal year was defined as the municipal government funding cycle which is from July 1 to June 30th.

- Net County Cost (NCC) was clarified. NCC was defined as County funds not designated for a specific purpose, but for general County services/use.
- The Minority AIDS Initiative (MAI) Part A funds were clarified. The funds were defined as specifically designated to target services for underserved communities of color. The Committee was concerned about reconciling underspending or rollover of MAI funds. It was thought this gives the impression that funds are not being used to address the needs of communities of color.

  DHSP addressed the use of Ryan White Part A and MAI funds and how communities of color are served through these funds. It was noted, current 2020 data is being prepared for reporting. DHSP explained RW funds are used as a payer of last resort. The uninsured and undocumented were noted as high users of RW services. DHSP provided examples of services serving communities of color. Transitional case management was identified as a program that ensures funds are serving communities of color, other services such as housing services through the (Housing for Health program) and mental health services were identified as well. DHSP noted surveillance data supports communities of color receiving services through Part A and MAI services.

  It was noted a need for nutritional services in communities of color is needed. DHSP indicated funds are targeted for those services in areas of high density which include communities of color.

  DHSP stated they are making efforts to ensure geographic distribution of services based on priority populations identified by the Commission.

  DHSP provided an example of a solicitation specifically targeting parts of the county that include vulnerable/targeted populations for comprehensive prevention services. DHSP indicated marginal success was achieved. Further, DHSP indicated they try to meet the geographic disparities and health equities in the administration of grants and services.

- Directives were clarified. Directives are intended to clarify ranking and allocation recommendations made by the Commission. They provide specifics on why recommendations were made. Directives encompass Caucus and Task Force recommendations.

- Clarification of the allocation and prioritization task included the following.
  - Allocation funding percentages by service category requires assessment of other payers for the same services. Other available funding will impact percentage recommendations. It was noted, understanding payer systems such as Medi-Cal, Medi-Care and/or Affordable Care Act (ACA) assist in the decision-making of allocation percentages. Percentages are used because funding may fluctuate.

- The ranking of services was clarified as a separate task based on consumer need.

- Clarification was provided on the frequency of reviewing Paradigms and Operating values which is done annually. It was noted, the Committee recently reviewed and approved values for the PY 33 planning process.
- The committee requested clarification on the fiscal example included in the presentation. The table included 2019 and 2020 fiscal information. The Executive Director explained the 2020 allocations were added to answer a committee request for additional funding received by LA County for the End of the HIV Epidemic (EHE) and CARES Act services.

- The Committee requested clarification on what input is used to plan and fund EHE services. DHSP identified consumers, Commission Committees, and DHSP EHE Steering Committee as resources.

It was noted, the Committee did multi-year planning (PY 30, 31 & 32). Miguel Martinez reviewed the Committee's decision to move to multiyear planning. Due to concerns with maximizing RW funds, expediting the administration of services to consumers and to address County contract procedures (contract implementation) the Committee determined multi-year planning would provide DHSP with long term service goals. The Committee will review PY 31 & 32 service and allocation plans and plan PY 33. HRSA is initiating a multiyear application model for this year's application process. Funding will continue to be allocated annually.

The Service Category Rankings PY 30, 31 & 32 Table included a "NP" in the PY30 Priority Number. NP indicates "Not Prioritized". The AIDS Drug Assistance Program (ADAP) is not prioritized by the Commission because it is a State program and is not administered by the County.

b. "So, You Want to Talk about Race" by I. Oluo Reding Activity" – Excerpt selected from Chapter I

a. Everardo Alvizo read a segment out of Chapter I of the "So You want to Talk About Race".

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

a. <u>Fiscal Update</u>

DHSP is in the process of closing out PY 30.

- DHSP will report 2020 fiscal information at the April 2021 PP&A meeting. DHSP will provide the report to the Committee prior to the April 20, 2021 meeting.

b. <u>Contracts and Procurement Update</u>

DHSP will provide the Commission with a new solicitation list. The document is to inform the Standards and Best Practices Committee on standards development or review. The document includes contract end dates for service categories, which can be useful in planning services. DHSP indicated agency information has been added to the table.

- The ED will distribute the service standards review date tracker upon receipt from DHSP.

HRSA is requesting jurisdictions develop integrated comprehensive HIV plans (CHP) due December 2022. The current CHP was a 5-year plan. It was noted the EHE Plan includes 4 pillars of prevention and treatment. DHSP has not yet received HRSA guidance.

The State echoed DHSP concerns about the CHP. HRSA and CDC are on record as stating guidance will be joint and provided by June 2021.

- Karl Halfman will provide HRSA letter received by the State regarding the integrated plan due in 2022.

8. PREVENTION PLANNING WORK GROUP UPDATE

Maribel Ulloa updated the Committee. She encouraged attendance to the Prevention Planning Workgroup (PPW) meeting schedule for Monday, March 22, 2021 from 5:30-7:00PM. The agenda for the meeting is included in the PP&A meeting packet. This meeting will provide a grounding of prevention services and prevention funding provided in Los Angeles County.

The Committee sought clarification of the workgroup purpose and reporting process. PPW reports to PP&A. PPW is meant to provide a focus on prevention services in the PSRA process. It was explained, PPW will define the specific tasks as part of their work and will work to lay a foundation for prevention planning within the planning process. In addition, DHSP will provide an overview of the EHE plan with a focus on prevention efforts.

<u>V. DISCUSSION</u>

The Committee discussed Black African American Community (BAAC) TF and Women Caucus recommendations. To clarify how the recommendations impact planning, priority setting and allocation. Further, the Committee is seeking direction on prioritizing recommendations.

Cultural sensitivity training was discussed in decision making and implementation of recommendations. The Committee had concerns about effectively measuring implemented recommendations. The Committee sought clarity on BAAC TF recommendations and future revisions. It was noted BAAC TF is reviewing recommendations and will assign recommendations to Committees, TFs, Caucuses, and workgroups as appropriate. Once completed the BAAC TF Co-Chairs will work with Committees to clarify assigned recommendations.

- Current approved Directives will be reviewed at the April 20, 2021 PP&A meeting.

- Staff will work with the BAAC TF for clarification on future recommendations anticipated from the TF. In addition, Dr. William King will take this issue back to the TF.
- Invite BAAC TF Co-chairs to the May 18, 2021 PP&A meeting.
- April 20, 2021 meeting will include a review of service categories and definitions.

10. REVIEW AND SELECT PARADIGMS AND OPERATING VALUES

VI. NEXT STEPS

11. TASK/ASSIGNMENTS RECAP: There were no additional items.

12. AGENDA DEVELOPMENT FOR NEXT MEETING: There were no additional items.

VII. ANNOUNCEMENTS

13. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: There were no announcements.

VIII. ADJOURNMENT

14. ADJOURNMENT: Meeting adjourned.

SUMMARY - RWP EXPENDITURE REPORT
As of April 8, 2021

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YEAR 30 AND PART B FY 2020 EXPENDITURES BY SERVICE CATEGORIES

1	2	3	4	5	6
SERVICE CATEGORY	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART A AND MAI	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL FULL YEAR ESTIMATED EXPENDITURES (Total Columns 2+3)	COH 2020 ALLOCATION PERCENTAGE APPLIED TO GRANT AWARD DIRECT SRVC PLUS PART B DIRECT SRVC	VARIANCE BETWEEN ALLOCATED BUDGETS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 5 - 4)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 8,226,884	$ -	$ 8,226,884	$ 9,584,184	$ 1,357,300
MEDICAL CASE MGMT (Medical Care Coordination)	$ 13,022,315	$ -	$ 13,022,315	$ 10,513,048	$ (2,509,267)
ORAL HEALTH CARE	$ 5,660,369	$ -	$ 5,660,369	$ 4,960,976	$ (699,393)
MENTAL HEALTH	$ 401,031	$ -	$ 401,031	$ 211,105	$ (189,926)
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,812,687	$ -	$ 2,812,687	$ 2,346,788	$ (465,899)
EARLY INTERVENTION SERVICES (HIV Testing Services)	$ 512,440	$ -	$ 512,440	$ 207,587	$ (304,853)
NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)	$ 1,974,172	$ -	$ 1,974,172	$ 2,291,134	$ 316,962
HOUSING (RCFCI, TRCF, and Permanent Supportive)	$ 3,109,131	$ 3,847,000	$ 6,956,131	$ 7,397,513	$ 441,382
OUTREACH (Linkage and Re-engagement Program and Partner Services)	$ 558,763	$ -	$ 558,763	$ 1,959,762	$ 1,400,999
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ 785,200	$ 785,200	$ 785,200	$ -
MEDICAL TRANSPORTATION	$ 472,750	$ -	$ 472,750	$ 664,982	$ 192,232
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 3,244,420	$ -	$ 3,244,420	$ 2,093,462	$ (1,150,958)
LEGAL	$ 170,705	$ -	$ 170,705	$ 56,295	$ (114,410)
SUB-TOTAL DIRECT SERVICES	$ 40,165,667	$ 4,632,200	$ 44,797,867	$ 43,072,036	$ (1,725,831)

ESTIMATED MAI CARRYOVER

YR 2020 Total Part A + MAI+FY 2019 MAI Carryover	$	44,625,625
YR 2020 Part A and MAI Expenditures	$	45,350,574
	$	**(724,949)**

* Please note, figures in parentheses indicate expenditures exceed allocations

RYAN WHITE PART A SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
SUMMARY REPORT
GRANT YEAR 30 RYAN WHITE PART A FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of April 8, 2021 and invoicing up to January 2021)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART A COH ALLOCATIONS	PART A TOTAL YTD EXPENDITURES	PART A FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	27.24%	7,240,735	8,226,884	$ 1,357,300
4	MEDICAL CASE MGMT (Medical Care Coordination)	29.88%	12,205,044	13,022,315	$ (2,509,267)
11	ORAL HEALTH CARE	14.10%	5,218,694	5,660,369	$ (699,393)
3	MENTAL HEALTH	0.60%	373,077	401,031	$ (189,926)
16	HOME AND COMMUNITY BASED HEALTH SERVICES	6.67%	2,598,891	2,812,687	$ (465,899)
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.59%	447,240	512,440	$ (304,853)
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services)	5.92%	1,289,177	1,341,606	$ 741,300
2	HOUSING (RCFCI, TRCF)	1.42%	406,316	406,316	$ 93,300
5	OUTREACH SERVICES (Linkage and Re-engagement Program and Partner Services)	5.57%	485,031	558,763	$ 1,400,999
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%	0	0	$ -
9	MEDICAL TRANSPORTATION	1.89%	356,297	472,750	$ 192,232
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	5.95%	3,163,649	3,244,420	$ (1,150,958)
21	LEGAL	0.16%	110,705	170,705	$ (114,410)
	SUB-TOTAL DIRECT SERVICES	**$ 35,184,230**	**33,894,856**	**36,830,286**	**$ (1,649,574)**
	QUALITY MANAGEMENT	1,330,192	640,844	750,936	$ 579,256
	ADMINISTRATION (Includes COH Budget) (10% of Part A award)	4,057,158	5,560,431	4,057,158	$ -
	GRAND TOTAL	**$ 40,571,580**	**$ 40,096,131**	**$ 41,638,380**	**$ (1,066,800)**

Year 30 Grant funding for Part A is $40,571,580

*Please note, figures in parentheses indicate expenditures exceed allocations

RYAN WHITE MAI SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE MAI FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of April 8, 2021 and invoicing up to Dec 2020 for Housing and Jan 2021

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	TOTAL ALLOCATION MAI FY 30	MAI FISCAL YEAR 30 TOTAL YTD EXPENDITURES	MAI FISCAL YEAR 30 FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	0.00%			$ -
4	MEDICAL CASE MGMT (Medical Care Coordination)	0.00%			$ -
11	ORAL HEALTH CARE	0.00%			$ -
3	MENTAL HEALTH	0.00%			$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES	0.00%			$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.00%			$ -
10	NON-MEDICAL CASE MANAGEMENT (Transitional Case Management)	6.14%	579,330	632,566	$ (424,339)
2	HOUSING (Permanent Supportive Housing/Housing for Health Program)	93.86%	2,027,112	2,702,815	$ 480,282
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)	0.00%			$ -
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%			$ -
9	MEDICAL TRANSPORTATION	0.00%			$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	0.00%			$ -
21	LEGAL	0.00%			$ -
	SUB-TOTAL DIRECT SERVICES	**3,391,324**	**2,606,442**	**3,335,381**	**$ 55,943**
	ADMINISTRATION (10% of MAI Year 30 award)	376,813	374,606	376,813	$ -
	GRAND TOTAL	**$ 3,768,137**	**$ 2,981,048**	**$ 3,712,194**	**$ 55,943**

The total MAI funding for Year 30 is $3,768,137 plus $285,908 from Year 29 approved roll over funding. However, this table only reflects the base award without the carryover funds

*Please note, figures in parentheses indicate expenditures exceed allocations

RYAN WHITE PART B SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE PART B FUNDING EXPENDITURES THROUGH MARCH 2021 (as of April 8, 2021 and invoicing through February 2021)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART B BUDGET	PART B TOTAL YTD EXPENDITURES	PART B FULL YEAR ESTIMTED EXPENDITURES	VARIANCE TOTAL BUDGET VS. FULL YR. ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE				$ -
4	MEDICAL CASE MGMT SVCS (Medical Care Coordination)				$ -
11	ORAL HEALTH CARE				$ -
3	MENTAL HEALTH				$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES				$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)				$ -
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)				$ -
2	HOUSING (RCFCI, TRCF)	3,714,800	3,660,088	3,847,000	$ (132,200)
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)				$ -
15	SUBSTANCE ABUSE TREATMENT- RESIDENTIAL	785,200	785,200	785,200	$ -
9	MEDICAL TRANSPORTATION				$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT				$ -
21	LEGAL				$ -
	SUB-TOTAL DIRECT SERVICES	**$ 4,500,000**	**$ 4,445,288**	**$ 4,632,200**	$ (132,200)
	QUALITY MANAGEMENT	$ -	$ -	$ -	$ -
	ADMINISTRATION (10% of Part B award)	$ 500,000	$ 295,408	$ 368,489	$ 131,511.00
	GRAND TOTAL	**$ 5,000,000**	**$ 4,740,696**	**$ 5,000,689**	**$ (689)**

Year 2 State allocation for Part B is $5,000,000.

*Please note, figures in parentheses indicate expenditures exceed allocations

LOS ANGELES COUNTY COMMISSION ON HIV

SERVICE STANDARDS REVISION DATE TRACKER as of 3/16/2021

	Standard Title	DHSP Program(s)	Date of Last Standard Revision	Program Currently Funded	Contract Expiration Date	Notes
1	AIDS Drug Assistance Program (ADAP) Enrollment		2009			ADAP contracts directly with agencies
Non-Medical Case Management						
2	Benefits Specialty	Benefits Specialty Services	2009	X	February 28, 2022	
3	Case Management, Transitional – Youth	Transitional Case Management-Youth	4/13/2017		March 31, 2020	Last funded two providers for this service through March 31, 2020
4	Case Management, Transitional – Incarcerated/Post Release	Transitional Case Management-Jails	4/13/2017	X	February 28, 2022	
5	Non-Medical Case Management	Linkage Case Management	12/12/2019		March 31, 2017	No longer funded.
6	Childcare		2009; currently being updated; latest draft revision date 12/14/2020			Last funded in 2009.
7	Emergency Financial Assistance Program (EFA)	EFA	6/11/2020	X	February 28, 2022	

8	Home-Based Case Management	Home-Based Case Management	2009	X	June 30, 2021	Contracts to be renewed for an additional 12 months in June 2021.
9	Hospice		2009			
10	Housing, Temporary: • Hotel/motel and meal vouchers, • Emergency shelter programs, • Transitional housing, • Income-based Rental Assistance, • Residential Care Facility for the Chronically Ill, and • Transitional Residential Care Facility	• Transitional Residential Care facilities (TRCF) • Residential Care facilities for the Chronically Ill (RCFCI) • Substance Use Transitional Housing (SUTH)	2/8/2018	X	February 28, 2022	
11	Housing, Permanent Supportive	Permanent Supportive Housing	2/8/2018		N/A	No contracts in permanent housing only temporary and worked with other entities for permanent housing (eg. DHS Housing for Health MOU).
12	Language Interpretation		2009		February 28, 2021	Contract expired 2-28-21, no response from provider need to solicit for new services again.
13	Legal	Legal Services	7/12/2018	X	August 24, 2024	New provider started December 2020
14	Medical Care Coordination	Medical Care Coordination	2/14/2019	X	February 28, 2022	New contracts started 3-1-19
15	Mental Health, Psychiatry, and Psychotherapy	Mental Health	2009	X	February 28, 2022	New FFS model started 8-1-17

16	Nutrition Support	• Food Bank • Home Delivery	2009	X	February 28, 2022	
17	Oral Health • Practice Guidelines for Treatment of HIV Patients in General Dentistry	• General Oral Health • Specialty Oral Health	2009 2015	X	February 28, 2022	
18	Outreach		2009		N/A	Never funded as a stand-alone contract. but has been part of Health Education/Risk Reduction. Linkage and Re-engagement Program (LRP) and partner services were supported as HRSA Part A Outreach Services. No contract for LRP and partner services because these activities are conducted by DHSP staff.
19	Peer Support		2009; integrated in Psychosocial Support 9/10/2020		October 15, 2009	No longer funded. Terminated due to state cuts back in 2009.
20	Permanency Planning		2009		February 28, 2010	No longer funded. It can be addressed by either BSS or Legal. Merged under legal contract in 2010.
21	Prevention Services: • Assessment; • HIV/STD Testing and Retesting; • Linkage to HIV Medical Care and Biomedical Prevention;		6/14/2018		HERR; 06/30/2021 VP: 12/31/2022 HIV Testing: 12/31 2022	"Take Me Home" online self HIV testing kits distributed through MOU with NASTAD. Self HIV tests kits also pending distribution through HIV/STD Testing contracts and with non-traditional community partners through MOUs.

	• Referral and Linkages to Non-biomedical Prevention; • Retention and Adherence to Medical Care, ART; and • Other Prevention Services				STD screening and Treatment: 12/31/2022 BIomedical: 6/30/2021	Currently evaluating extension of Biomedical contracts
22	Psychosocial Support		9/10/2020		August 31, 2017	No longer funded
23	Referral Services		2009		N/A	Not funded as a standalone service, included under various modalities
24	Residential Care and Housing		2009; integrated in Temporary and Permanent Supportive Housing 2/8/2018		(See #9 and 10)	
25	Skilled Nursing Facilities		2009		February 28, 2010	No longer funded replaced with RCFCI and TRCF- see under #24
26	Substance Use and Residential Treatment		4/13/2017		February 28, 2019	No longer funded. Funded by SAPC
27	Transportation		2009	X	February 28, 2023	New contracts began 6-1-20 and 9-1-20
28	Treatment Education		2009		October 15, 2009	No longer funded. Terminated due to state cuts. Activities incorporated into other programs (e.g. U=U social marketing)
29	Universal Standards		9/12/2019; currently being updated; latest draft		N/A	Not a program – standards that apply to all services

			revision date 12/16/2020 released for public comments			

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG VALUES
(APPROVED JANUARY 19, 2021)

PARADIGMS (Decision-Making)

- Compassion: response to suffering of others that motivates a desire to help
- Equity: Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically. [1]

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 stakeholders/constituencies are adequately represented in the decision-making process
- Humility: Acknowledging that we do not know everything and need to listen carefully to others.

[1] Based on the World Health Organization's (WHO) definition of equity.

LOS ANGELES COUNTY
COMMISSION ON HIV

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October 9, 2020

To: Mario J. Perez, Director of HIV and STD Programs (DHSP), Department of Public Health

From: Alvaro Ballesteros and Bridget Gordon, Co-Chairs, Commission on HIV

Re: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32

In keeping with the Commission on HIV's commitment to engage in multi-year priority setting and resource allocation planning for the next three years, the PP&A Committee has developed a set of program directives for program years (PY) 30, 31, and 32. The multi-year service rankings and allocations aim to assist DHSP in your programmatic planning and initiating the solicitations process so that services are in place by the start of the upcoming Ryan White program years.

Part A Planning Councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Recipient should consider in allocating funds under a grant based on numerous factors including: "size and demographics of the population of individuals with HIV disease;" "priorities of the communities with HIV disease;" and "capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)
This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure

alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

Based on epidemiological data, the disproportionately impacted populations in Los Angeles County are **young MSM (YMSM), African American MSM, Latino MSM, and transgender persons**. Given the physiologic role that sexually transmitted diseases (STDs) play in HIV transmission, it is recognized that maximizing HIV prevention will require significant reduction in syphilis and gonorrhea cases, among these aforementioned groups and **women of color** (LACHAS, pg. 14).

The 2019 HIV Surveillance Report notes following areas of disparities:

- Largest gaps in awareness of HIV-positive status existed for persons aged <35 years, where over 50% of HIV-infected persons aged 13-24 years and one third of HIV-infected persons aged 25-34 years were unaware of their infection. Disparities also existed for persons who inject drugs (PWID), with over one-third of HIV-infected PWID unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

- There are continued disparities in HIV diagnosis by population and geographic location. Rates of new HIV diagnosis are higher among men than women. Across age groups, young men aged 20-29 years and women aged 30- 39 years had highest HIV diagnosis rates. Black men and women had higher rates of HIV diagnosis compared with other race/ethnicity groups. Among men the highest rates of diagnoses were seen in the Central, South, and Hollywood-Wilshire Health Districts, and the highest rates for women were seen in the Central, South, and Southeast Health Districts.

- Populations with lowest achievements in linkage to care were females, Blacks, adolescents, persons aged ≥ 60 years, and persons with injection drug use (IDU) or heterosexual transmission risk. Health Districts with greatest need for interventions to improve linkage to HIV care services were Antelope Valley, El Monte, and South Health Districts where linkage rates were ≤ 70%.

- Approximately 9 in 10 people living with diagnosed HIV were on HIV treatment. Of those, 8 in 10 had adhered to their drugs in the past 3 days. Treatment coverage was lowest for Black populations and persons aged < 40 years, while adherence was lowest for younger persons aged <30 years and the Latinx population.

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income

and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

It is important to note that during the Committee's service ranking deliberations, the consumers, ranked housing as their number one service need for PY 31 and 32. This speaks to the need for keeping PLWH stably housed to support their retention to care, viral suppression and overall health. Medical/outpatient care also remains a top priority for consumers.

The program directives below expand on the directives sent to DHSP on April 23, 2019:

1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

    - Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.
    - In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.
    - Assess available resources by health districts by order of high prevalence areas.
    - Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.
    - Fund mental health services for Black/African American women that are responsive to their needs and strengths.
    - Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
    - It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional

locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

6. Continue to support the expansion of medical transportation services.

7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distribution of eligibility cards as stated by DHSP representatives.

8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children.

   Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

In order to inform the Commission's planning efforts around HIV/STD prevention and care services, we direct DHSP to provide written fiscal reports and status updates on these directives to the PP&A Committee and full Commission on a regular basis.

In support of the recommendations from the PP&A Committee, Standards and Best Practices (SBP) will continue updating and/or developing service standards for the following service categories. These service categories were prioritized by the PP&A Committee as recommended by DHSP and because of the feasibility of releasing solicitations in 2020-2022. Status updates on the development of service standards are noted below.

1. **Universal Service Standards -**Completed; updated and approved on 9/12/19
2. **Non-Medical Case Management –** Completed; updated and approved on December 12, 2019
3. **Psychosocial Support -**in progress and on the 9/10/20 Commission agenda for approval
4. **Emergency Financial Assistance –** Completed; approved by the Commission on 6/11/20
5. **Childcare** - in progress; public comment period 9/11-9/23; target month for Commission approval is October/November

The Commission is committed to ongoing collaborations with DHSP and we seek your feedback on how we can work together to implement these directives. We thank DHSP for ongoing regular progress reports on implementing directives and efforts to maximize Ryan White funds and activities to end the HIV epidemic. Furthermore, we appreciate feedback from DHSP in updating service standards. Thank you, we appreciate the ongoing partnership and support from you and your staff.

cc: Raquel Cataldo, PP&A Co-Chair
Kevin Stalter and Erika Davies, SBP Committee Co-Chairs
Miguel Martinez and Jason Brown, 2019 PP&A Committee Co-Chairs

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

(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

LOS ANGELES COUNTY
COMMISSION ON HIV

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September 24, 2020

Mario J. Pérez, MPH, Director
Division of HIV and STD Programs (DHSP)
Department of Public Health, County of Los Angeles
600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005

Dear Mr. Pérez:

This letter assures that the Los Angeles Commission on HIV (Commission), Los Angeles County's Ryan White Part A Planning Council (PC), has addressed the following items in accordance with the Fiscal Year (FY) 2021 Ryan White Part A application guidance:

a) The Commission can attest that Conditions of Award for 2020 were addressed and met by DHSP. The FY 2020 Part A and MAI Allocation Table, indicating the priority areas established by the Commission was submitted to HRSA, along with the letter of concurrence from the PC Co-Chairs endorsing priorities and allocations. A roster containing information about the members of the Commission and the representativeness table was also submitted as part of the Program Submissions requirement.

b) For PY 30 (Year 2020), the Commission ranked the following as the top ten Ryan White Part A service categories: 1) ambulatory outpatient medical 2) housing; 3) mental health; 4) medical care coordination; 5) outreach; 6) health education/risk reduction; 7) early intervention; 8) emergency financial assistance; 9) medical transportation; and 10) non-medical case management. Through the financial and programmatic reports provided to the Commission by the DHSP for Fiscal Year (FY) 2020 Formula, Supplemental, MAI and other funding sources awarded to the Los Angeles County Eligible Metropolitan Area (EMA), the Commission can attest that financial resources were expended according to the priorities established by the Commission. The Commission understands and supports efforts made by DHSP to maximize Part A and minimize underspending for MAI funds.

c) The Planning, Priorities and Allocations (PP&A) Committee leads the annual priority and allocation setting process for the Commission. Because of the profound impact of COVID-19 on the community and deployment of staff to COVID response activities, the Commission used the following data sources to help inform the FY 2021 priority setting process: 1) Program Year (PY) 29 and first quarter PY 30 Ryan White Service Utilization data; 2) COVID-19 DHSP Provider Survey; 3) COVID-19 Community Survey; 4) program expenditures information; 5) impact of COVID-19 on the County contracting and procurement process; and 6) Part D service utilization data for women ages 18 and over. For Program Year (PY) 31 (Year 2021), the Commission ranked the following as the top ten Ryan White Part A service categories: 1) housing; 2) ambulatory outpatient medical; 3) non-medical case management; 4) emergency financial assistance; 5) psychosocial support; 6) medical care coordination; 7) mental health; 8) medical transportation; 9) early intervention; and 10) outreach. The PY 2021 service rankings were determined under the assumption that the impact COVID-19 public health crisis will persist and will continue to have profound impact on the County and the nation. We speculate that Ryan White services will see an increase in patients as more people lose their jobs and that the affordable housing and homelessness crises will worsen. These recommendations were approved by the full body on September 10, 2020 with the understanding the Commission will need to work with DHSP to

continually track and monitor service needs, all funding sources, and respond accordingly. Regular and timely sharing of expenditures information is a critical piece of the resource allocation process. With the opportunities presented by the national Ending the HIV Epidemic initiative, the Commission will work with DHSP to ensure that EHE-related spending plans are shared with the planning council as these funds will help advance our local goals of ending HIV and must be taken into account in our decision making process.

d) The Commission has established an ongoing comprehensive training and mentorship program for its members, which includes information about the Los Angeles County ordinance establishing the Commission, the Ryan White Program and Part A specifically, the Planning Council legislative authority, committees and Brown Act training. New member orientations are held within a month of membership approval from the Board of Supervisors and the all member annual training was held on October 10, 2019. A make-up session was held on March 5, 2020. New members also received an additional one-hour orientation on their primary committee assignment. Because of COVID-19, the Commission established a series of virtual training for PC members and the public from September 2 to November 19, 2020.

   To foster leadership among unaffiliated consumers, the Consumer Caucus has received additional training targeted to their interests and priority topics. On 4/24/19, the Consumer Caucus received training on "How to Turn Data into Action" from the UCLA. The group also received a public speaking training and quality improvement training from DHSP on 5/9/19; Community Engagement Skills and Strategies: Special Focus on the Important Role of Consumers in the Priority-Setting and Resource Allocations Process on 7/11/19; and Trauma-Informed Care and HIV on 9/12/19. PC staff deliver the training or collaborate with local partners to customize training sessions during regular Consumer Caucus meetings. Unaffiliated consumers on the PC regularly attend local HIV community advisory boards and Service Planning Network meetings throughout the county to share information about the work of the PC and to also bring back critical information about client needs and services to the PC to help inform their discussions and promote service coordination and resource sharing.

   PP&A Committee members also receive training throughout the year during standing meetings on the priority setting and resources allocation process. The purpose of the three hour all member training held in October is to provide a refresher on the roles and responsibilities of the Commission as an integrated HIV prevention and care planning council. To ensure that consumers fully understood the PY 31 recommendations, the PP&A Co-Chairs and DHSP staff meet with the Consumer Caucus on August 28, 2020 to review the allocations table and answer questions regarding how the PP&A Committee arrived at their recommendations. The PSRA process is important and complex and an ongoing training on the decision-making process and will be integrated at all Consumer Caucus meetings to increase parity in knowledge, comfort level among consumers and providers.

   In addition to these formal trainings, staff provide ongoing coaching and support for PC members. "Member" and "Library" tabs have been added to the Commission website so that PC members and interested applicants can access training materials online. A series of virtual trainings for Commissioner and members the public will begin in late August 2020.

If you have any questions or need further assistance, please do not hesitate to contact us at 213.738.2816.

Sincerely,

Bridget Gordon, Co-Chair, Los Angeles County Commission on HIV

Alvaro Ballesteros, Co-Chair, Los Angeles County Commission on HIV

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
			Engaged/Retained in Care		
6	17	17	Health Education/Risk Reduction	S	Health Education/Risk Reduction

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)
7	9	9	Early Intervention Services	C	Early Intervention Services
8	4	4	Emergency Financial Assistance	S	Emergency Financial Assistance
9	8	8	Medical Transportation	S	Medical Transportation
10	3	3	Non-Medical Case Management	S	Non-Medical Case Management Services
			Linkage Case Management		
			Benefit Specialty		
			Benefits Navigation		
			Transitional Case Management		
			Housing Case Management		
11	12	12	Oral Health Services	C	Oral Health Care
12	5	5	Psychosocial Support Services	S	Psychosocial Support Services
13	11	11	Nutrition Support	S	Food Bank/Home Delivered Meals
14	13	13	Child Care Services	S	Child Care Services
15	15	15	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
16	18	18	Home Based Case Management	C	Home and Community Based Health Services
17	19	19	Home Health Care	C	Home Health Care
18	16	16	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
19	20	20	Referral	S	Referral for Health Care and Support Services

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)
20	21	21	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
21	14	14	Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
22	22	22	Language	S	Linguistics Services
23	23	23	Medical Nutrition Therapy	C	Medical Nutrition Therapy
24	24	24	Rehabilitation Services	S	Rehabilitation Services
25	25	25	Respite	S	Respite Care
26	26	26	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27	27	27	Hospice	C	Hospice

LOS ANGELES COMMISSION ON HIV
PERCENTAGE ALLOCATIONS FOR RYAN WHITE PROGRAM YEARS 30, 31, 32
Approved 9/10/2020

	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%
3	Mental Health Services	0.60%	0.00%	0.60%	0.00%	0.00%
23	Medical Nutritional Therapy	0.00%	0.00%	0.0%	0.00%	0.05%
4	Medical Case Management (MCC)	29.88%	0.00%	29.83%	0.00%	25.60%
18	Substance Abuse Services Outpatient	0.00%	0.00%	0.0%	0.00%	0.00%
10	Case Management (Non-Medical) BSS/TCM	5.92%	6.14%	5.91%	10.53%	8.60%
14	Child Care Services	0.00%	0.00%	1.00%	0.00%	1.00%
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%**

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

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

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

Purpose of PCN

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

Background

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

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

HRSA HAB has developed program policies that incorporate both HHS regulations

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

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

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

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

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

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

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

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

Eligible Individuals:

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

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

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

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

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

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

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

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

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

Other unallowable costs include:

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

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

Service Category Descriptions and Program Guidance

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

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

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

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

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

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

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

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

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

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

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

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

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

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

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

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

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

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

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

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

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

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

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

Early Intervention Services (EIS)

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

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

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

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

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

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

Description:

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

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

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

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

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

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

when determined to be cost effective.

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

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

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

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

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

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

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

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

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

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

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

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

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

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

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

Key activities include:

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

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

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

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

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

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

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

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

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

See also Food-Bank/Home Delivered Meals

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

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

See also Psychosocial Support Services

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

Program Guidance:
None at this time.

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

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

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

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

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

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

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

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

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

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

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

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

Allowable use of funds include:

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

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

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

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

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

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

Food Bank/Home Delivered Meals
Description:

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

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

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

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

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

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

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

See also Early Intervention Services

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

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

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

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

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

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

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

Legal Services
See Other Professional Services

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

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

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

Program Guidance:
Medical transportation may be provided through:

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

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

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

Unallowable costs include:

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

Non-Medical Case Management Services

Description:

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

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

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

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

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

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

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

See 45 CFR § 75.459

Outreach Services

Description:

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

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

Outreach Services must:

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

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

Program Guidance:

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

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

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

See also Early Intervention Services

Permanency Planning
See Other Professional Services

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

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

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

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

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

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

See also Respite Care Services

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

Program Guidance:

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

vocational therapy.

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

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

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

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

See also Early Intervention Services

Respite Care
Description:

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

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

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

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

See also Psychosocial Support Services

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

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

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

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

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

From: HRSA HAB DSHAP <HABDSHAP@hrsa.gov>
Sent: Friday, February 26, 2021 7:01 AM
To: HRSA HAB DSHAP <HABDSHAP@hrsa.gov>
Subject: CDC/HRSA Updated Integrated Planning Guidance

Dear Health Resources and Services Administration Ryan White HIV/AIDS Program and Centers for Disease Control and Prevention HIV Prevention Colleagues:

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and the Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention (DHAP) issued guidance for the Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for Ryan White HIV/AIDS Program (RWHAP) Part A and B recipients in June 2015. This guidance established that health departments and planning groups funded by DHAP and HAB develop an Integrated HIV Prevention and Care Plan. The guidance format allowed jurisdictions to submit one Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), to CDC and HRSA by September 30, 2016, covering calendar years 2017 – 2021. Submission of the Integrated HIV Prevention and Care Plan not only meets the legislative and programmatic requirements of CDC and HRSA, but also serves as a jurisdictional HIV Strategy or roadmap.

As HAB and DHAP notified you last summer, the updated Integrated HIV Prevention and Care Plan guidance and plan submission for the calendar years 2022 – 2027 was postponed due to the unprecedented COVID-19 pandemic. This delay was to provide you with an opportunity to stay focused on the work to address the COVID-19 pandemic and to consider how HIV prevention and care planning may need to evolve going forward, while you also consider what activities are necessary to move us toward ending the HIV epidemic. We continue to hear of the innovative changes in the prevention and care delivery system and in HIV planning that you have implemented as a result of the pandemic and continue to applaud you in your efforts.

We are planning to issue the updated Integrated HIV Prevention and Care Plan guidance in June 2021 with submission of the plans targeted for December of 2022, allowing for sufficient time to develop your plans. Our continued joint expectation is that RWHAP Part A and B recipients and DHAP funded state and local health departments continue to utilize the existing Integrated HIV Prevention and Care Plans and other jurisdictional plans (e.g., Ending the HIV Epidemic Plans, Fast Track Cities), as applicable, as their jurisdictional HIV Strategy or roadmap. In acknowledgement that many of you have developed Ending the HIV Epidemic (EHE) Plans, we encourage you to incorporate your community engagement efforts for the EHE plans with your integrated planning activities to the extent that is helpful. The Integrated HIV Prevention and Care Plan is the umbrella plan for all your HIV-related resources and activities and the EHE plan should work in conjunction as a subset of focused resources and activities.

We appreciate the work that you are doing to support people with HIV and people at risk for HIV through your programs during this continued public health emergency.

Sincerely,

/Laura W. Cheever/

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HIV/AIDS Bureau
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