LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, September 27, 2022
1:00PM-4:00PM (PST)

****Please note extended meeting duration.****

Agenda and meeting packet will be available on the Commission's 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, SEPTEMBER 27, 2022, 2022|1:00 – 4:00 PM

To Join by Computer:

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**Link is for non-committee members only*

To Join by Phone: 1-213-306-3065 US Toll Access code: 2597 670 2773

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA, Co-Chair	Felipe Gonzalez	Joseph Green
Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW	Anthony M. Mills, MD
Derek Murray	Jesus "Chuy" Orozco	LaShonda Spencer, MD	Michael Green, PhD
QUORUM:	7		

AGENDA POSTED: September 23, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, please click here.

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. All Public Comments will be made part of the official record.

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

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

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

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

Call to Order | Introductions | Statement – Conflict of Interest 1:00 PM – 1:02 PM

I. ADMINISTRATIVE MATTERS 1:02 PM – 1:04 PM

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

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

II. PUBLIC COMMENT 1:04 PM – 1:14 PM

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

III. COMMITTEE NEW BUSINESS 1:14 PM – 1:19 PM

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:19 PM – 1:25 PM
   a. Staffing Update

6. CO-CHAIR REPORT 1:25 PM – 1:40 PM

a. Committee Workplan Review
b. Prevention Planning Workgroup (PPW) | Updates
c. Sexually Transmitted Infections (STI) Letter to the Board of Supervisors
d. Letter of Assurance FY 2023 Non-Competing Continuation Progress Report

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:40 PM – 2:30 PM

a. Fiscal and Program Updates
i. Ryan White Program (RWP) Service Utilization Report
ii. Net County Cost Funds Used to Support HIV Services

8. CITY OF LOS ANGELES HOUSING OPPORTUNITIES FOR PEOPLE LIVING WITH AIDS (HOPWA) REPORT

i. Housing Services | Updates
a. Service Utilization, Costs and Gaps
b. Available Housing Inventory for PLWH
c. Waiting Lists

BREAK **2:30 PM – 2:40 PM**

V. DISCUSSION

9. Strategies for Reallocations of Ryan White Funds 2:40 PM – 3:20 PM

10. Comprehensive HIV Plan 2022-2026 3:20 PM – 3:45 PM

VI. NEXT STEPS

3:45 PM – 3:50 PM

11. Task/Assignments Recap

12. Agenda Development for the Next Meeting
a. DHSP response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34.

VII. ANNOUNCEMENTS

3:50 P.M. – 3:55 P.M.

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

VIII. ADJOURNMENT

4:00 P.M.

14. Adjournment for the Meeting of September 27, 2022.

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 8/31/22

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CAO	**Michael**	Golden Heart Medical	No Ryan White or prevention contracts
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
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
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
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
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
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)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	No Affiliation	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

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

August 16, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	EA
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	EA
Joseph Green	EA	Derek Murray	P
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	P
Karl T. Halfman, MS	A	LaShonda Spencer, MD	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Sonja Wright, AJ King			
DHSP STAFF			
Pamela Ogata, Victor Scott, Anait Arsenyan			

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

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST
Kevin Donnelly, Co-Chair, called the meeting to order at approximately 1:05 PM, welcomed attendees, and led introductions.

I. ADMINISTRATIVE MATTERS

1. **Approval of Agenda**
   MOTION #1: Approve the Agenda Order ***(✓Passed by Consensus)***
2. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes ***(✓Passed by Consensus)***

II. PUBLIC COMMENTS

3. **Opportunity for members of the public to address the Committee on items of interest that are within the jurisdiction of the Committee.** *There were no public comments.*

III. COMMITTEE NEW BUSINESS

4. **Opportunity for Committee members to recommend new business items for the full body or a committee-level discussion on non-agenized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.** *There were no committee new business items.*

IV. REPORTS

5. **Executive Director/Staff Report**
   a. **Operational Update**
      - Cheryl Barrit reported that on August 9, 2022, the Board of Supervisors (BOS) voted to extend the continuation of virtual meetings for another 30 days.
      - C. Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the Commission training schedule is available in the meeting packet.
      - There are several vacancies on the Commission on HIV (COH). Attendees were encouraged to spread the word about the COH to assist with membership recruitment.
      - Several Commissioners need to turn in their IRS Form 700 to COH staff. C. Barrit informed Commissioners that COH staff is available to answer any questions.

6. **Co-Chair Report**

   The next PP&A meeting is scheduled to take place on September 20, 2022. The date conflicts with the Presidential Advisory Council on HIV/AIDS (PACHA) meeting which will be held in Los Angeles. The group decided to reschedule their September meeting to September 27th at 1 PM to 4 PM to allow for participation at the PACHA meeting.

   a. **Committee Workplan Review**
      - K. Donnelly provided an overview of the PP&A 2022 Workplan, which can be found in the meeting packet.
      - K. Donnelly identified integrating prevention planning, developing strategies for maximizing Part A and Minority AIDS Initiative (MAI) funding, and monitoring the implementation of the Comprehensive HIV Plan (CHP) as major tasks for the PP&A Committee for the remainder of the year.
      - "Discuss systems of care changes and impact on care and prevention planning" is a new item that was added to the Workplan. Pamela Ogata requested if this item could be revised to include the words "low-income" in the description.
      - Add "HRSA Part A Non-Competing Continuation Progress Report for FY 23/PY33."

   b. **Prevention Planning Workgroup (PPW) Updates**

i. PPW Workplan

- Miguel Martinez, PPW Co-Chair, provided an overview of the PPW Workplan. The PPW is working on knowledge, attitudes, and beliefs (KAB) survey for Commissioners to better understand knowledge and capacity to engage in prevention planning. The survey will be disseminated to Commissioners by the end of the month and the responses will help the PPW develop training strategies to help the Commission become an effective integrated prevention and care planning council.

7. Division of HIV and STD Programs (DHSP)

a. Fiscal and Program Updates and Comprehensive Review of Funding Streams

- Victor Scott provided an overview of the sources of funding for HIV and STD programs managed by DHSP. V. Scott noted that net county cost (NCC) funding to support services will be provided at the September PP&A meeting.
- The Ryan White Program (RWP) Fiscal Year (FY) 2021 closed out with $1.74 million carryover in Minority AIDS Initiative (MAI) funding. The Part A and Part B awards were fully maximized.
- The award for RWP Part A FY 32 is $42,142,230.
- Part B funds ($5,446,800) are used to support residential care for chronically ill and transitional care residential facilities as well as substance abuse residential facilities.
- MAI funds total $3.7 million and are used to support non-medical case management and housing through the Housing for Health program managed by the Department of Health Services.
- The HRSA Ending the HIV Epidemic (EHE) funds total $6.1 million and support data system, infrastructure, and surveillance improvements; and activities aimed at improving rapid linkage to care, viral suppression and re-engagement in care.
- K. Donnelly asked if the MAI rollover funds were included in the $3.8 million. Dr. Michael Green stated that it was not.
- AJ King asked what the Hepatitis Supplement money is used for. V. Scott stated this is used for population-specific surveys under the National HIV Behavioral Survey program.
- Al Ballesteros asked which funding stream is used directly for STD testing and treatment. Dr. Green stated this comes from the Centers for Disease Control and Prevention (CDC).
- A. Ballesteros pointed out the low amount of funding allocated for STD testing and treatment, given the high rates of STDs in LA County. A. Ballesteros recommended bringing the severe gap in STD funding to the attention of the Board.

b. Ryan White Program and DHS Clinics

Dr. Green provided a presentation titled, "Changing Healthcare Landscape in Los Angeles County: Impact to Local Ryan White Program in FY 2022." The presentation provided an in-depth overview of the Department of Health Services (DHS)'s decision to no longer bill the RWP for HIV-related services in DHS clinics.

i. **Number of Patients Affected:** The change is not expected to affect current RWP recipients.

ii. **Number of Patients at DHS Clinics:** In CY 2021, 5,678 people living with diagnosed HIV (PLWDH) got lab work done at a DHS site. In FY 2021, 16,963 PLWDH received one or more RWP services. 5,351 RWP clients received AOM services; approximately 28% received services from a DHS site. 8,244 RWP clients received MCC services; approximately 13% received services from a DHS site. Retention in care and viral suppression measures were higher at DHS RWP sites compared to the overall RWP data.

- Due to various care system changes, DHSP anticipates a re-allocation estimate of $5 million and $6 million.
- It was noted that CalAIM's Enhanced Care Management (ECM) program is not as robust as the RWP Medical Care Coordination (MCC) program.
- Dr. Green reported that due to COVID, HRSA has temporarily waived the penalty for unspent Part A and formula grant funds for FY 2021 and 2022. While DHSP anticipates that FY 2022 funds will be maximized, PP&A will need to plan for FY 2023 and 2024 and begin reviewing current service category allocations now.
- K. Donnelly stated the Committee will need to review the FY 2022 expenditures to help with the reallocations discussion. Dr. Green replied that it would take 3 to 4 months to develop the FY 2022 fiscal report. Dr. Green recommended using data that PP&A has already received to engage in the reallocations discussion. Service utilization data does not change much from year to year.
- A. Ballesteros recommended the Committee start the conversation as soon as possible regarding community needs to help determine funding allocations for RW services. Further, he inquired how much housing services are being purchased with RW funds currently, how much more is needed to close the housing gap, and what is the current inventory of housing services for PLWHA in the County.
- In response to a question about the feasibility of receiving performance metrics from DHS now that they have exited the RW system, Dr. Green noted that it is possible to use surveillance data to measure HIV health outcomes, however, they cannot guarantee that there will not be a drop in performance since DHSP will no longer have contractual oversight of HIV services provided by DHS.
- In response to a question if RW funds may be used for STD treatment, Dr. Green replied that RW funds may be used for STD treatment only if they are an RW client. RW funds may not be used for high-risk negatives or persons with unknown HIV status.

V. DISCUSSION

c. Comprehensive HIV Plan (CHP) 2022-2026

a. Proposed Goals and Objectives

- AJ King facilitated a group discussion on the development of goals and objectives for the CHP. AJ King requested feedback from the group on a list possible goals and objectives.
- The goals and objectives are divided by the EHE pillars: Diagnose, Treat, Prevent, and Respond.
- A. Ballesteros reacted favorably to the objective related to rapid STI testing but questioned if DHSP has the funding and capacity to implement such a program.
- It was suggested that for the objective related to CalAIM, add "provide feedback to the State on how to improve services for PLWH."
- A. Ballesteros recommended adding an objective to fast-track enrollment for clients so that they do not have to jump through RWP hoops. He also recommended adding "explore a set of benefits and services that clients would automatically receive if they meet the eligibility criteria for RW; target individuals with unknown status and focus on removing barriers to care." The MCC and AOM programs cannot remain the same or stagnant if the county is to make any significant progress in ending HIV.
- Felipe Gonzalez recommended altering the language used when addressing the gay community. Current messages generalize the behaviors of gay men and assume this community is sexually promiscuous. He advocated for less paperwork and more action.
- A. Ballesteros recommended targeted efforts for hard-to-reach populations such as homeless individuals and people who use drugs.
- AJ King acknowledged the sense of planning fatigue in the community as stakeholders are constantly working in an overloaded environment. A feedback form will be sent to Commissioners to elicit additional thoughts and insights on the draft list of objectives.

VI. NEXT STEPS

d. Task/Assignments Recap

- C. Barrit will send an e-mail to solicit ideas for reallocating RW funds.
- The PP&A Committee will not be meeting on their regularly scheduled September 20th meeting date due to the PACHA Conference. PP&A will be meeting on September 27th from 1-4 PM instead.
- C. Barrit and AJ King will send out a feedback form for the CHP goals and objectives.
- The PP&A Committee will continue working on the reallocation of the $5-$6 million RW funds as well as finalizing the CHP.

e. Agenda Development for the Next Meeting

- The next PP&A meeting will be extended by one hour.

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

g. Adjournment for the Meeting of August 16, 2022.

The meeting was adjourned by K. Donnelly at 3:45 PM.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly & Alvaro Ballesteros
Committee Adoption Date: 1/18/22	Revision Dates: 1/18/22; 7/26/22; 9/7/22 (new additions in RED)
Purpose of Work Plan: To focus and prioritize key activities for COH 2022	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Develop the Comprehensive HIV Plan (CHP) 2022-2026	The Committee will gather, discuss, develop and provide planning priorities for inclusion in the plan.	10/2022	PP&A will continue to agendize the CHP. The Committee is the conduit for information obtained from all Commission Committees and subgroups. ***In progress.***
2	Monitor the implementation of the CHP	The Committee will work with DHSP and various partners to implement and monitor progress toward meeting the goals and objectives of the CHP.	Ongoing beginning 1/1/2023 – 12/31/2026	Agendize item at PP&A meetings.
3	Address Areas of Improvement from the HealthHIV Planning Council Effectiveness Assessment	The Committee will engage the broader community in developing and shaping the CHP.	**Ongoing**	PP&A is discussing activities to enhance community representation/engagement of underserved populations impacted by HIV in LAC. Conducted listening sessions with priority populations to help shape the CHP.
4	Strengthen Core Planning Council Responsibilities	The Committee will continue to improve the Commission's prevention and care multi-year planning process and decision-making.	**Ongoing**	PP&A has increased the scope and frequency of data reviewed in the decision-making process to optimize services offered.
5	Develop Strategies for Maximizing Part A and MAI Funding	Monitor, assess and create directives for DHSP to effectively expend Part A and MAI funds to	03/2022 -	The Committee has used data provided by DHSP, Ending the HIV Epidemic (EHE) Plan, Transgender, Women and Consumer

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		meet the needs of the underserved with specific focus on minority communities.	**Ongoing**	Caucuses; Black African American Community (BAAC) and Aging Taskforces (TF) recommendations in multi-year planning efforts. ***Program Directives for PY 32, 33, and 34 approved by the COH on 6/9/22*** PP&A will create specific DHSP Directives for the use of MAI funding to fully expend funds within the allocation program year. DHSP response on the Program Directives for PYs 32, 33 and 34 due to PP&A in Sept. 2022. PP&A received funding sources and estimates ($5-$6M) of RW funds that need to be reallocated on 8/16/22.
6	Review, discuss and understand financial information from DHSP	Review and monitor fiscal reports on all HIV funds supporting LAC HIV Care and Prevention services.	**Ongoing**	The Committee has requested DHSP provide this information on a monthly basis.
7	Annual Progress Report (APR)	Review progress report prepared for Health Resources and Services Administration (HRSA) by DHSP	08/2022 COMPLETED	Report completed per DHSP. Summary of annual progress report to be provided to PP&A (report back date TBD).
8	Rank Service Categories for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Rank (HRSA) Ryan White services numerically and obtain Commission approval to provide service rankings to DHSP for program implementation.	08/2022 COMPLETED	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before ranking services. ***PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY***

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2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

				32 allocations approved by the COH 7/14/22
9	Allocations for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Determine financial resource allocation percentages for HRSA ranked services and obtain Commission approval to provide to DHSP for program implementation.	08/2022	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before determining funding allocations. ***PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY 32 allocations approved by the COH 7/14/22***
10	Prevention Planning	Develop integrated prevention and care planning strategies. Participate in the CDC prevention application process by recommending strategies for inclusion in the CDC prevention plan.	Ongoing	The committee established a Prevention Planning Workgroup (PPW) to prepare short- and long-term prevention activities for recommendation to DHSP; DHSP to provide prevention data *****See PPW Workplan for details*****
11	Discuss systems of care changes and impact on care and prevention planning.	Agendize the following topics for Committee discussion: 1. Medi-Cal expansion to low income 50+ individuals regardless of documentation status. 2. CalAIM (California Advancing and Innovating Medi-Cal)	August-December 2022 ***Ongoing***	P. Ogata (DHSP) presented "Medi-Cal Expansion: Preliminary Analysis on the Impact to Los Angeles County's Ryan White Program" 6/21/22.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		3. Decrease in purchasing power of grant funds due to inflation 4. Making status-neutral planning the norm for PP&A and COH		
12	Complete Letter of Assurance for HRSA FY23/PY33 Non-Competing Continuation Progress Report		Report to HRSA 10/3/22	Letter of Assurance emailed to DHSP 9/2/22
13	Revise funding allocations for FY 2022, 2023, and 2024 based on estimates and landscape analysis provided by DHSP.		Sept-Dec 2022	

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Letter of Assurance

September 2, 2022

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) 2023 Non-Competing Continuation (NCC) Progress Report for the Ryan White Part A Emergency Relief Grant Program Instructions.

a) Planning

i. The Division of HIV and STD Programs (DHSP) and the Commission engages in an ongoing needs assessment process by harnessing data from surveillance systems, service utilization, Medical Monitoring Projects, and local quantitative and qualitative research studies that focus on specific populations or service access issues. Analyses from these data sources consistently show the need for reducing barriers to accessing prevention and care services; increasing demand and need for housing, financial assistance, and other social services; and persistent inequities in HIV health outcomes among communities most impacted by HIV. In addition, an ongoing review of the State of California's Medicaid system (Medi-Cal) continues to expand access to care outside of the Ryan White HIV care system which brings about ongoing challenges with maximizing Part A grant funds and the need to nimbly shift investments in service categories not supported or underfunded by non-Ryan White funding sources.

ii. The Commission, DHSP, and community at large are currently engaged in developing the Integrated Plan, locally referred to as the Comprehensive HIV Plan. The initial community planning process started in December 2021 with DHSP and Commission leadership and to date, has involved the completion of data synthesis, workforce capacity surveys and focus groups among priority populations: 1) Black/African American MSM; 2) Latinx MSM; 3) women of color; 4) transgender persons; 5) people living with HIV 50 years and older; 6) persons under 30 years of age; and 7) people who inject drugs. In an effort to align the overall goals and objectives of the CHP, Los Angeles County and the State Office of AIDS (OA), participate in each other's community planning meetings, share data, and provide feedback on state and local plans. A representative from the OA serves on the Planning, Priorities and Allocations

(PP&A) Committee and a member of the Statewide Integrated Plan consulting team attends the PP&A Committee meetings regularly to share updates and collaborate on the State's planning process.

In addition, the development of the local Ending the HIV Epidemic (EHE) plan presented an opportunity for enhanced community planning and developing strategies for improved service coordination on a more regional basis. The Commission participated in the virtual townhall events convened by DHSP and other partners such as the Region IX Prevention through Community Engagement (PACE) team, UCLA Center for HIV Identification, Prevention and Treatment Services (CHIPTS), and the California Department of Public Health, State Office of AIDS. Local townhall meetings held by various LAC departments on mental health, substance use, and homelessness helped to underscore issues that have been exacerbated even more by the COVID-19 pandemic. These convenings informed the Commission's FY 2023 overall community planning and PSRA process.

b) Priority Setting and Resource Allocation (PSRA)

i. The Planning, Priorities and Allocations (PP&A) Committee leads the multi-year priority and allocation setting process for the Commission. The PP&A Committee moved to a multi-year (3 years) service rankings and funds allocations by percentages in 2019 which facilitated a smooth virtual process in preparation for HRSA's multi-year Part A application and non-competing continuing progress report process. Despite the residual impact of COVID-19 on the community and deployment of some DHSP staff to COVID, and more recently, Monkeypox, response activities, the Commission engaged in a robust and thoughtful deliberation to rank Ryan White service categories and allocate funding.

   a. The Commission commenced the PY 32 PSRA process with a data summit on July 20, 2021 where DHSP presented the following data: 1) Utilization by Service Category among Ryan White Priority Populations PY 30; 2) Overlap across Ryan White Priority Populations & Estimated HIV Care Continuum; 3) Outcomes across Priority Populations PY 30; 4) Ryan White PY 30 Utilization Report Summary; 5) program expenditures information; 6) HIV testing and PrEP client demographic data; and 7) HIV and STD surveillance summaries. The PY 32, 33, and 34 (FY 2022, 2023, and 2024) planning process discussed the impact of COVID-19 on PLWH on the local RW care system, the lack of affordable housing, and the psychological/mental health toll of living in a pandemic environment.

      PP&A used feedback from the various caucuses, workgroups, task forces, and providers to understand unique impacts on communities of color and other highly impacted populations. The Prevention Planning Workgroup (PPW) was formed as a subset of PP&A to strengthen the prevention component of the PC's planning process. The PPW-led discussions focused on the needs of women of color, the need to increase testing and PrEP uptake. The Black/African American Caucus worked with DHSP in developing a training focused on implicit bias and medical mistrust in the Black community, identified strategies for culturally tailored mental health services, and opportunities for Black-led organizations to successfully compete for County contracts. The Aging Task Force outlined recommendations for leveraging the medical care coordination teams to include a geriatrician and screenings that capture the changing health needs of PLWH over 50. The Transgender Caucus discussed the importance of fostering safe and welcoming spaces that embrace gender-fluid identities and providing gender-affirming care.

For FY 2023, the Commission ranked the following as the top ten Ryan White Part A service categories: 1) housing; 2) non-medical case management; 3) Ambulatory Outpatient Medical Services; 4) emergency financial assistance; 5) psychosocial support; 6) medical care coordination; 7) mental health; 8) outreach; 9) Substance Abuse Outpatient; and 10) early intervention. The FY 2023 (PY 33) service rankings were determined under the following key realities: 1) lack of affordable housing and increased risk for homelessness will remain a significant crisis for PLWH; 2) financial instability will persist due to inflation and unlivable wages; and 3) ongoing demand for culturally competent medical and mental health services. Furthermore, the ongoing methamphetamine crisis in Los Angeles will likely compound substance use conditions. As women with children have assumed the unequal burden of homeschooling and childcare, the PP&A Committee allocated funds to childcare services to enable patients to remain in care. These recommendations were approved by the full body on January 13, 2022, with the understanding the Commission will need to work with DHSP to continually track and monitor service needs and respond accordingly. Regular and timely sharing of expenditure information is a critical piece of the resource allocation process.

b. According to the 2020 DHSP Annual Surveillance Report, due to the COVID-19 pandemic, access to routine HIV care services decreased in 2020. Consequently, we saw a reverse in progress along key steps in the HIV care continuum for adults, adolescents and children living with diagnosed HIV. Compared with 2019 achievements, we observed declines in the percentage of PLWDH who received care, were retained in care, and were virally suppressed in 2020. In addition, persons who were unhoused continue to experience less optimal outcomes along the HIV care continuum. HIV diagnosis rates are increasing among unhoused persons, and compared with housed persons, unhoused persons had lower rates of receiving HIV care, retention in care, and achieving viral suppression in 2020. Given that the greatest disparities in viral suppression were among Black populations, females and transgender persons, persons aged 30-49 years, and persons whose transmission risk included injection drug use, the Commission allocated over 87% of the MAI funds to housing and over 12% to non-medical case management to improve health outcomes amongst these groups. According to the Los Angeles Homeless Services Authority Report and Recommendations of the Ad Hoc Committee on Black People Experiencing Homelessness, Black people are more likely than White people to experience homelessness in the United States, including in Los Angeles County. In 2017, Black people represented only 9% of the general population in Los Angeles County yet comprised 40% of the population experiencing homelessness. This sobering statistic, along with the multiple social justice inequities and barriers to care faced by the Black community and other communities of color, played a key role in the Commission's service prioritization and funding allocation decisions.

   The service allocations for FY 2023 (PY 33) aim to sustain a comprehensive array of medical and support services that prioritize key populations defined by DHSP in the EHE plan: Black/African American men who have sex with men (MSM), Latinx MSM, women of color, people who inject drugs, transgender persons, and persons under 30 years of age. The Commission and DHSP continue to coordinate with the Part D grantees in Los Angeles County to share data, assess the needs of women, infants, children and youth, and braid Part A funding with appropriate services. The Commission's decision to allocate funding to childcare services is a direct response to the needs of women living with HIV and their families.

ii. People living with HIV represent over 50% of the Commission with several unaffiliated consumers serving in leadership positions in committees and subgroups. The strong representation of PLWH on the Commission lends to a process and outcome that is driven by their lived experience, strengths, and vision for optimal health. For the PY 33 PSRA process, representatives from various caucuses participated in the service ranking and allocation deliberations. The Consumer Caucus discusses the needs of PLWHA and their experience with the local RW service delivery system at their monthly meetings. The pandemic and inflation have led to a greater need for housing, food bank/nutrition services, and emergency financial services. The Women's Caucus appealed for childcare services and in response, the PC allocated funding to childcare services in the hopes that contracts may be implemented in PY 32 and 33.

iii. The Commission attests that the FY 2022 Part A funds were expended according to the priorities established by the Commission. In addition, the Commission approved revisions to the FY 2022 (PY 32) allocations table on June 14, 2022, by shifting 3.7% of funds to emergency financial assistance from medical care coordination (MCC) to maximize grant funds.

iv. The Commission confirms that all Ryan White HIV/AIDS Program HIV core medical and support services were prioritized during the PSRA process as defined by the RW Care Act.

c) Training

The Commission established a series of virtual training for PC members and the public from March 29 to December 13, 2022. These training sessions also include virtual study hours, where PC members and the public may drop in and seek additional technical assistance, ask questions, on any concepts related to the PC. The dates for the trainings are as follows: 1) Commission on HIV Overview (3/29/22); 2) Ryan White Program Legislation Overview (7/21/22); 3) Membership Structure and Responsibilities 7/21/22); 4) Priority Setting and Resource Allocation Process (9/15/22); 5) Service Standards Development Process (9/15/22); and 6) Policy Priorities and Legislative Docket Development Process (11/16/22); and 7) Co-Chair Roles and responsibilities (11/17/22). In addition to these formal trainings, staff provide ongoing coaching and support for PC members. "Member" and "Library" tabs are available on the Commission website so that PC members and interested applicants can access training materials online.

d) Assessment of Administrative Mechanism (AAM)

The PY 31 Assessment of Administrative Mechanism (AAM) survey for contracted providers is currently in progress with the deadline for providers to respond by September 15. The AAM contractor survey was intentionally delayed in order to minimize survey burnout and prioritize community surveys aimed at shaping the development of the Integrated Plan. While the provider survey is still pending, past AAMs have consistently yielded similar themes and findings. In broad terms, the current AAM shows that the overall administrative mechanism that supports the system of Ryan White Care Act-funded service delivery in Los Angeles County is healthy and works well. While a few challenges were identified in the key informant interviews, the overarching assessment is that a mature and competent system is in place. Additionally, the 2020 AAM interviews with contracted providers noted the following themes:

- Gratitude: Many participants acknowledged that despite challenges, certain staff and systems at DHSP are supportive and useful.

- Inconsistency: Many participants commented that there were major inconsistencies between DHSP program managers over time (i.e. previous program managers compared to current program manager) and across programs (i.e. different contracts).
- Turnover of staff at DHSP: Many commented about the high turnover rate and how they perceive this to be a major driver of these inconsistencies.
- Concern about smaller organizations not getting funded: While overall, participants felt the system was mostly fair with respect to funding decisions, there were concerns raised about smaller agencies that do good work but cannot seem to compete.
- Understanding of context: Participants acknowledged that the larger context within which DHSP operates may be contributing to some of these challenges.

The Commission remains firmly committed to staying the course in our shared value and vision of ending the HIV epidemic in Los Angeles County and beyond. The residual impact of COVID-19, the worsening economic divide, and the expansion of Medicaid in California to provide care to people over 50 years of age, regardless of documentation status will continue to pose challenges and opportunities for care for PLWH in Los Angeles County. The Commission will work closely with DHSP in monitoring service needs and making funding allocations as appropriate to ensure continuity of care for PLWH.

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

Sincerely,

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

Danielle Campbell
Danielle Campbell, Co-Chair, Los Angeles County Commission on HIV

LOS ANGELES COUNTY
COMMISSION ON HIV

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August 26, 2022

Honorable Holly J. Mitchell, Chair
Honorable Hilda L. Solis, Supervisor
Honorable Sheila Kuehl, Supervisor
Honorable Janice Hahn, Supervisor
Honorable Kathryn Barger, Supervisor
Los Angeles County Board of Supervisors

Dear Chair Mitchell and Supervisors Solis, Kuehl, Hahn, and Barger,

The Los Angeles County Commission on HIV (COH) applauds and welcomes the motions approved by the Board on August 2 to curb the Sexually Transmitted Infections (STIs) crisis in the County of Los Angeles. These motions are steps in the right direction to bring much-needed resources to the County, sustain a coordinated countywide effort, and improve infrastructure to increase testing, treatment, education, surveillance, and disease control efforts.

The motions respond to the testimonies and appeals provided by the COH and the community-at-large to harness focus and urgency to alleviate the impact of STIs on communities across the County. The COH is committed to working with you and various County Departments to reduce the spread of STIs, bring critical health information and services to the community, and advocate for additional resources from our local, State, and Federal partners.

On September 6, 2018, the COH wrote to the Board to advocate for a multi-year investment of $30 million in funding for increased STI surveillance, disease investigation and intervention, screening, diagnosis, and treatment services, prevention, and evaluation as well as adopt and implement an accelerated contracting process to respond to the urgency of the crisis. The Board responded by approving a motion that directed the Chief Executive Officer (CEO) to allocate $5 million from tobacco settlement funds to support the delivery of STD screening and treatment services specifically targeting underserved geographic areas and sub-populations of the County. Closing the gap between the enormity of the STI epidemic and available resources must continue to be a priority for the County.

Your motions will address what the COH has learned. There is much involved in the STI crisis, and we need solid, accurate, and consistent data. We have also learned that how residents are treated matters. In every area of life, how well or poorly one is received can cause exponential growth or produce what we see daily, desperation, failure(s) to thrive, and rampant incivility.

Often, healthy relationship(s), *at least one*, can produce healthy human beings, families, and communities. We must open the door to discussions and deeper more accurate conversations about healthy relationships in homes, among friends, within families on an age-appropriate basis, and in the streets. In addition to the education laid out in the motion, there is much more involved in the STI crisis, and we need this solid data discussed with everyday residents to

make an impact. A simple and easy place to start is a constant long-standing (5 years) campaign laid out locally, statewide and across the country helping Americans understand how to live within healthy human relationships. This is the door that opens deeper conversations and discussions across communities regarding healthy sexuality and STI education.

Finally, we are living in traumatic times, many in the HIV community have lived a lifetime experiencing relentless trauma. Trauma often precedes the acquisition of an STI (or alcoholism, drug abuse, or addictions), so the last key factor, often ignored in reducing STIs, is tackling the ways trauma impacts human beings and their relationships. Trauma is a byproduct of every epidemic we deal with today. This matters if we want to stop the rampant and long-standing STI epidemic that continues to devastate women, men, adolescents, and children in America and Los Angeles County.

We appreciate and recognize your leadership in tackling the STI epidemic in the County.

Sincerely,

Danielle Campbell, MPH, Co-Chair	*Bridget Gordon, Co-Chair*	Miguel Alvarez	Everardo Alvizo, LCSW
Jayda Arrington	Al Ballesteros, MBA	Alasdair Burton (Alternate)	Michael Cao, MD
Mikhaela Cielo, MD	Erika Davies	Kevin Donnelly	Felipe Findley, PA-C, MPAS, AAHIVS
Alexander Luckie Fuller	Jerry D. Gates, PhD	Joseph Green	Thomas Green
Felipe Gonzalez	Karl Halfman, MA	William King, MD, JD, AAHIVS	Lee Kochems, MA
Jose Magaña (*Alternate)	Eduardo Martinez (Alternate)	Anthony Mills, MD	Carlos Moreno
Derek Murray	Dr. Paul Nash, CPsychol, AFBPsS FHEA	Katja Nelson, MPP	Jesus “Chuy” Orozco
Mario J. Pérez, MPH	Mallery Robinson (Alternate)	Ricky Rosales	Harold Glenn San Agustin, MD
Martin Sattah, MD	LaShonda Spencer, MD	Kevin Stalter	Justin Valero, MPA

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

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

Expenditures reported by September 14, 2022

1	2	3	4	5	6	7	8	9	10	11	12	13	14
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	PART A + MAI EXPENDITURES %	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)	COH YR 32 ALLOCATIONS %	OTHER CONTRACTED FUNDING PART A/MAI - HIV NCC (FY 2021/22)	OTHER CONTRACTED FUNDING PART B - HIV NCC (FY 2021/22)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 2,634,774	$ -	$ 2,634,774	$ 5,982,615	$ -	$ 5,982,615	16.37%	$ -	$ -	$ 2,634,774	23.70%	$ 742	$ -
MEDICAL CASE MGMT (Medical Care Coordination)	$ 3,654,228	$ -	$ 3,654,228	$ 8,960,217	$ -	$ 8,960,217	24.51%	$ -	$ -	$ 3,654,228	21.87%	$ 100,198	$ -
ORAL HEALTH CARE	$ 1,938,955	$ -	$ 1,938,955	$ 7,387,253	$ -	$ 7,387,253	20.21%	$ -	$ -	$ 1,938,955	16.36%	$ 344,157	$ -
MENTAL HEALTH	$ 117,250	$ -	$ 117,250	$ 284,561	$ -	$ 284,561	0.78%	$ -	$ -	$ 117,250	3.78%	$ -	$ -
EARLY INTERVENTION SERVICES	$ -	$ -	$ -	$ 250,000	$ -	$ 250,000	0.68%	$ -	$ -	$ 250,000	0.00%	$ -	$ -
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 1,028,306	$ -	$ 1,028,306	$ 2,095,420	$ -	$ 2,095,420	5.73%	$ -	$ -	$ 1,028,306	6.30%	$ -	$ -
CHILD CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ -	$ -	$ -	0.88%	$ -	$ -
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 575,765	$ -	$ 575,765	$ 1,324,587	$ -	$ 1,324,587	3.62%	$ -	$ -	$ 575,765	2.27%	$ -	$ -
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 235,392	$ 235,392	$ -	$ 546,198	$ 546,198	1.49%	$ -	$ -	$ 235,392	0.99%	$ -	$ -
HOUSING-RCFCI, TRCF	$ 321,180	$ -	$ 321,180	$ 765,689	$ -	$ 765,689	2.09%	$ 1,226,489	$ 4,202,239	$ 1,547,669	0.91%	$ -	$ 200,241
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,009,965	$ 1,009,965	$ -	$ 3,029,896	$ 3,029,896	8.29%	$ -	$ -	$ 1,009,965	7.38%	$ -	$ -
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ 175,850	$ 701,450	$ 175,850	--	$ -	$ -
MEDICAL TRANSPORTATION	$ 211,146	$ -	$ 211,146	$ 423,833	$ -	$ 423,833	1.16%	$ -	$ -	$ 211,146	2.01%	$ 21	$ -
LANGUAGE SERVICES	$ 1,291	$ -	$ 1,291	$ 3,098	$ -	$ 3,098	0.01%	$ -	$ -	$ 1,291	0.60%		$ -
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 1,400,694	$ -	$ 1,400,694	$ 2,947,102	$ -	$ 2,947,102	8.06%	$ -	$ -	$ 1,400,694	8.31%	$ 41,198	$ -
EMERGENCY FINANCIAL ASSISTANCE	$ 217,349	$ -	$ 217,349	$ 948,856	$ -	$ 948,856	2.60%	$ -	$ -	$ 217,349	3.70%	$ -	$ -
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 355,492	$ -	$ 355,492	$ 1,066,477	$ -	$ 1,066,477	2.92%	$ -	$ -	$ 355,492	--	$ 101,194	$ -
LEGAL	$ 267,462	$ -	$ 267,462	$ 537,628	$ -	$ 537,628	1.47%	$ -	$ -	$ 267,462	0.93%	$ -	$ -
SUB-TOTAL DIRECT SERVICES	$ 12,723,892	$ 1,245,357	$ 13,969,249	$ 32,977,336	$ 3,576,094	$ 36,553,430	100.00%	$ 1,402,339	$ 4,903,689	$ 15,621,588	100.00%	$ 587,510	$ 200,241
YR 32 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 2,987,077	$ 169,983	$ 3,157,060	$ 4,214,223	$ 378,020	$ 4,592,243		$ 176,000	$ 504,249	$ 3,333,060		$ 3,456,088	$ 270,242
YR 32 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 376,037	$ -	$ 376,037	$ 973,910	$ -	$ 973,910		$ -	$ -	$ 376,037		$ -	$ -
TOTAL EXPENDITURES	$ 16,087,006	$ 1,415,340	$ 17,502,346	$ 38,165,469	$ 3,954,114	$ 42,119,583		$ 1,578,339	$ 5,407,938	$ 19,330,685		$ 4,043,598	$ 470,483
TOTAL GRANT AWARD				**$ 42,142,230**	**$ 3,780,205**	**$ 45,922,435**			**$ 5,446,809**				
VARIANCE				(3,976,761)	173,909				(38,871)				
MAI Carryover from YR 31 to YR 32	$	1,747,329											
Estimated MAI Carryover from YR32 to YR 33	**$**	**3,402,185**											

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

Ryan White Program Year 31
Care Utilization Data Summary

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

Sep 27, 2022
COH Planning, Priorities, and Allocations Committee

Presentation Overview:

- Introduction to the Ryan White Program (RWP) utilization data summary
- Trends in demographic and socio-economic characteristics of RWP clients
- Impact of COVID-19 on RWP service utilization
- HIV Care Continuum Outcomes among RWP clients
- RWP service utilization and expenditures by service category
- Q&A and Discussion

What data are used for the utilization report?

- HIV Casewatch (local RWP data reporting system)
  - Reported by RWP contracted service agencies
  - Electronic transfer of data files
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

The data only reflects clients and services reported in the measurement period

What can be learned from the utilization report?

Opportunities:

- How many unduplicated RWP clients served each reporting year
- How many clients enrolled/used each service
  - If there are differences in utilization
- How many service units were provided by DHSP subrecipients
- HIV care continuum outcomes
  - If there are disparities in outcomes
- How services were utilized (in-person vs. telehealth)

Limitations:

- What services clients need
- Where there are service gaps
- Why the number of clients changes from one year to next
- Don't know how many PLWDH are uninsured
- Why there are disparities in utilization or outcomes
- Doesn't describe or represent characteristics or service use among PLWDH outside of the RWP

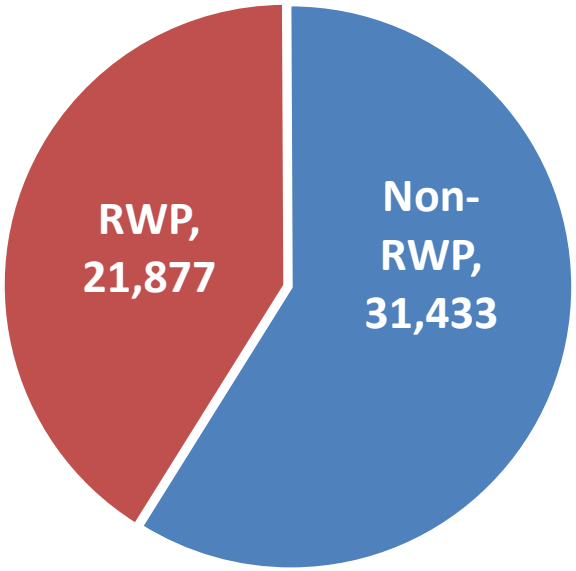
Characteristics of Ryan White Program Clients

Year 31 Los Angeles County Ryan White Program (RWP) Population

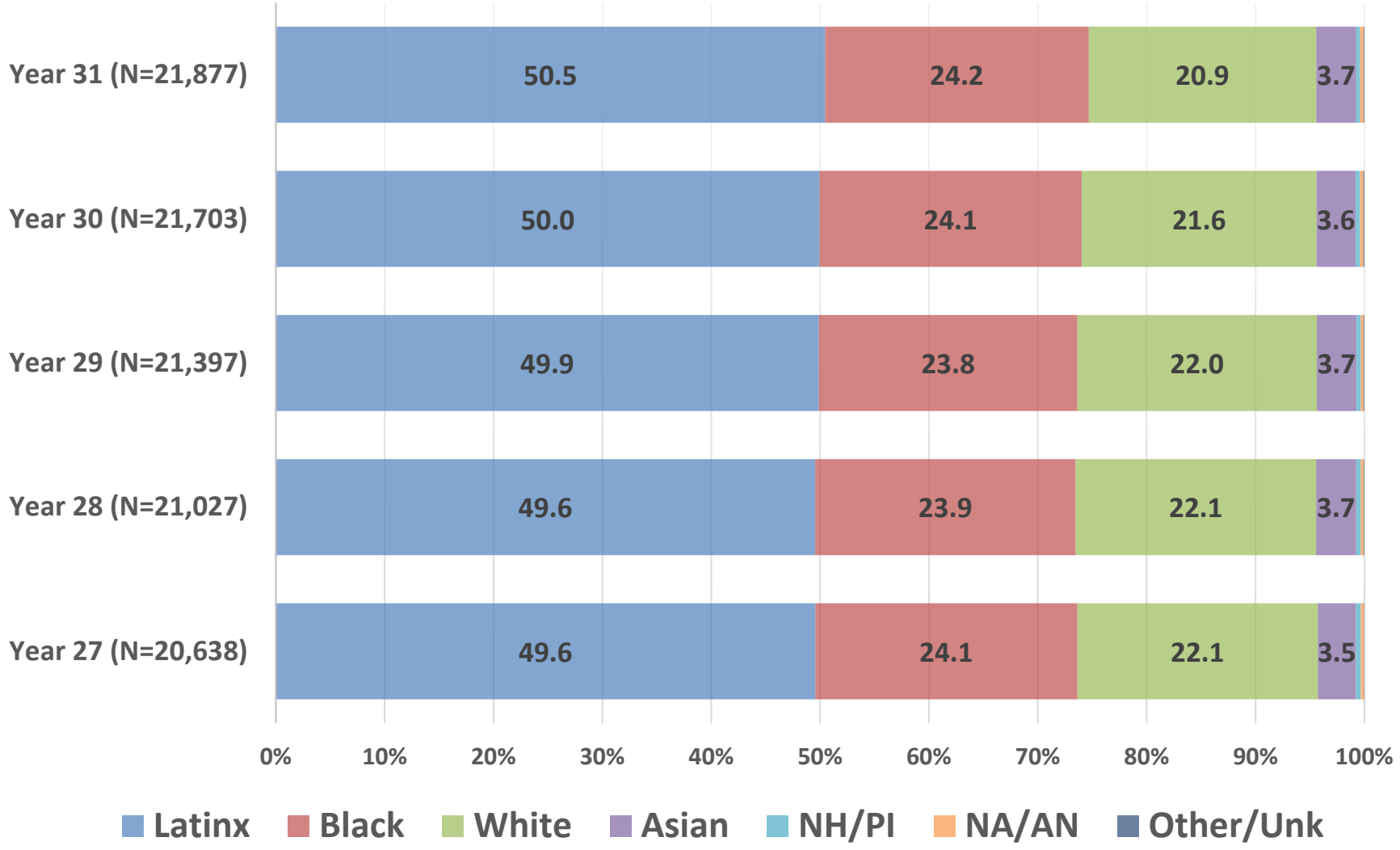
In Ryan White Program Year 31 (March 1, 2021 - February 28, 2022) **21,877** clients received at least one core or support RWP service

Approximately **2 out of every 5 people living with diagnosed HIV (PLWDH)** in LAC in 2021 used RWP HIV services

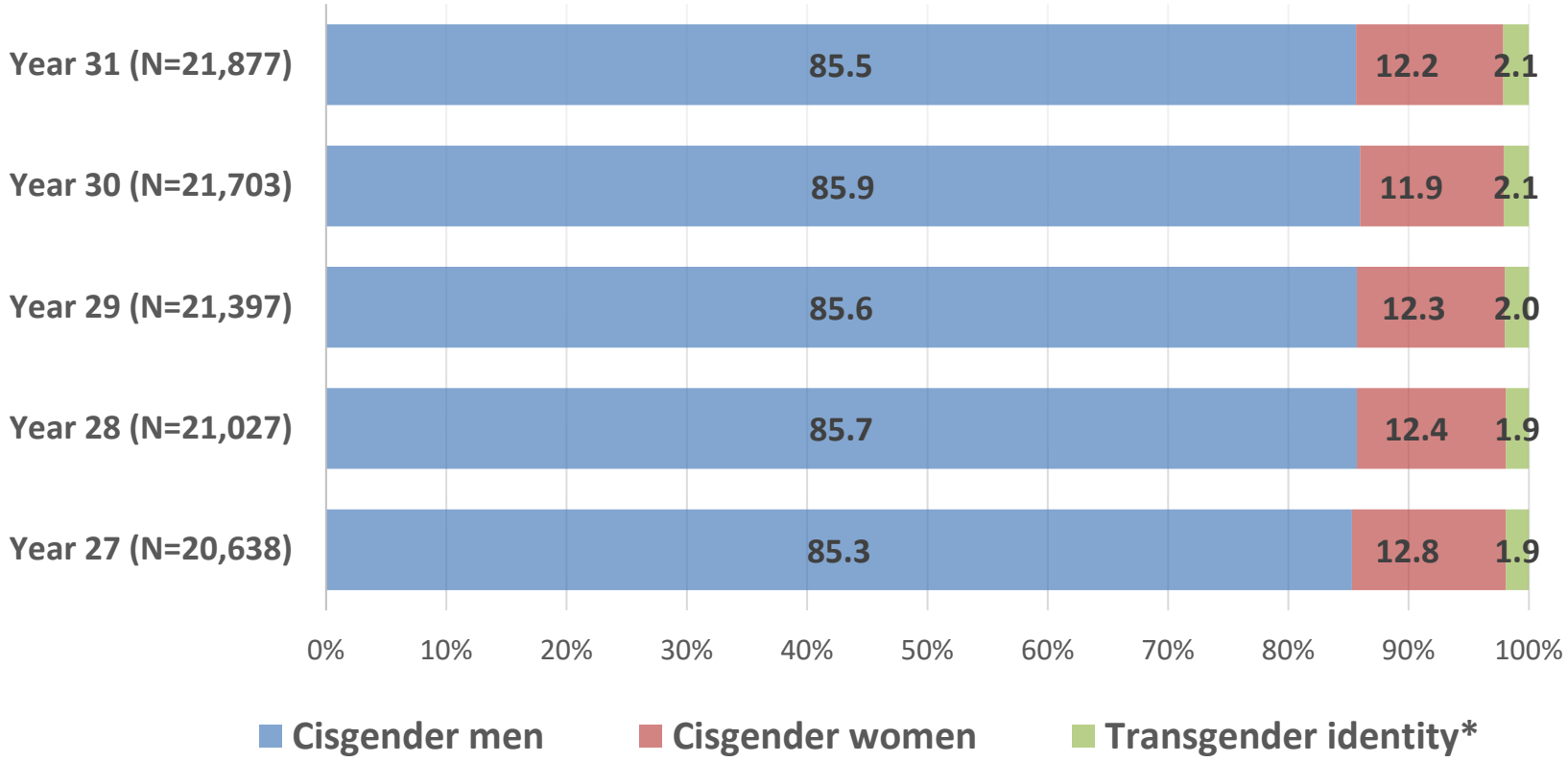
RWP Utilization among PLWDH in LAC, 2021



Latinx and Black clients continue to represent the largest percentage of RWP clients.



Majority of RWP clients continue to be cisgender men.



*Includes clients who identify as transgender women. In each year, transgender women represent ~95% of RWP clients who report a transgender or another gender identity

From Year 27 to Year 31 the proportion of RWP clients aged 60 years and older has continued to increase

Note: Clients aged 13-17 represent <0.05% of RWP clients and are not included on the figure

- **Stable number of clients per year, including during COVID-19 in Year 30**
- **Key social determinants among clients have changed little over time**

		Year 27 N=20,638	Year 28 N=21,027	Year 29 N=21,397	Year 30 N=21,703	Year 31 N=21,877
Social determinants	Living ≤ 100% FPL	66%	65%	62%	62%	64%
	Uninsured	35%	35%	35%	33%	32%
	Spanish-speaking	27%	27%	26%	26%	26%
	Incarcerated ≤2 years	8%	9%	8%	9%	8%
	Experiencing homelessness	8%	9%	10%	10%	9%
HD of Residence	Hollywood-Wilshire	13%	17%	16%	17%	16%
	Central	9%	12%	12%	12%	11%
	Southwest	5%	7%	7%	7%	7%
	Long Beach	6%	6%	6%	6%	6%

- **Increase in % of RWP clients receiving MCC since YR27**
- **Increase in % of RWP receiving Oral Health in YR 31, recovered following COVID-19**
- **Decrease in % of RWP clients using SA – Residential and Outreach Services (LRP) over the past 5 years**

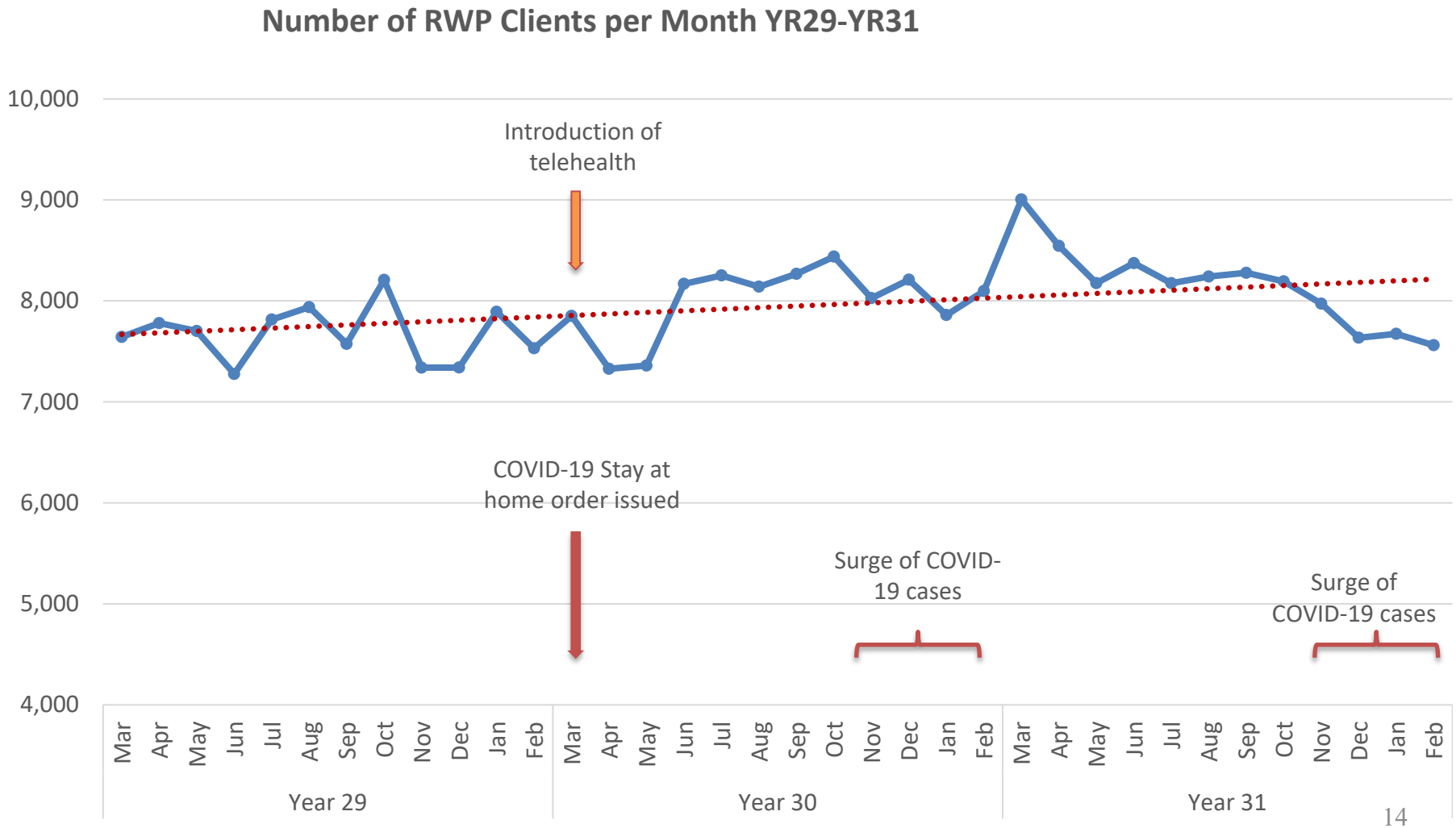
	Year 27 N=20,638	Year 28 N=21,027	Year 29 N=21,397	Year 30 N=21,703	Year 31 N=21,877
Medical Outpatient	73%	69%	70%	70%	70%
Medical CM	**29%**	**35%**	**34%**	**39%**	**38%**
Non-Medical CM	27%	17%	22%	23%	24%
Oral Health	19%	19%	21%	16%	19%
Nutrition Support	9%	9%	9%	10%	9%
Mental Health	4%	4%	3%	4%	3%
HBCM	2%	1%	1%	1%	1%
Housing Services	1%	1%	1%	1%	1%
SA Services - Residential	2%	1%	1%	1%	<1%
Outreach Services (LRP)	1%	1%	1%	<1%	<1%

Questions and Discussion

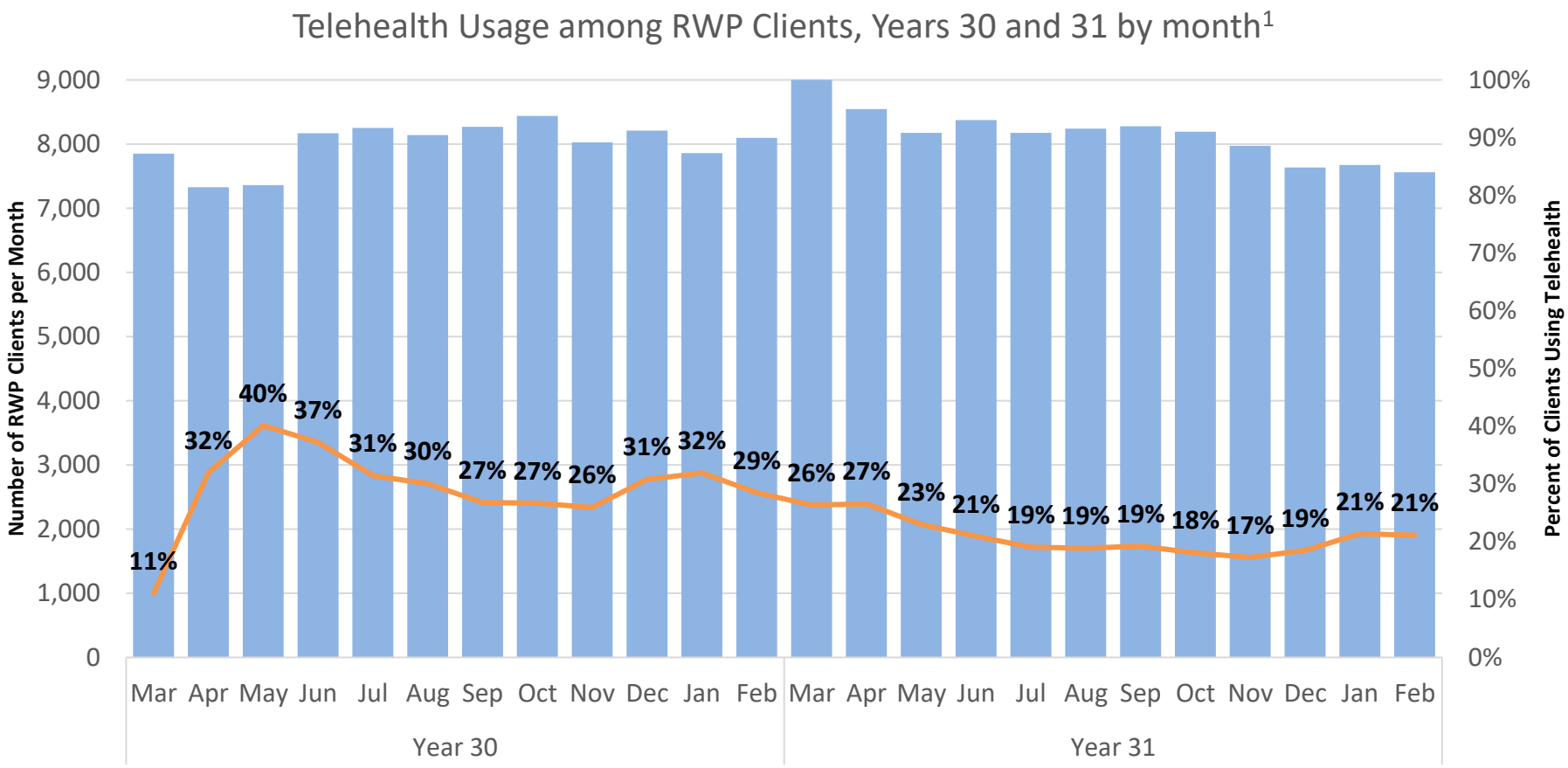
County of Los Angeles Public Health

COVID-19 Impact and Recovery on RWP Service Utilization

Three-year trend suggest an increase in average number of clients per month (as indicated by dashed red line)

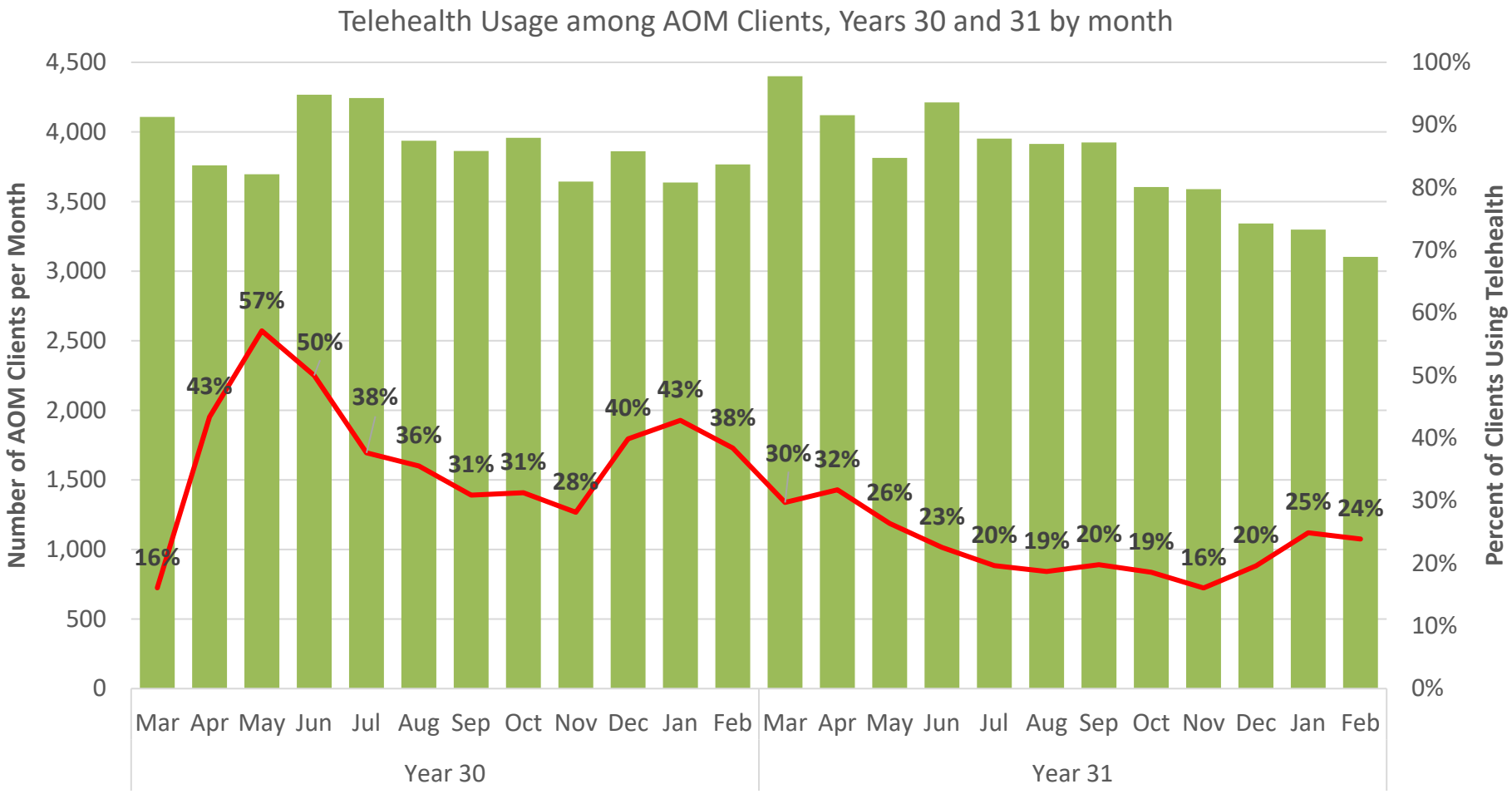


While telehealth use has decreased since peaking in May 2020, it still represents an important strategy to promote service continuity

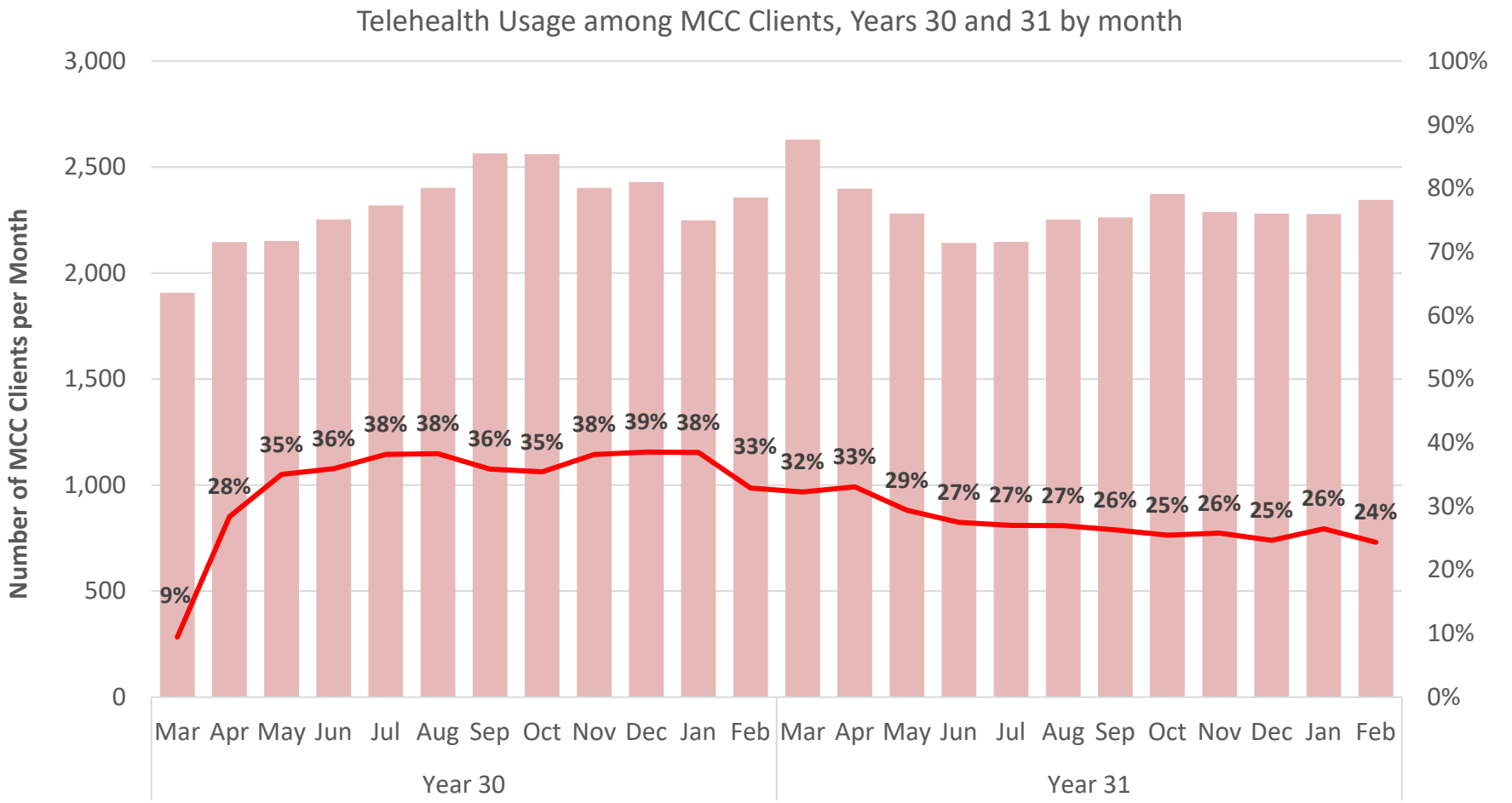


[1]Service with telehealth modalities were Medical Care Coordination (MCC), (AOM), Mental Health (MH) and HBCM (Home Based case Management

- **Telehealth was critical for continuity of medical care among AOM clients during COVID-19**
- **The percentage of AOM clients using telehealth decreased from 56% in Year 30 to 38% in Year 31**



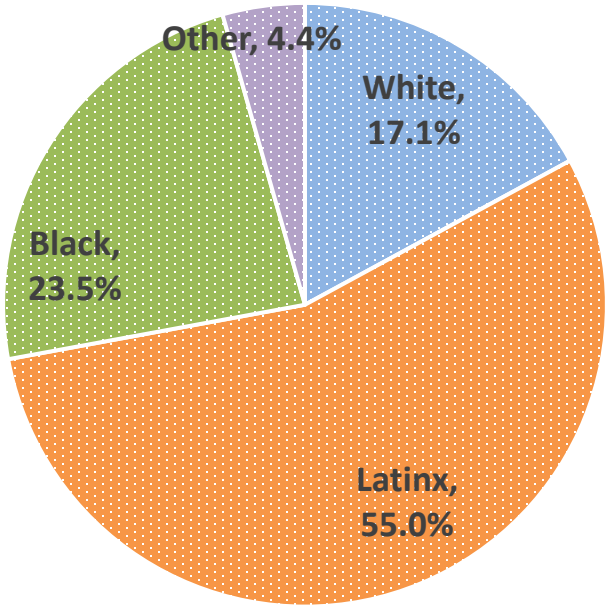
- **Significant percentages of MCC clients each month used telehealth over the past two years**
- **By year, the percent of MCC clients using telehealth decreased from 51% in Year 30 to 46% in Year 31 but remains important for expanded service access**



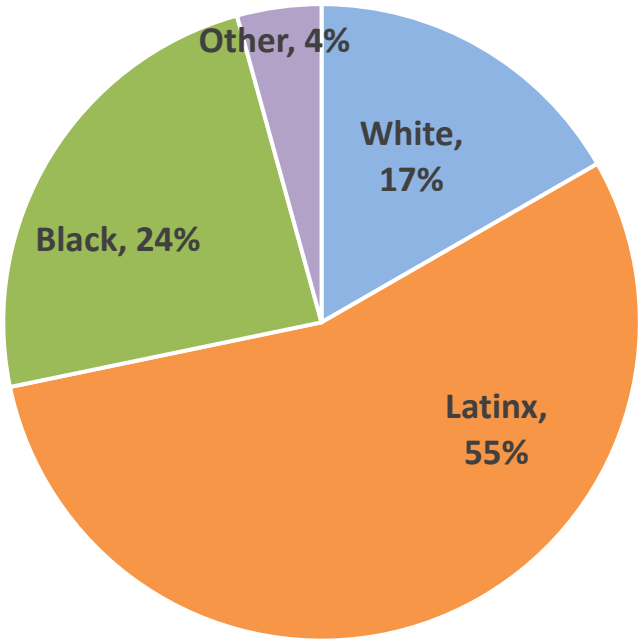
The majority of clients receiving at least one RWP service via telehealth were Latinx and Black and have remained steady over time

Percentage of RWP Clients Receiving Telehealth Services in Y30 and Y31 by Race/Ethnicity

Telehealth Clients **YR 30**



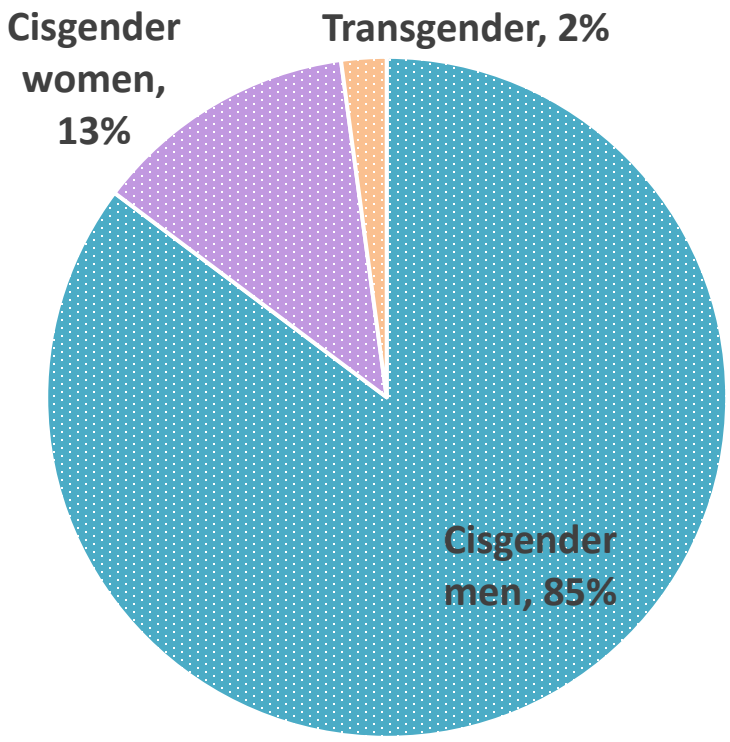
Telehealth Clients **YR 31**



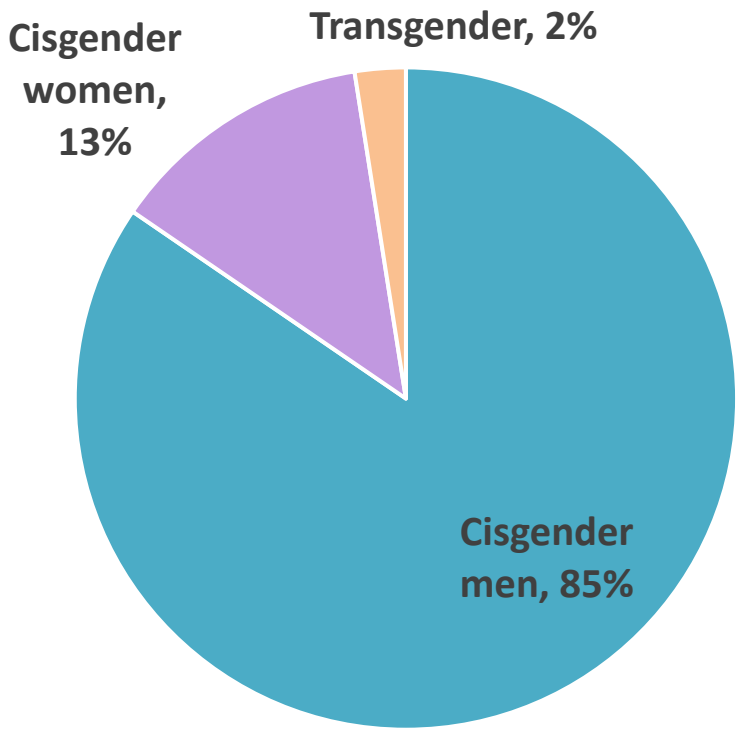
The majority of clients receiving at least one RWP telehealth service were cisgender men and have remained steady from Year 30 to Year 31

Percentage of RWP Clients Receiving Telehealth Services in Y30 and Y31 by Gender

Telehealth Clients **YR 30**



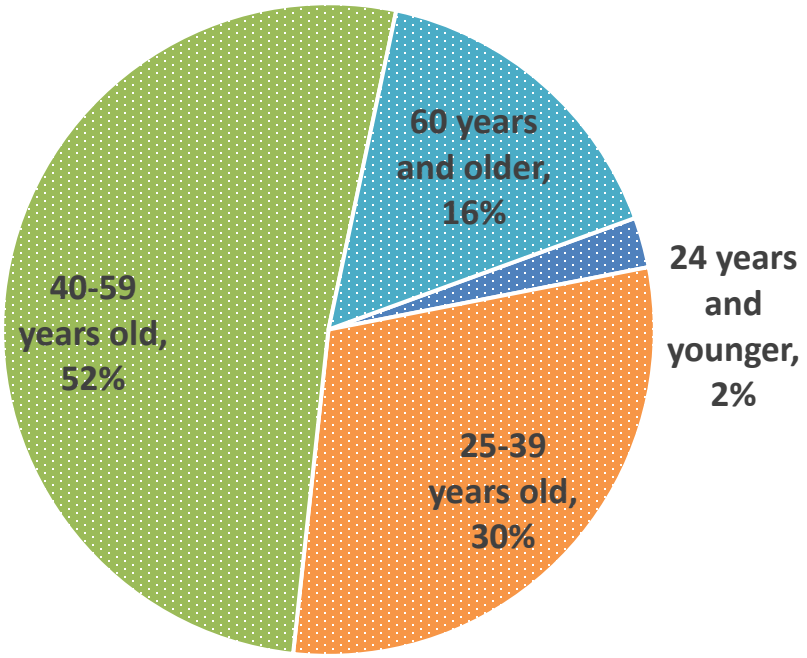
Telehealth Clients **YR 31**



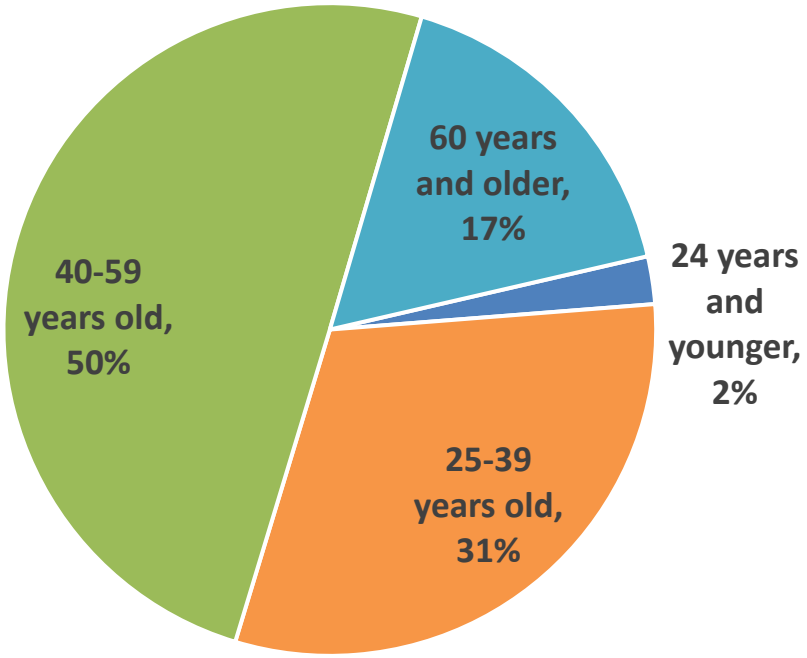
The majority of clients using RWP services via telehealth were age 40-59 years of age and have changed little over time

Percentage of RWP Clients Received Telehealth Services in Y30 and Y31 by Age

Telehealth Clients YR 30



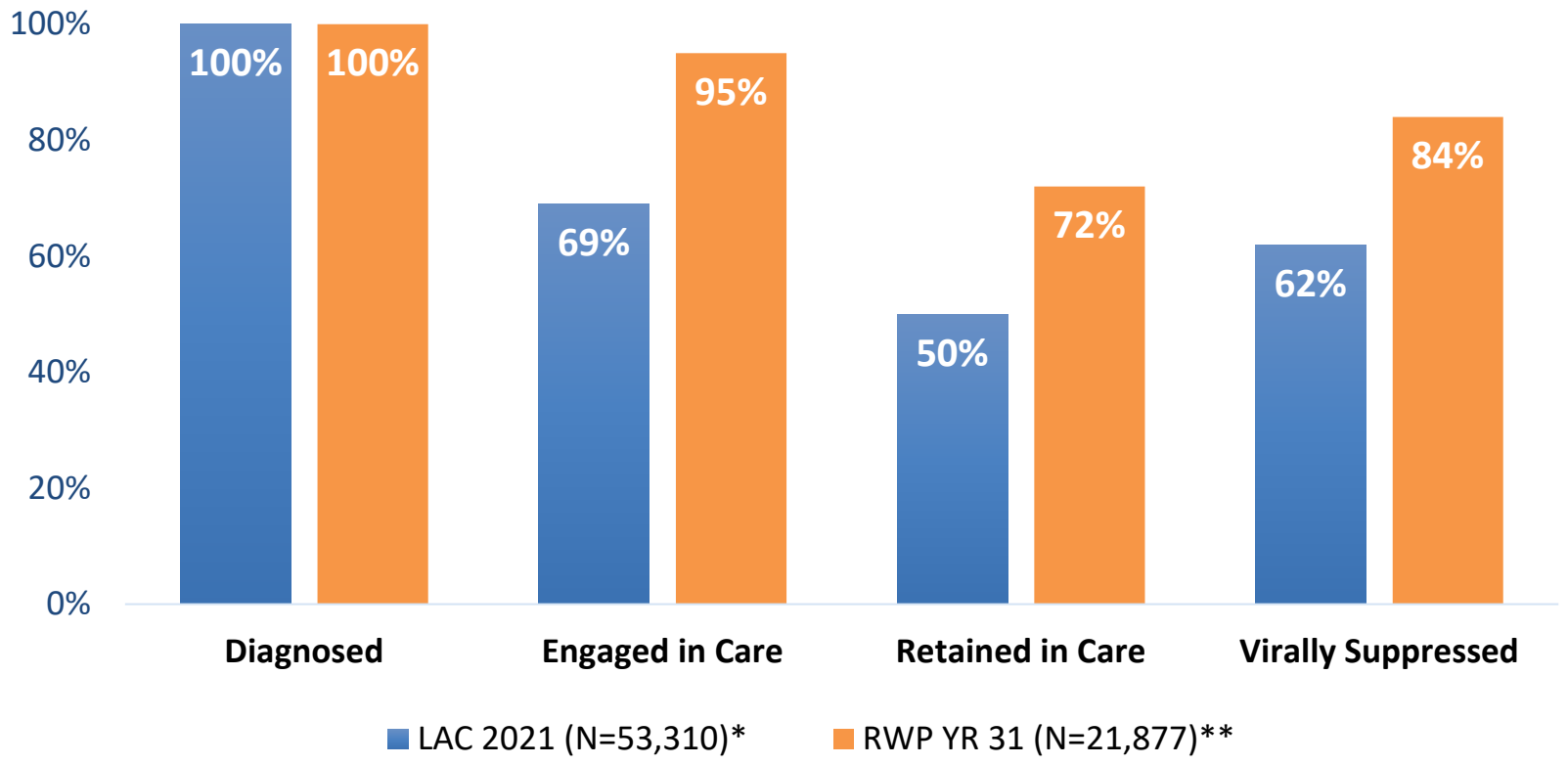
Telehealth Clients YR 31



Questions and Discussion

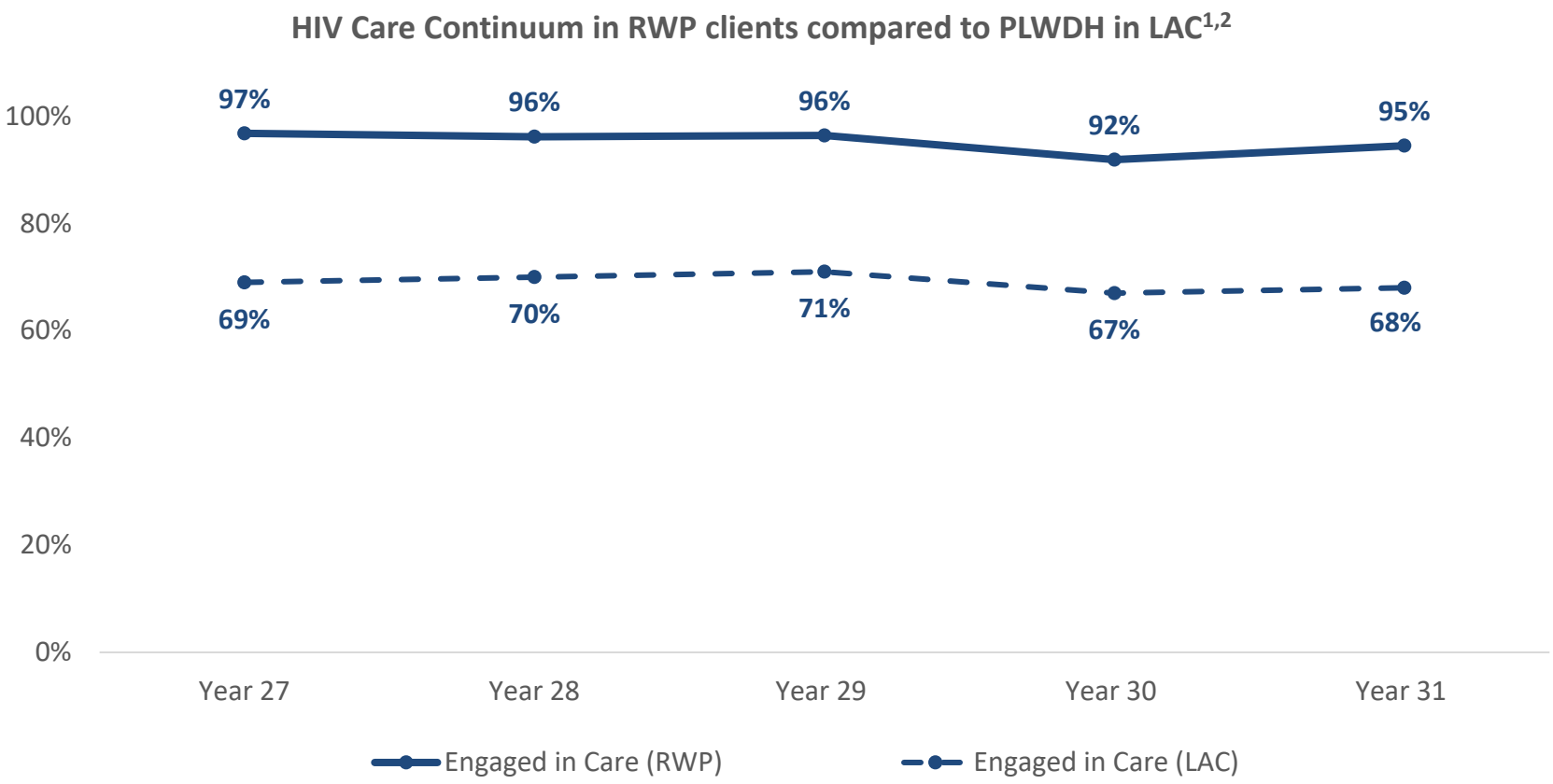
HIV Care Continuum Outcomes

Engagement, retention in care and viral suppression were higher among RWP clients compared to all PLWDH in LAC.



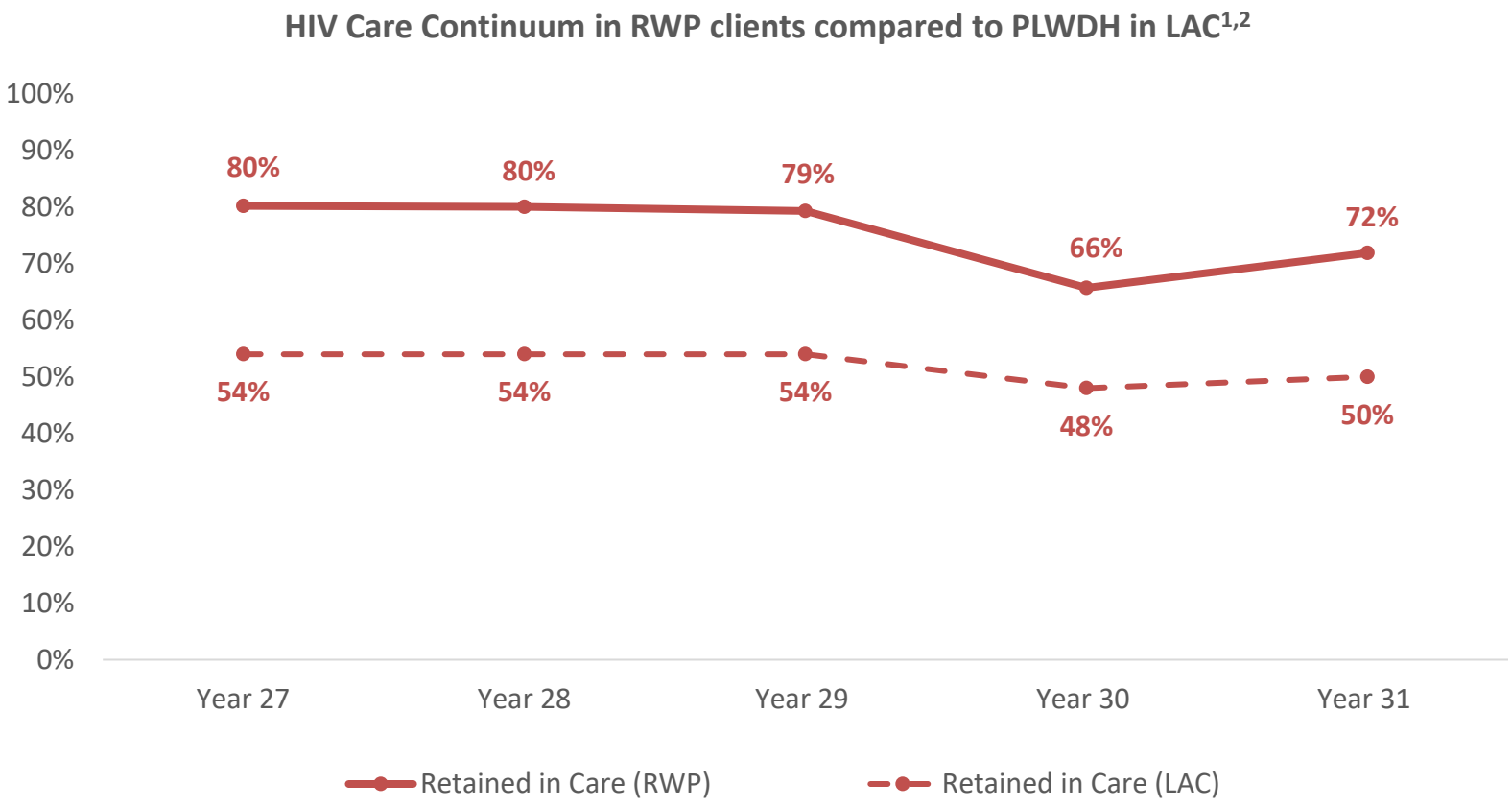
Note: LAC surveillance data is for Jan-Dec 2021 and RWP data is Mar 2021-Feb 2022
*Source: Los Angeles County HIV Surveillance Program
** Source: CaseWatch

- **Engagement in care was higher among RWP clients (solid lines) compared to all PLWDH in LAC (dotted lines)**
- **Small decrease in engagement in care in Year 30 likely due impact of COVID-19 on access to care, but data suggest recovery**



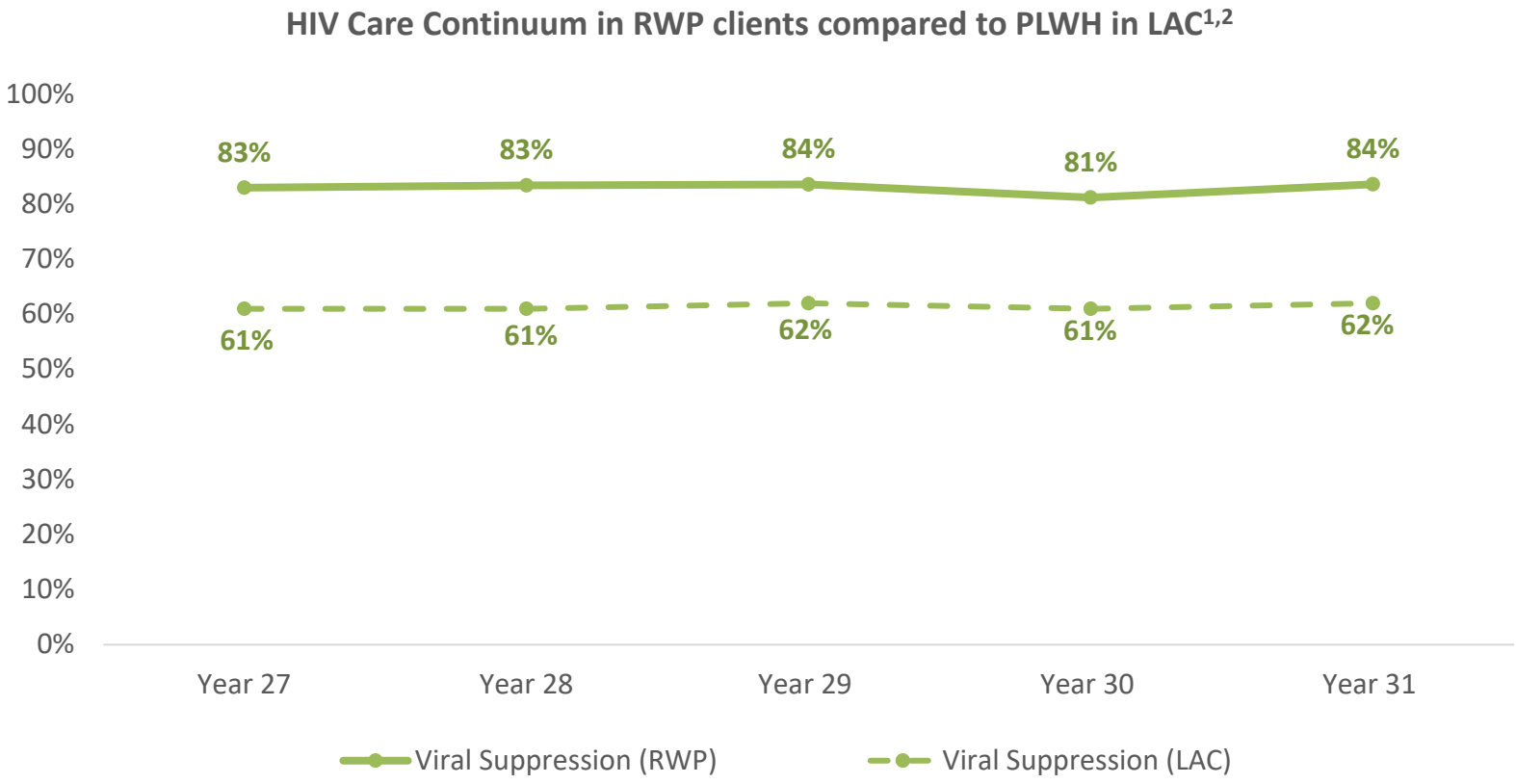
[1]CaseWatch Data for RWP years YR27-YR31 (from 03/01/2017 – 02/28/2022)
[2]LAC HIV Surveillance Data for calendar years 2017-2021 (Data as of 06/30/2022)

- **Retention in care (RiC) was higher among RWP clients (solid lines) compared to all PLWDH in LAC (dotted lines)**
- **Decrease in RiC in Year 30 likely due to impact of COVID-19 on access to care; slow recovery**



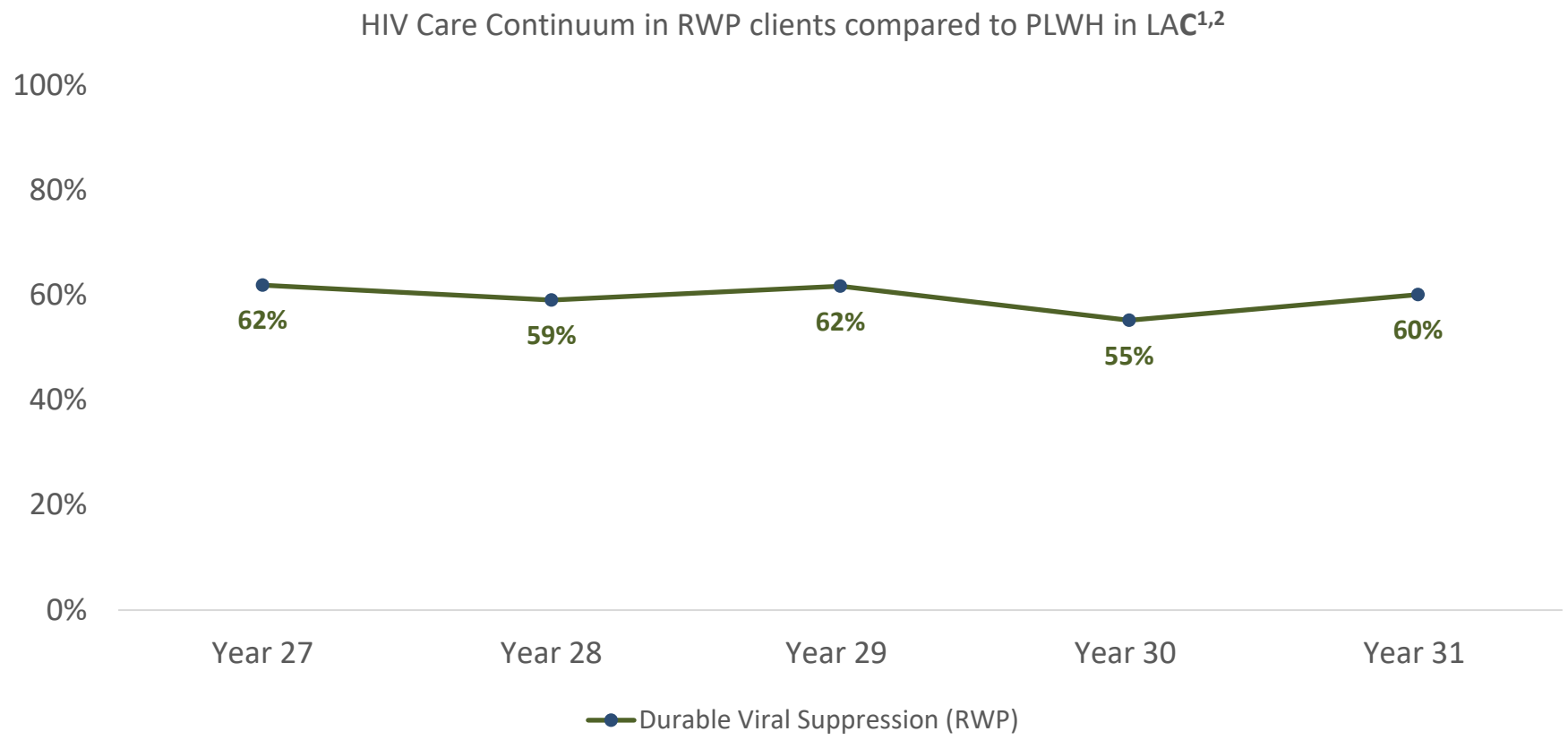
[1]CaseWatch Data for RWP years YR27-YR31 (from 03/01/2017 – 02/28/2022)
[2]LAC HIV Surveillance Data for calendar years 2017-2021 (Data as of 06/30/2022)

- **Viral Suppression (VS) was higher among RWP clients (solid lines) compared to all PLWDH in LAC (dotted lines)**
- **Decrease in VS in Year 30 likely due impact of COVID-19 on access to care, but the impact was minimal**
- **Viral suppression recovered**



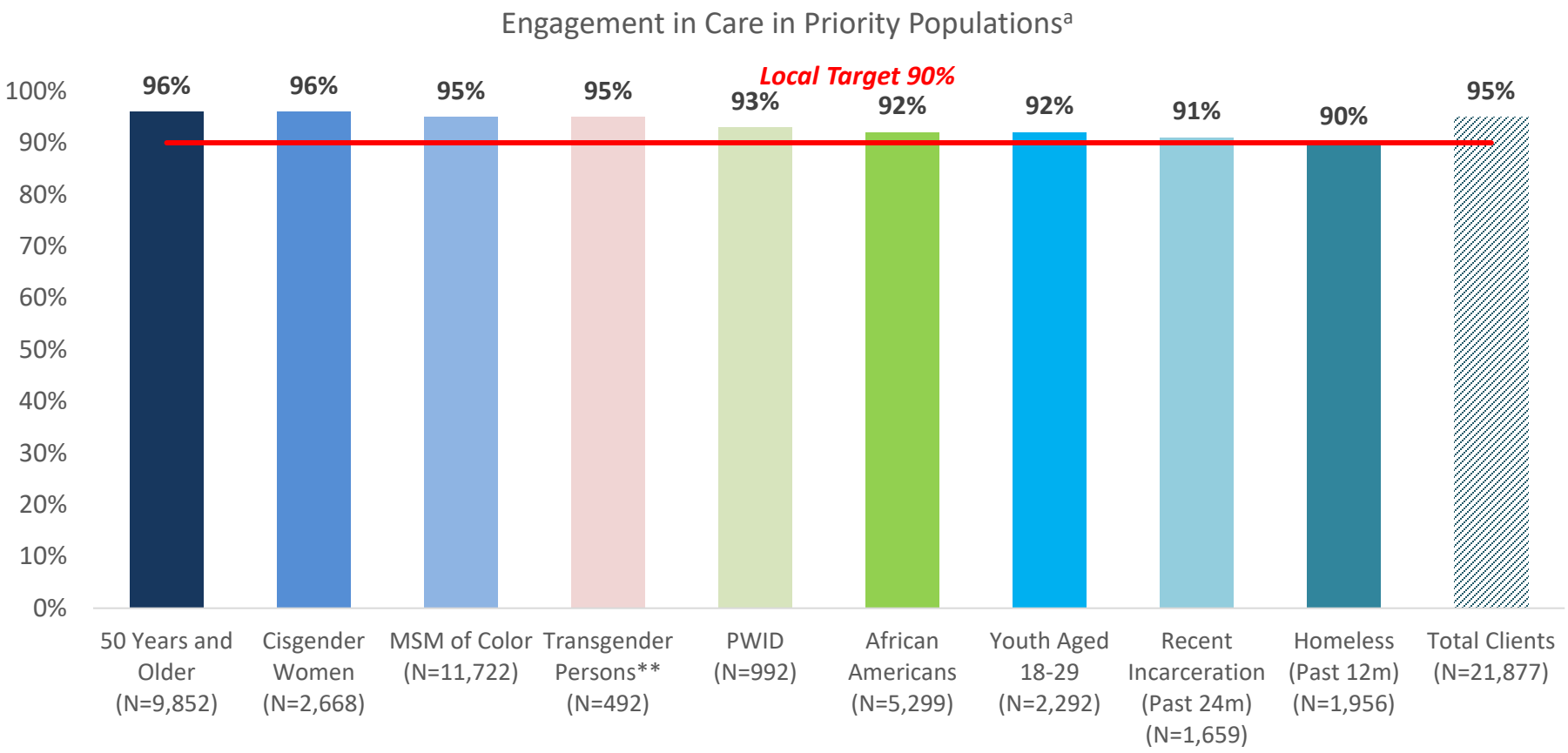
[1]CaseWatch Data for RWP years YR27-YR31 (from 03/01/2017 – 02/28/2022)
[2]LAC HIV Surveillance Data for calendar years 2017-2021 (Data as of 06/30/2022)

- **Durable Viral Suppression (VS) was lower than just viral suppression among RWP clients (solid line); durable VS was not available for all PLWDH in LAC**
- **Decrease in durable VS in Year 30 likely due impact of COVID-19 on access to care**
- **Durable VS is recovering**



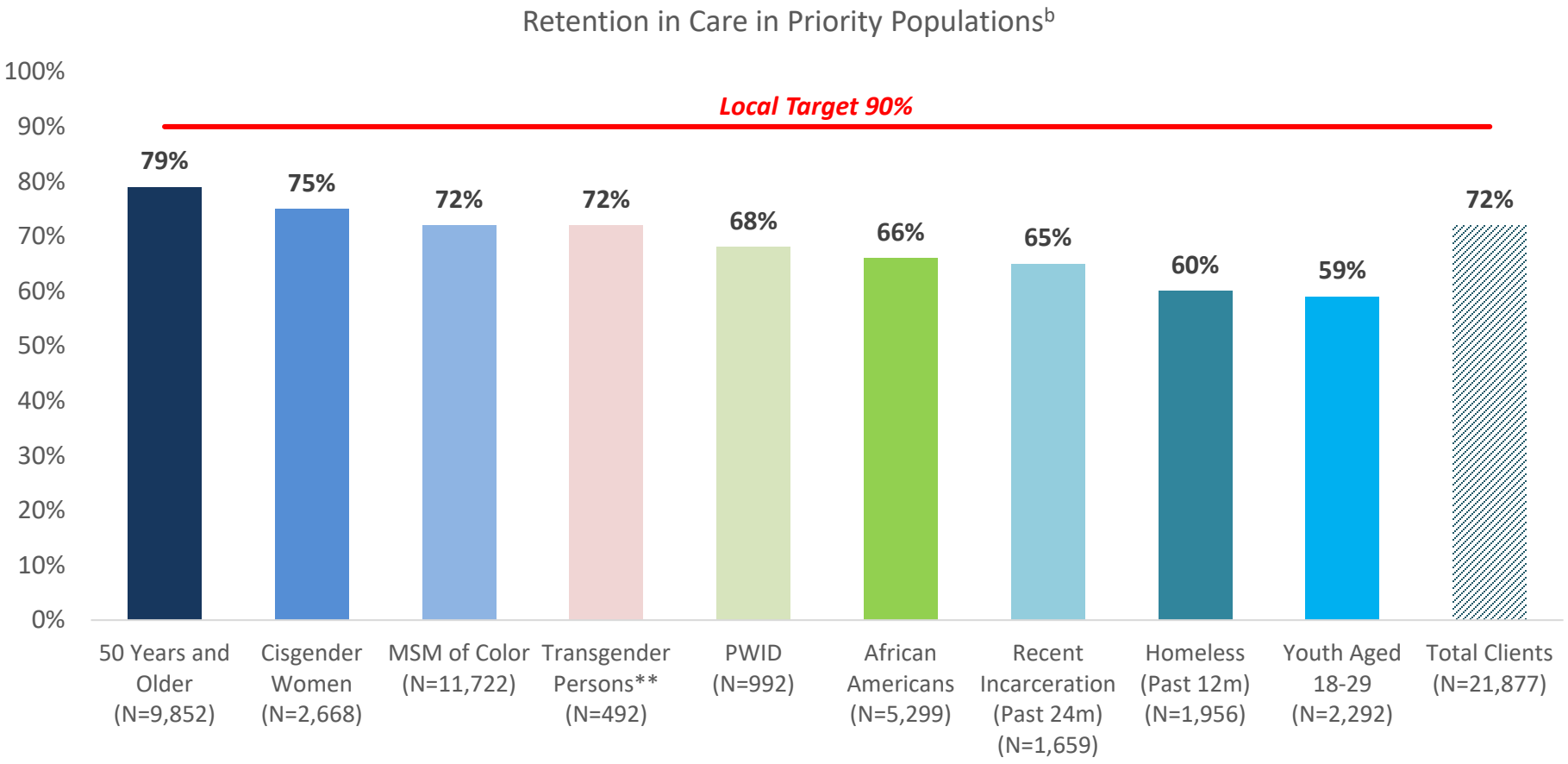
[1]CaseWatch Data for RWP years YR27-YR31 (from 03/01/2017 – 02/28/2022)
[2]LAC HIV Surveillance Data for calendar years 2017-2021 (Data as of 06/30/2022)

- In Year 31 Engagement in Care in Priority Populations was high overall and exceeded local target
- Highest among older clients and cisgender women and lowest among those experiencing homelessness or recently incarcerated



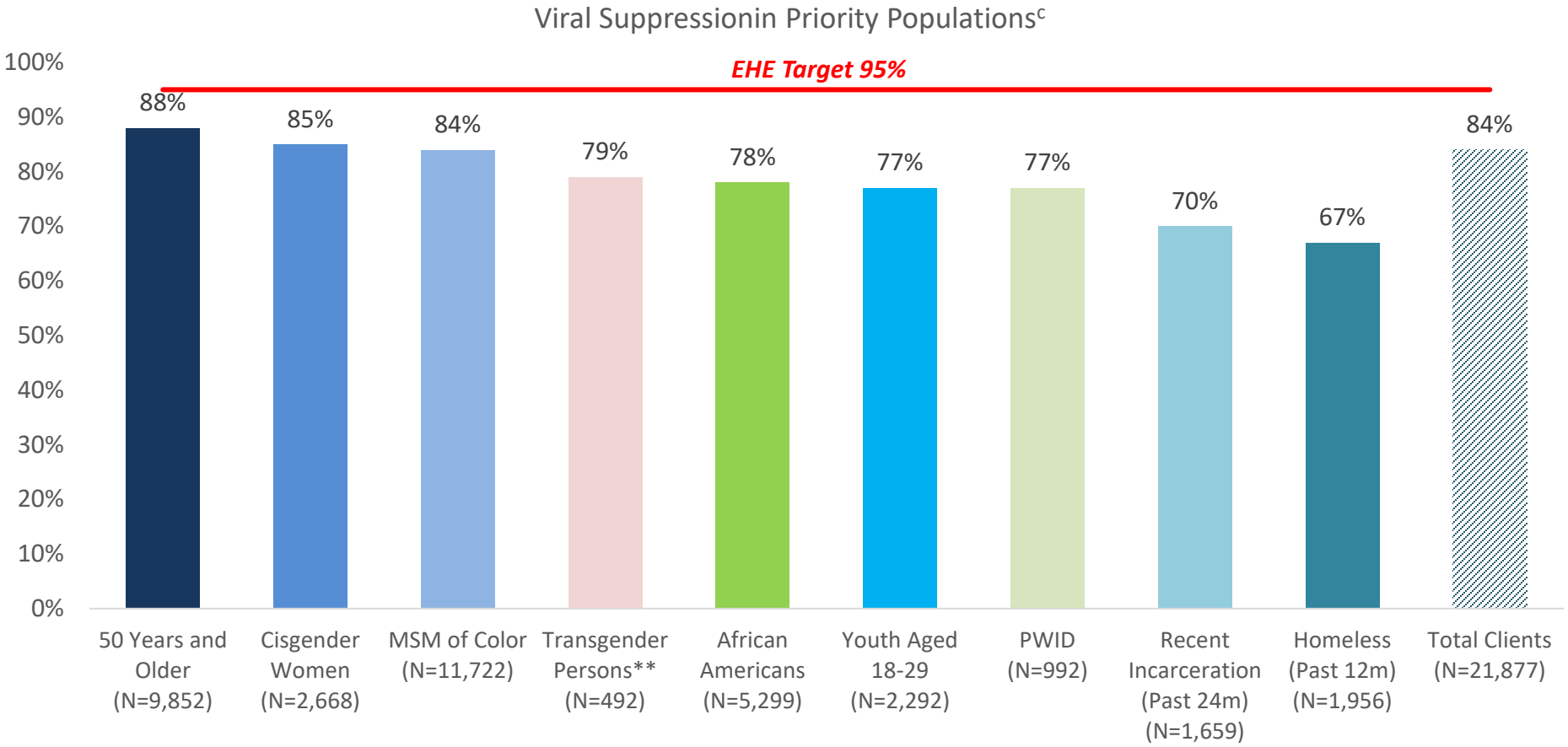
[a]Defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/20/2022
*MSM of Color defined as PLWDH who reported male sex at birth, sex with men as primary HIV risk category and non-White race/ethnicity
**Includes 467 transgender women and 25 transgender men

- In Year 31 Retention in Care (RiC) in Priority Populations was the highest among older adults and the lowest among youth
- Retention in care is lower than EHE/local target (90%) for all priority populations and in the RWP



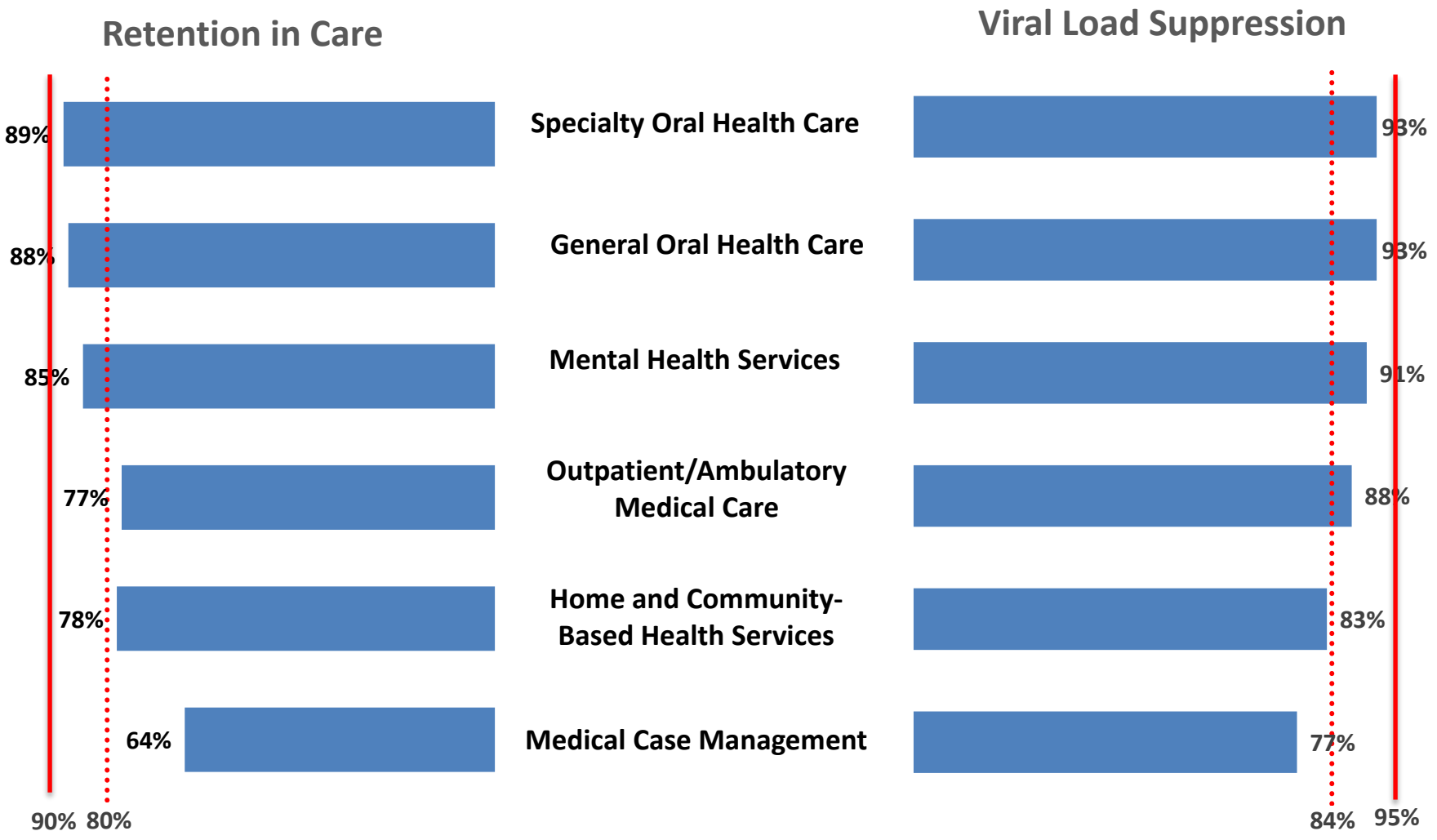
[b]Defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 05/20/2022
*MSM of Color defined as PLWDH who reported male sex at birth, sex with men as primary HIV risk Local category and non-White race/ethnicity
**Includes 467 transgender women and 25 transgender men

- In Year 31 Viral Suppression (VS) in Priority Populations was the highest among older adults and the lowest among homeless people
- Viral suppression is lower than the EHE local target for all priority populations in the RWP

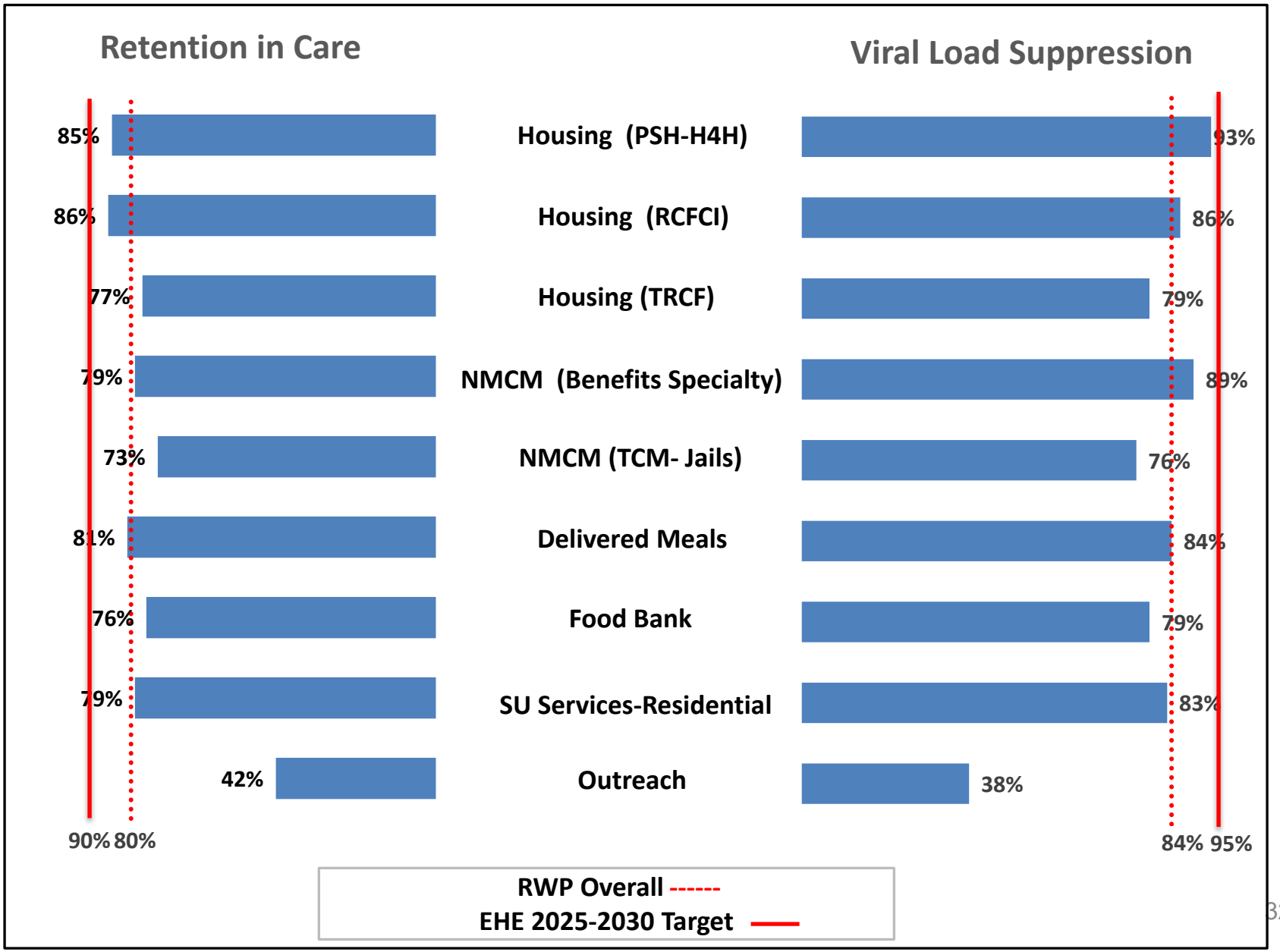


[c]Defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 05/20/2022
*MSM of Color defined as PLWDH who reported male sex at birth, sex with men as primary HIV risk category and non-White race/ethnicity
**Includes 467 transgender women and 25 transgender men

HIV Care Continuum-Core Services Yr 31



HIV Care Continuum Support Services Yr 31



Questions and Discussion

Overview of RWP Year 31 Utilization Data and Expenditures by Service Category

RWP Services Paid for by DHSP

- Not all clients who access RWP services end up having them paid for by DHSP
  - As the payer of last resort, all other payer sources must be evaluated in addition to service-level eligibility criteria
- To understand how grant funds are being spent, we need to focus on those clients who used services ultimately paid for with RWP monies ("funded" clients)
- In Year 31 (March 1, 2022-February 28, 2023), DHSP paid for 16,963 ("funded") of the 21,877 clients ("fundable") who used RWP services
  - "Funded" clients were different from "fundable" clients:
    - A lower percent were Black, age 50 and older, identified as cisgender or transgender women, and with public insurance
    - A higher percent were uninsured and experienced homelessness in the reporting period

Year 31 RWP Part A, Part B, and MAI Core and Support Services

County of Los Angeles Public Health

Core Services

1. Medical Case Management (MCC)
2. Outpatient/Ambulatory Health Services
3. Oral Health
4. Home and Community Based Case Management
5. Early Intervention Services*
6. Mental Health Services

Support Services

1. Housing Services
2. Non-Medical Case Management (NMCM)
3. Food Bank/Home Delivered Meals
4. Outreach Services (Linkage and Re-engagement Program, Partner Services)*
5. Substance Use Residential
6. Medical Transportation*
7. Professional Services/Legal*
8. Emergency Financial Assistance*

**Not currently reported in HIV Casewatch, data pending*

Medical Case Management (Medical Care Coordination) - Array of services to facilitate and support access and adherence to HIV primary medical care and to enhance patients' capacity to manage their HIV disease (*24% of total service units were via telehealth in Year 31*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
MCC	8,244 (Yr 30: 8,350)	Hours	119,208 (Yr 30: 118,793)	14 (Yr 30: 14)	$9,652,814	$1,171

Funding Sources: Part A, MAI, NCC

Outpatient/Ambulatory Health Services - Primary health care services (*4% of total service units were via telehealth in Year 31*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Medical Outpatient	5,351 (Yr 30: 5,653)	Clinic visits	15,559 (Yr 30: 16,973)	3 (Yr 30: 3)	$7,478,232	$1,398

Funding Source: Part A, MAI, NCC

Oral Health Services - General and endodontic oral health services

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Oral Health (Overall)	**4,145 (Yr 30: 3,377)**	**Procedures**	**44,196 (Yr 30: 29,424)**	**11 (Yr 30: 9)**	**$6,699,203**	**$1,616**
General	3,841 (Yr 30: 3,119)	Procedures	26,650 (Yr 30: 18,752)	7 (Yr 30: 6)	**$5,032,351**	**$1,310**
Specialty	3,469 (Yr 30: 2,698)	Procedures	17,546 (Yr 30: 10,672)	5 (Yr 30: 4)	**$1,666,852**	**$480**

Funding Source: Part A

Core Services

County of Los Angeles Public Health

Home and Community Based Case Management (CM) - Skilled health services in the client's home (*telehealth – 2% of total service units were via telehealth in Year 31*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Home and Community Based CM	151 (Yr 30: 162)	Hours Nutritional Supps Medical Equipment	48,154 (Yr 30: 52,729)	319 (Yr 30: 325)	$2,318,710	$15,356

Mental Health Services- outpatient psychological and psychiatric services (*18% of total service units were via telehealth in Year 30*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Mental Health Services	331 (Yr 30: 312)	Sessions	2,724 (Yr 30: 3,168)	8 (Yr 30: 10)	$362,699	$1,096

Funding Source: Part A

Support Services

County of Los Angeles Public Health

Housing Services - Provide permanent supportive housing with case management, short-term transitional and residential care facilities and related support (*NO telehealth*)

Service Category	Unique Clients Served Yr 30 (Yr 29)	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Housing (Overall)	**237 (Yr 30: 234)**	**Days**	**68,026 (Yr 30: 59,538)**	**287 (Yr 30: 254)**		
Permanent Supportive Housing	151 (Yr 30: 147)	Days	48,699 (Yr 30: 39,839)	323 (Yr 30: 271)	$1,695,682	$11,230
Residential Care for the Chronically Ill	60 (Yr 30: 59)	Days	14,298 (Yr 30: 14,767)	238 (Yr 30: 250)	Part A: $235,329 Part B: $3,859,442 **Total: $4,094,771**	$46,531
Transitional Residential Care Facilities	28 (Yr 30: 29)	Days	5,029 (Yr 30: 4,773)	180 (Yr 30: 165)		

Funding Sources: Part A, MAI, Part B

Non-Medical Case Management - Assist with eligibility, linkage and engagement in HIV care and support services (*17% of total service units were via telehealth in Year 31*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Non-Medical CM (Overall)	**5,146 (Yr 30: 5,044)**	**Hours**	**21,950 (Yr 30: 18,201)**	**4 (Yr 29: 4)**		
Benefits Specialty	4,627 (Yr 30: 4,567)	Hours	18,755 (Yr 30: 16,413)	4 (Yr 30: 4)	$1,403,115	$303
Transitional CM - Jails	559 (Yr 30: 476)	Hours	3,195 (Yr 30: 1,652)	6 (Yr 30: 3)	$527,592	$944

Funding Sources: Part A, MAI

Outreach Services - Identify out-of-care clients, verify care status, contact, linkage to care, and provide intervention and referrals (Linkage and Re-engagement Program) and partner services *(NO telehealth)*

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Outreach Services	--	--	--	--		
LRP	26* (Yr 30: 15)	Hours	279 (Yr. 30: 69)	11 (Yr. 30: 5)	$614,470	$23,633
Partner Services	Data not available (Yr. 30: not funded)					

Funding Sources: Part A

*Limited to clients registered in HIV Casewatch and receiving re-engagement case management. Total clients referred to LRP services were: **167** in Year 30, in **227** Year 31

Food Bank/Home Delivered Meals - Provide access to food and meals to promote retention in medical care (*NO telehealth*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
Nutrition Support (Overall)	**1,971 (Yr 30: 2,130)**	**Meals Bags of groceries**	**341,115 (Yr 30: 361123)**	**173 (Yr 30: 170)**	**$2,504,284**	**$1,271**
Delivered Meals	560 (Yr 30: 579)	Meals	229,513 (Yr 30: 249,293)	410 (Yr 30: 431)		
Food Bank/ Groceries	1,562 (Yr 30: 1,725)	Bag of groceries	111,602 (Yr 30: 111,830)	71 (Yr 30: 65)		

Funding Sources: Part A, HRSA CARES, NCC

Substance Use Services – Residential: Treatment of drug or alcohol use disorders in a residential setting (*NO telehealth*)

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditure ($)	$ Invested per Client
SU Residential	90 (Yr 30: 112)	Days	11,032 (Yr 30: 12,727)	123 (Yr 30: 114)	$744,825	$8,276

Funding Sources: Part B, Non-DMC

Summary

- More clients were served in Year 31 compared to Year 30 and previous years (Years 27-31), despite COVID, underscoring the importance of expanded modalities (telehealth) to access services
- Consistent with previous years, growing number of clients aged 50 and older
- Services with limited access during COVID-19 in Year 30 saw increased utilization in Year 31 (Oral Health, TCM-Jails)
- Service units per client increased in Oral Health, Permanent Supportive Housing, TRCF, and Substance Use-Residential services
- Overall viral suppression levels among RWP clients suggest that clients continued to have access and adhere to antiretroviral therapy through Years 30-31
- Improvements in retention in care among RWP clients in Year 30 suggest that providers have increased capacity to serve clients and clients returning to in-person services following COVID-19 impacts in Year 30
- Some priority populations, however, still fall behind the average numbers for retention in care and viral suppression, particularly homeless, with recent incarceration experience, PWID, youth and African-Americans

Next Steps

- Data tables for Year 31
- Summary of Utilization Report Year 31
- Combined expenditure and utilization reports to PP&A (quarterly?)

Questions and Discussion

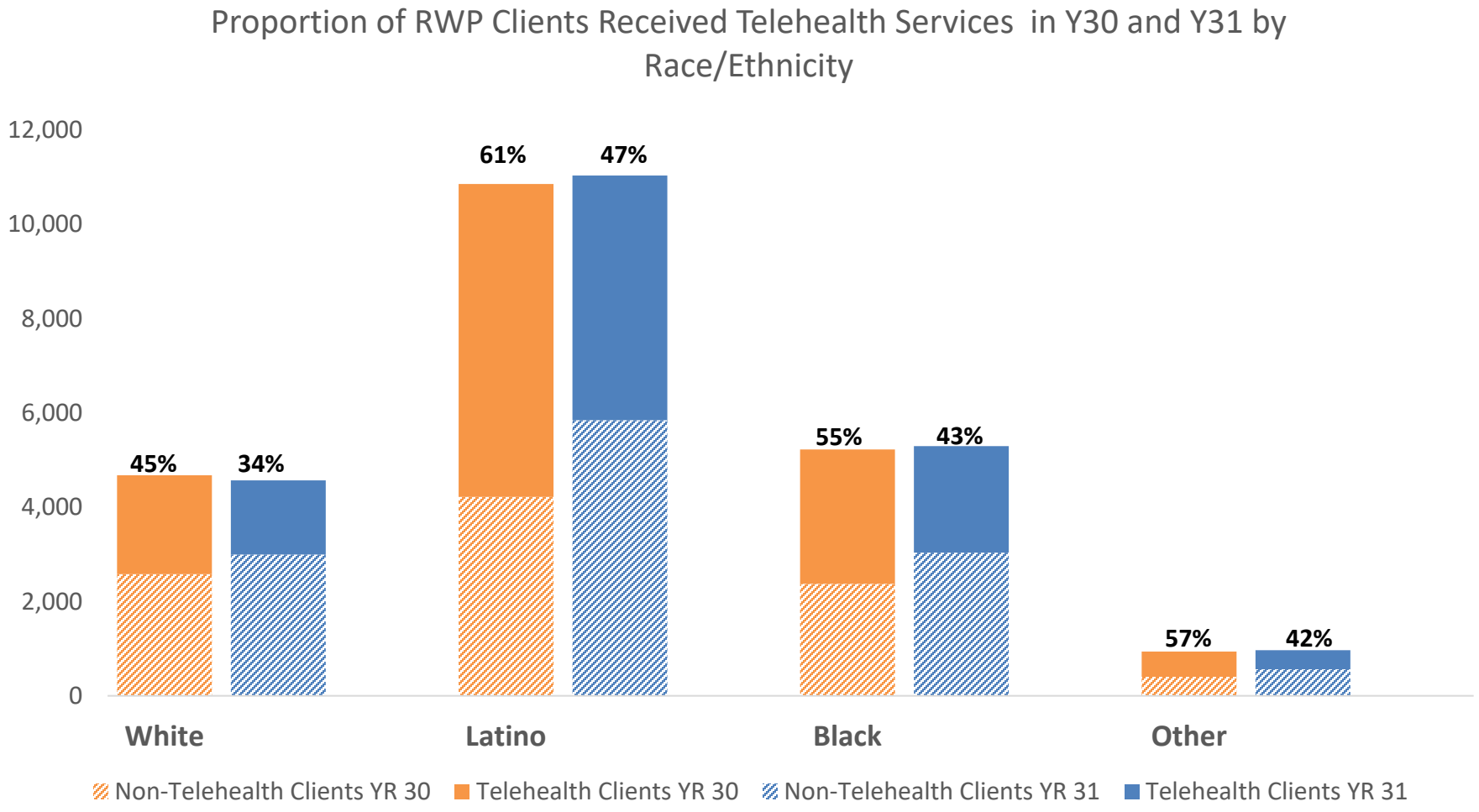
Acknowledgements

DHSP

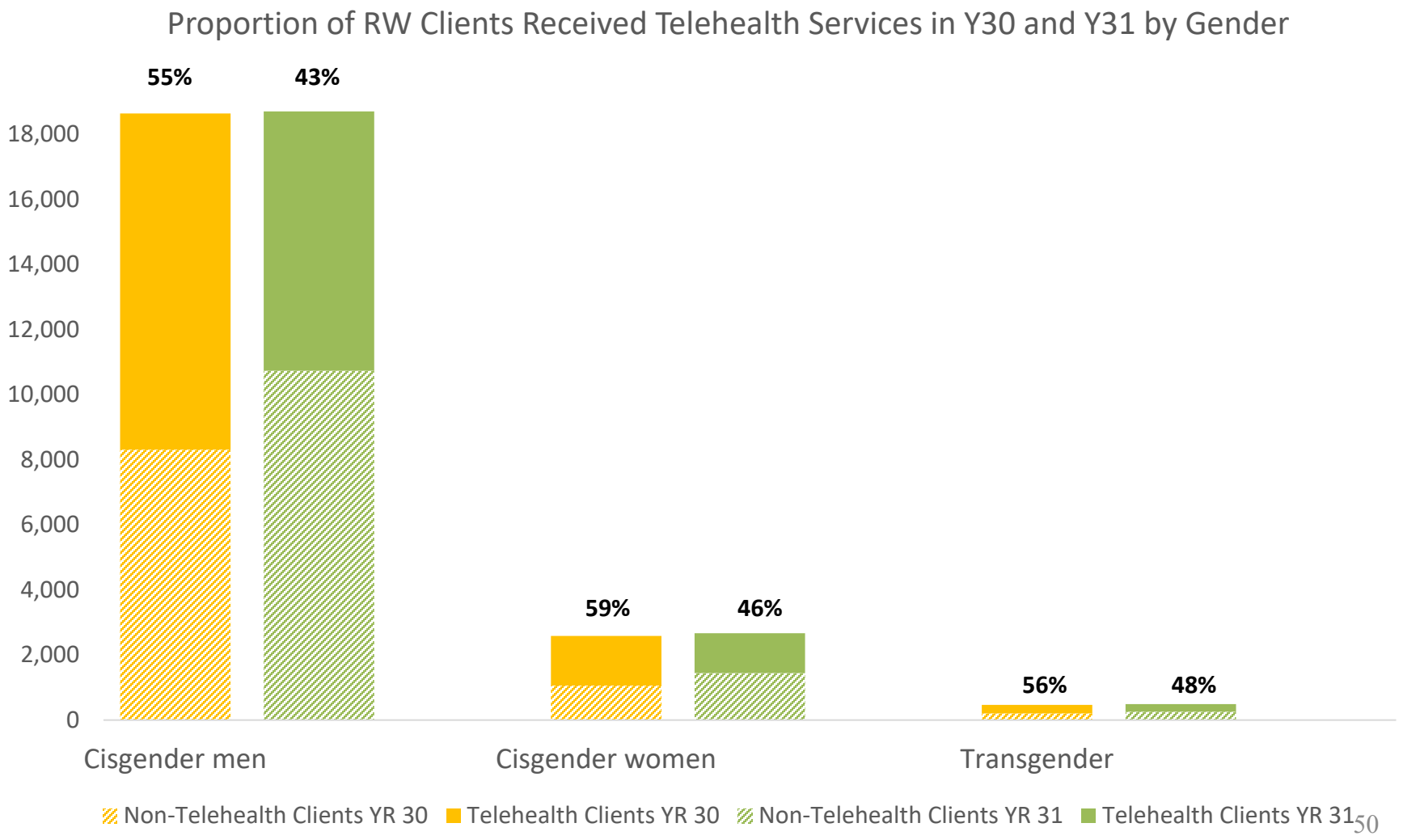
- Planning, Development and Research (Michael Green, PhD)
  - Program Monitoring and Evaluation (Wendy Garland, MPH)
    - Janet Cuanas, MPP
- HIV/STD Surveillance (Sherry Yin, MPH)

Ryan White Program Agencies, Providers and Clients

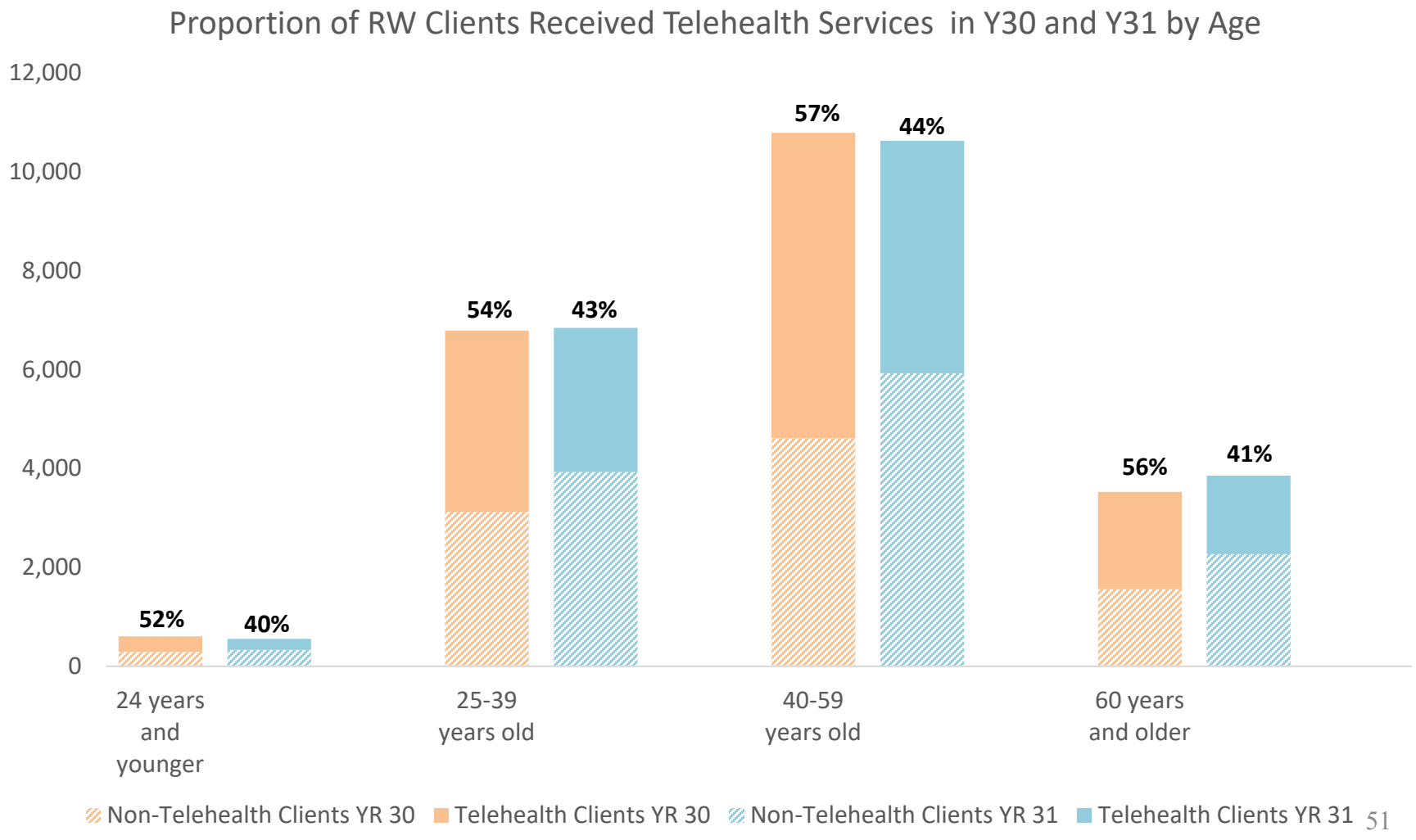
In Years 30 and 31 largest percentage of clients receiving at least one telehealth service were Latinx, followed by Blacks; the lowest percentage was among Whites.



While high across all gender categories, a slightly higher percentage of transgender clients and cisgender women compared to cisgender men used services through telehealth in Years 30 and 31.



- **Highest telehealth use was among clients aged 40-59 and 25-39 in Years 30 and 31.**
- **Lowest telehealth use was among clients 24 years old and younger in both years.**



Source Tables

RWP Clients and Utilization Trends

- Table 1: Sociodemographic Characteristics of RWP Clients, Years 27-31
- Table 2: Service Utilization by RWP Clients by Service Category, Years 27-31
- Table 3. Crosswalk Comparison of RWP Priority Populations in Year 31
- Table 4. Estimated HIV Care Continuum Outcomes for RWP Priority Populations in Year 31
- Table 5. RWP Utilization by Service Category in Year 31
- Table 6. RWP Services Provided via Telehealth by Sociodemographic Characteristics for Selected Service Categories in Year 31

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.

Los Angeles County Commission on HIV
Planning, Priorities and Allocations Committee (FOR DISCUSSION ONLY)
Compilation of Ideas for Ryan White (RW) Funding Reallocations

I. **Program Directives for Maximizing Health Resources Services Administration (HRSA) Ryan White Part A and MAI Funds for Program Years (PY) 32, 33, 34 and Centers for Disease Control and Prevention (CDC) Funding Approved by COH 6/7/22**		
#	***IDEA***	***RW SERVICE CATEGORY***
1	Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in person. Develop a network of Black mental health providers to promote equity and reduce stigma and medical mistrust.	Mental Health
2	Earmark funds for peer support and psychosocial services for Black gay and bisexual men. The Commission allocated 1% funding for Psychosocial Support Services in PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component.	Psychosocial Support
3	Provide Non-Medical Case Management (NMCM) services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 years). The COH's approved allocations for NMCM for PYs 32, 33, and 34 are as follows: 2.44% Part A and 12.61% MAI.	Non-Medical Case Management (NMCM)
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, rideshare services) to clients to facilitate expanded access to food.	Nutrition/Foodbank
5	Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase the 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.	Housing

6	Continue to support the expansion of medical transportation services for all individuals regardless of their HIV status.	Medical Transportation
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 the paperwork burden on clients.	Referral for Healthcare and Support Services
8	Augment contracts to permit agencies to have an operational line-item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Explore funding informal childcare for Medical Care Coordination (MCC) programs for maximum flexibility. The County's Department of Public and Social Services administers a program under CalWORKs that provides childcare allowances to foster care parents. This model may provide insights on a possible contractual or administrative mechanism to expand childcare options using Ryan White or Net County Cost funding.	Childcare Medical Transportation Medical Care Coordination
9	Continue to expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM, and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.	Emergency Financial Assistance
10	Fund mobile care teams or clinics that provide holistic care for women living with HIV. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged. Mobile clinics should aim to be all-inclusive and include bilingual services, STI services, linkages to clinics for ongoing care, STI/HIV testing, PrEP, mammograms, health education, and made available to women of all ages. Mobile clinics should have the capacity to provide community referrals to food, childcare, housing, recreation and wellness resources, and other support services. Explore partnering with existing street medicine programs to enhance mobile care teams specifically designed for women.	Outpatient/Ambulatory Services Health Education/Risk Reduction Outreach Services Referral for Healthcare and Support Services
11	Fund psychosocial services and support groups for women. Psychosocial support services must include peer support to build a stronger sense of community, empowerment, and resilience among women living with HIV. Maximize access to psychosocial and support group services by offering services remotely and in person. The Commission allocated 1% funding for Psychosocial Support Services for PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis.	Psychosocial
12	Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program and integrate the HIV and Aging care framework developed by the Aging Task Force. This framework seeks to facilitate medical wellness	Medical Care Coordination

	examinations and offers a flexible and adaptable guide to customizing care for older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, who experience aging-related issues earlier in life (before age 50). See Attachment C for the HIV and Aging Framework.	Outpatient/Ambulatory Medical
13	Integrate a geriatrician in medical home teams and establish a coordination process for specialty care services for older adults living with HIV.	Medical Care Coordination Outpatient/Ambulatory Medical
II. Black/African American Community Task Force Recommendations		
#	***IDEA***	***RW SERVICE CATEGORY***
1	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.	Mental Health Health Education/Risk Reduction Psychosocial Support Referral for Healthcare and Support Services
2	Address Chemsex within the Black/AA MSM community through CBO-led group sessions, evidence-based medicine-directed intervention and medication-assisted treatment.	Substance Use
III. Aging Task Force Recommendations		
#	***IDEA***	***RW SERVICE CATEGORY***
1	Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist patients affected by cognitive decline in navigating their care.	Medical Care Coordination and Ambulatory/Outpatient Medical
2	Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.	Medical Nutrition Rehabilitation Services
3	Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.	*PAYMENT STRUCTURE*

4	Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.	Emergency Financial Assistance
5	Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.	Psychosocial
6	Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.	Ambulatory/Outpatient Medical Medical Care Coordination
7	Ensure access to transportation and customize transportation services to the unique needs of older adults.	Medical Transportation
8	Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV	Referral for Healthcare and Support Services Non-Medical Case Management/Benefits Counseling
IV. Other Ideas		
#	***IDEA***	***RW SERVICE CATEGORY***
1	Use RW funds to provide increased amounts of incentives to patients care, adherence, retention and engagement using gift cards and/or vouchers (direct cash payment and pre-paid cards are not allowed by HRSA)	Ambulatory/Outpatient Medical Medical Care Coordination RW Core and Support Services *PAYMENT STRUCTURE*
2	Use RW funds for STD testing and treatment for RW clients	Ambulatory/Outpatient Medical Medical Care Coordination