LOS ANGELES COUNTY
COMMISSION ON HIV

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EXECUTIVE COMMITTEE
Meeting

Thursday, September 28, 2023
1:00pm-3:00pm (PST)

510 S. Vermont Ave
9th Floor, Terrace Conference Room A
Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

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

For those attending in person, as a building security protocol, attendees entering from the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting to access the Terrace Conference Room (9th flr) where our meetings are held.

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COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
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(REVISED) AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

EXECUTIVE COMMITTEE

THURSDAY, SEPTEMBER 28, 2023 | 1:00PM - 3:00PM

510 S. Vermont Ave
Terrace Level Conference Room A
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020
**As a building security protocol, attendees entering from the first floor lobby must notify security personnel that they are attending a Commission on HIV meeting in order to access the Terrace Conference Room (9th flr) where our meetings are held*

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EXECUTIVE COMMITTEE MEMBERS			
Luckie Fuller, Co-Chair (LOA)	*Bridget Gordon, Co-Chair*	*Joseph Green, Co-Chair Pro Tem*	Everardo Alvizo, LCSW
Miguel Alvarez (Executive At-Large)	Al Ballesteros, MBA	Danielle Campbell, MPH (Executive At-Large)	Erika Davies
Kevin Donnelly	Lee Kochems, MA	Katja Nelson, MPP	Mario J. Peréz, MPH
Kevin Stalter	Justin Valero, MPA		
QUORUM: 7			

AGENDA POSTED: September 22, 2023

SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

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 submit in person, email to hivcomm@lachiv.org , or submit electronically here. All Public Comments will be made part of the official record.

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

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

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Introductions, Roll Call, & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Approval of Agenda	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Meeting Minutes	**MOTION #2**	1:07 PM – 1:10 PM

II. PUBLIC COMMENT 1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS 1:15 PM – 1:20 PM

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

IV. REPORTS

7. Executive Director/Staff Report 1:20 PM – 1:30 PM

A. Commission (COH)/County Operational Updates

(1) Updated HRSA Planning Council Requirements and Expectations Letter

(2) November 9, 2023 COH Annual Conference

(3) Upcoming COH-Sponsored Activities & Events

8. Co-Chair Report 1:30 PM – 1:45 PM

A. Evaluating Hybrid Meeting Format Effectiveness

B. September 14, 2023 COH Meeting | FOLLOW UP & FEEDBACK

(1) DHS HIV Data Cascade Presentation

(2) City Representatives Harm Reduction/Substance Use Presentations

C. October 12, 2023 COH Meeting Agenda Development

(1) RWP Part C Presentation (pending)

(2) UCLA LAFAN Presentation Re: Latina Women & HIV Podcast Series (pending)

(3) DHSP Presentation: HIV Surveillance Update & Data Challenges for LA County Native American Communities (Part 2: Programmatic Overview)

(4) New/Renewing Member Applications

(5) National HIV Awareness Days

a. National Latinx AIDS Awareness Day #NLAAD2022

D. Conferences, Meetings & Trainings | OPEN FEEDBACK

(1) Collaboration in Care Conference: Improving HIV and Aging Services | September 17-19

(2) "Let's Talk About Sex" | September 22

E. Member Vacancies & Recruitment

F. 2023 Holiday COH & Committee Meeting Schedule for November & December

G. 2024 Committee Co-Chairs Open Nomination & Elections Preparation

10. Division of HIV and STD Programs (DHSP) Report 1:45 PM – 1:55 PM

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI

(2) Fiscal

(3) Ending the HIV Epidemic (EHE) Initiative | UPDATES

(4) Mpox | UPDATES

11. Standing Committee Report 1:55 PM – 2:35 PM

A. Operations Committee

(1) Membership Management

a. Renewal Application – Derek Muray | City of West Hollywood Rep **MOTION #3**

b. Renewal Application – Dr. Mikhaela Cielo | Part D Rep **MOTION #4**

c. Mentorship Volunteer Opportunities

d. Parity, Inclusivity & Reflectiveness (PIR) | UPDATES

(2) PY 33 Assessment of the Administrative Mechanism (AAM) | UPDATE

11. Standing Committee Report (cont'd) 1:55 PM – 2:35 PM

(3) Policies & Procedures
   a. COH 2 Person/Per Agency Policy
(4) (REVISED) 2023 Training Schedule | REMINDER
(5) Recruitment, Retention and Engagement

B. Standards and Best Practices (SBP) Committee

C. Planning, Priorities and Allocations (PP&A) Committee
(1) Los Angeles Housing Service Authority (LAHSA) Data Request Update
(2) Fiscal Year 2022 RWP/MAI Expenditures and Utilization Report Updates
(3) Community Listening Sessions Questionnaire Feedback

D. Public Policy Committee (PPC)
(1) County, State and Federal Policy, Legislation, and Budget
   a. 2023-2024 Legislative Docket | UPDATES
   b. House Appropriations FY24 Labor-HHS Spending Proposal
   c. Coordinated STD Response | UPDATES
   d. Act Now Against Meth (ANAM) | UPDATES
(2) Ryan White Care Act (RWCA) Modernization: Determine Strategy and Outline Presentation Schedule

12. Caucus, Task Force, and Work Group Reports: 2:35 PM – 2:45 PM

A. Aging Caucus
B. Black/AA Caucus
C. Consumer Caucus
D. Transgender Caucus
E. Women's Caucus
F. Bylaws Review Taskforce
H. Prevention Planning Workgroup

V. NEXT STEPS 2:45 PM – 2:55 PM

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

VI. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

Adjournment for the meeting of September 28, 2023.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve Renewal Member Application for Derek Murray, City of West Hollywood representative, as presented or revised.
MOTION #4	Approve Renewal Member Application for Dr. Mikhaela Cielo, Part D representative, as presented or revised.

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COMMISSION ON HIV

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Approved by COH 6/8/23

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

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DRAFT

Commission member presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges. Members of the public may confirm their attendance by contacting Commission staff. Approved meeting minutes are available on the Commission's website and may be corrected up to one year after approval. Meeting recordings are available upon request.

EXECUTIVE COMMITTEE MEETING MINUTES

August 24, 2023

COMMITTEE MEMBERS **P = Present | A = Absent | EA=Excused Absence | AB2449=Virtual**			
Luckie Fuller, Co-Chair (LOA)	EA	Erika Davies	P*AB2449
Joseph Green, Co-Chair, Pro Tem	P*AB2449	Kevin Donnelly	P*AB2449
Bridget Gordon, Co-Chair	EA	Lee Kochems, MA	EA
Miguel Alvarez (EXEC At-Large)	P	Katja Nelson, MPP	P
Everardo Alvizo, LCSW	P	Mario J. Peréz, MPH	P*Member of Public
Al Ballesteros, MBA	A	Kevin Stalter	P
Danielle Campbell, MPH (EXEC At-Large)	P	Justin Valero	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Lizette Martinez, MPH; Dawn McClendon; Jose Rangel-Garibay, MPH; Sonja Wright,			
DHSP STAFF			
No other DHSP staff in attendance			

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER & MEETING GUIDELINES/REMINDERS

Joseph Green, Co-Chair Pro-Tem, Commission on HIV (COH), commenced the meeting at around 1:00PM and provided an overview of the meeting guidelines.

2. INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS

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

ROLL CALL (PRESENT): M. Alvarez, D. Campbell, E. Davies (AB2449), K. Donnelly (AB2449), J. Green (AB2449), K. Nelson, M. Perez (Virtual; MOP), and K. Stalter

3. **ASSEMBLY BILL 2449 ATTENDANCE NOTIFICATION FOR "EMERGENCY CIRCUMSTANCES"**
   MOTION #1: Approve remote attendance by members due to "emergency circumstances," per AB 2449. ***Not applicable.***

4. **APPROVAL OF AGENDA**
   MOTION #2: Approve the Agenda Order, as presented or revised. ***✓Passed by consensus***

5. **APPROVAL OF MEETING MINUTES**
   MOTION #3: Approve the Executive Committee minutes, as presented or revised. ***✓Passed by consensus***

II. PUBLIC COMMENT

6. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.**
   No public comments.

III. COMMITTEE NEW BUSINESS ITEMS

7. **OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.**
   No committee new business items.

IV. REPORTS

8. **EXECUTIVE DIRECTOR/STAFF REPORT**
   A. **Commission (COH)/County Operational Updates**
   November 9, 2023 COH Annual Conference
   Cheryl Barrit, MPIA, Executive Director, led the Committee through a review of the proposed agenda for the November 9 Annual Conference and noted that key speakers have not yet been contacted pending the Committee's approval of the agenda.

   C. Barrit added that Commissioner Kevin Stalter will provide centerpieces for tables.

Suggestions included networking and entertainment activities to engage attendees to keep them from leaving.

Commissioner Katja Nelson volunteered to coordinate with K. Stalter to reach out to various BOS' offices to invite them to the Annual Conference.

9. CO-CHAIR REPORT

A. Welcome COH Co-Chair Pro Tem, Joseph Green

B. August 10, 2023 COH Meeting | FOLLOW UP & FEEDBACK *None.*

C. September 14, 2023 COH Meeting Agenda Development

(1) 2024-2026 Co-Chair Open Nomination & Elections

Three members were nominated for the 2024-2026 COH Co-Chair elections at the August 14 COH meeting – Bridget Gordon (declined), Alasdair Burton (accepted) and Kevin Donnelly (accepted). Danielle Campbell was subsequently nominated (acceptance pending). Nominations remain open until the start of the elections at the September 14 COH meeting.

(2) 2023 United States Conference on HIV/AIDS (USCHA) Report

Commissioners Lilieth Conolly, Miguel Alvarez and K. Donnelly all received scholarships to attend the USCHA on behalf of the Commission and will report back at the September 14 COH meeting on their experiences. Commissioners K. Nelson and D. Campbell will also be attending USCHA.

(3) Presentation: HIV Surveillance Update & Data Challenges for LA County Native American Communities (Part 2: Programmatic Overview)

(4) Presentation: LA County Department of Health Services (DHS) Data on HIV Cascade

(5) New/Renewing Member Applications

(6) Universal Service Standards

Additional feedback was received from the Prevention Planning Workgroup (PPW) which resulted in further review and possible updates to the draft standards therefore temporarily removing from the agenda until further notice.

(7) National HIV Awareness Days

a. September 18 National HIV/AIDS and Aging Awareness Day #HIVandAging

b. September 27 National Gay Men's HIV/AIDS Awareness Day #NGMHAAD

D. Conferences, Meetings & Trainings | OPEN FEEDBACK

(1) 2023 United States Conference on HIV/AIDS (USCHA) | September 5-9, 2023

E. Member Vacancies & Recruitment

As a reminder, COH promotional materials will be made available at upcoming in-person meetings for outreach and recruitment efforts. The Commission's digital toolkit can be access via its website HERE. Members are encouraged to use these resources for outreach and recruitment activities.

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

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI

(2) Fiscal – *No fiscal update provided.*

(3) Mpox | UPDATES

Mario J. Peréz, MPH, Director (DHSP) reported the following:

- There is an uptick in COVID cases with mild symptoms being reported.
- Seven (7) MPox cases were reported; a decrease from 10 in prior weeks. DHSP continues to remain vigilant amid upcoming Pride events scheduled.
- M. Perez continued to stress the urgency of those living with HIV (PLWH) to get at least one (1) Mpox vaccination as data shows that the severity of Mpox is significantly minimized for those who are vaccinated; only 24% of PLWH are vaccinated.
- DHSP and its community partners continues to identify various methods to promote Mpox vaccination to include launching an incentive program for PLWH out of care.
- M. Perez acknowledged the Bicillen shortage citing its critical nature as a prevention tool in protecting the health of an unborn child from a mother who is diagnosed with Syphilis. He shared that he along with other STD prevention advocates and stakeholders are working with the CDC to marshal more production of Bicillen. M. Peréz noted that providers are using Doxycycline as an alternative, citing it is more intensive and not necessarily the best alternative.
- The County's BOS supported an additional $10 million this fiscal year to help with STD control efforts and that conversations are being held with 11 community-based organizations with ties to STD clinical services to determine best approach to address the STD crisis in LA County; more concrete spending proposals to be shared in the upcoming weeks.

11. STANDING COMMITTEE REPORTS

A. Operations Committee

(1) Membership Management

a. Seat Vacate | Mallery Robinson MOTION #4 (√Approved by Roll Call Vote)

b. Renewal Application – PP&A Committee-Only| Miguel Martinez MOTION #5 (√Approved by Roll Call Vote)

c. Parity, Inclusivity & Reflectiveness (PIR) | UPDATES

Commissioner Everardo Alvizo, Co-Chair, briefly reviewed the updated PIR spreadsheet and cited the need for increased recruitment efforts around Latinx, Male, and Native Americans communities; yet acknowledged the COH's continued efforts in meeting its PIR.

(2) Assessment of the Administrative Mechanism (AAM) | UPDATE

The Committee is planning for its PY 33 AAM and currently deliberating on procuring a consultant, updates forthcoming. A draft proposal is in the meeting packet and will focus on the speed and efficiency with which contracts and services are implemented. Feedback on the proposal is requested.

(3) Policies & Procedures

a. Bylaws Review Taskforce (BRT) | UPDATE

The BRT continues to meet and review the bylaws for updates pursuant to the Executive Committee's directive. There are several key items, i.e., stipends, DHSP's role, conflict of interest, that require guidance or clarification by HRSA and/or County Counsel. Staff is currently seeking guidance from both County Counsel and HRSA and will provide updates as they are received.

(4) 2023 Training Schedule | REMINDER

Refer to the training schedule to register for mandatory and optional trainings.

(5) Recruitment, Retention and Engagement

COH members continue to identify opportunities and participate in community events to engage and recruit members. Additionally, the Committee is extending an invitation to the full body to volunteer as a mentor as part of the COH's Mentorship Program.

B. Standards and Best Practices (SBP) Committee

Commissioner Erika Davies, Co-Chair, reported the following:
The Committee hasn't met since the August 14, 2023 COH meeting and therefore no new updates to report. Additionally, the September 5, 2023, Committee meeting has been cancelled to accommodate those attending the USCHA. The next meeting will be held on October 3, 2023 @ 10AM-12PM.

(1) Universal Service Standards | MOTION #6 *Item pulled.*

(2) Prevention Services Standards Review| UPDATES

The Committee continues to work with the PPW in reviewing and proposing updates to the Prevention Services Standards.

(3) Medical Care Coordination (MCC) | UPDATES

The Committee continues to review the Medical Services Standards for updates; proposed updates will be released for public comment in the upcoming weeks.

C. Planning, Priorities and Allocations (PP&A) Committee

Commissioner K. Donnelly, Co-Chair, reported the following:

- Committee welcomed three (3) new members.
- Committee approved a renewal Committee-only membership application for Miguel Martinez. Application to be elevated to the Operations Committee, the Executive Committee, and the full body for further approval.
- Committee heard from DHSP on its utilization reports in a more digestible format.
- The Committee was not able to address the questionnaire to assess client's needs; will continue development at the next Committee meeting.
- LAHSA submitted data requested regarding homelessness, however, the data is incomplete. Staff will perform an analysis and present to the Committee once completed.
- The Committee will extend its meeting to three hours (1-4PM) moving forward for the remainder of 2023 to allow DHSP to finish its utilization reports which are being presented in increments to allow for a more digestible format.
- The next Committee meeting will be September 19, 2023 @ 1-4PM at the Vermont Corridor.

D. Public Policy Committee (PPC)

Commissioner K. Nelson, PPC Committee Co-Chair, reported the following:

(1) County, State and Federal Policy, Legislation, and Budget

a. 2023-2024 Legislative Docket | UPDATES *No updates.*

b. 2023-2024 Policy Priorities | UPDATES *No updates.*

c. Coordinated STD Response | UPDATES

DPH Memo in response to STD Board of Supervisors (BOS) motion

A community of providers will be elevating their concerns regarding the STD crisis to Dr. Barbara Ferrer, Director, DPH; updates forthcoming in the next month or so.

2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings

Members, especially unaffiliated consumer members, are strongly encouraged to attend Health Deputies and BOS meetings to champion funding and programmatic initiatives that support the health and wellness of people living with HIV.

d. House Appropriations FY24 Labor-HHS Spending Proposal *No updates.*

e. Act Now Against Meth (ANAM) | UPDATES *No updates.*

(2) Ryan White Care Act (RWCA) Modernization: Determine Strategy and Outline Presentation Schedule

The Committee is currently discussing strategies in developing a white paper consisting of recommendations on what the community would like to see via RWP modernization and cautioned that not everyone is on board, i.e., status neutral proponents, Southern states.

E. CAUCUS, TASK FORCE, AND WORKGROUP REPORTS

(1) Aging Caucus

The Caucus in collaboration with the County of Los Angeles Department of Aging, APLA and the LGBT Center, is hosting a "Let's Talk About Sex" educational event for service providers to promote sexual health education among older adults. The event will take place on September 22, 2023 @ 9:30AM-2PM at the Vermont Corridor.

A Collaboration in Care conference is being held in Sacramento on September 17-19, 2023 to focus on improving HIV and Aging services.

In the spirit of the USCHA where the focus is on Black women living with HIV, the Caucus would like to dedicate an upcoming meeting to women of color living with HIV.

(2) Black/African American Caucus

Commissioner D. Campbell, Co-Chair, reported:
Caucus is continuing its planning for community listening sessions to address the sexual health needs of the Black community which will be organized by the key populations reflected in the Black African American Community Taskforce (BAAC) recommendations.

Caucus continues to work with DHSP to finalize the organizational capacity needs assessment; pilot to be administered to Dr. William King.

The Caucus, in partnership with the Women's Caucus, is co-branding a lecture, hosted by UCLA Luskin School of Public Affairs and CHIPTS, presented by Dr. Ijeoma Opara whose work is centered around Black women and girls, HIV prevention and substance use. The presentation will be held on October 19, 2023 at UCLA; more details HERE.

The Caucus is partnering with Supervisor Holly Mitchell's office to host a World AIDS Day (WAD) event; details forthcoming.
The Caucus will be participating in the October 21, 2023 Taste of Soul.

Lastly, the Caucus will be submitting application for funding opportunities to help support Caucus activities.

(3) Consumer Caucus

Commissioner A. Burton, Co-Chair, reported that the Caucus at its last meeting received a presentation from DHSP and their contractor, Rescue Agency, on the development of a Ryan White Program services social media marketing campaign to which the Caucus provided feedback.

(4) Transgender Caucus

Jose Rangél-Garibay, COH staff, reported that the Caucus is currently planning for the Trans Health Summit scheduled for November 2 2023, will cover topics: Community Building Space, Policy and Advocacy, Trans History, Trans Media, Trans and HIV, Building Collaborative Partnerships.

(5) Women's Caucus

Dawn Mc Clendon, COH Staff, reported that the Caucus met on July 17, 2023 and discussed the PP&A Program Directives and DHSP's response concerning women-centered programming**.** DHSP shared that the Childcare RFA is ongoing and continuous despite an initial deadline being applied. The Caucus will conduct a hybrid meeting on October 17th and will continue its review and discussion around the PP&A directives and Caucus recommendations.

(6) Bylaws Review Taskforce (BRT)

E. Alvizo, Co-Chair, reported that the BRT continues to meet monthly to review the Bylaws for updates and that staff is currently working with County Counsel for guidance.

(8) Prevention Planning Workgroup (PPW)

K. Donnelly reported that the PPW is currently reviewing the Prevention standards in collaboration with the SBP Committee.

V. NEXT STEPS

12. TASK/ASSIGNMENTS RECAP

- All motions to be elevated to the September 14, 2023 COH meeting.
- 2024-2026 COH Co-Chair Elections will be held at the September 14 COH meeting.
- Universal Service Standards will go back to the Committee for further review and updates.
- AAM feedback requested.

13. AGENDA DEVELOPMENT FOR THE NEXT MEETING

Refer to minutes.

VI. ANNOUNCEMENTS

14. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS

VII. ADJOURNMENT

15. ADJOURNMENT FOR THE MEETING OF AUGUST 24, 2023.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857
HIV/AIDS Bureau

August 29, 2023

Dear Ryan White HIV/AIDS Program Part A Recipients:

This letter provides clarification on the Health Resources and Services Administration, HIV/AIDS Bureau's (HRSA HAB) expectations of a required community input process for Ryan White HIV/AIDS Program (RWHAP) Part A awards. The Chief Elected Official, as the recipient of RWHAP Part A funds, is ultimately responsible for establishing the planning body to spearhead the development of a comprehensive HIV service system for the Eligible Metropolitan Area or Transitional Grant Area (EMA/TGA) through a planning council (PC) or planning body (PB).

Section 2602(b) of Title XXVI of the Public Health Service Act outlines the roles and responsibilities of the PC. Section 2609(d)(1) outlines the requirement for TGAs to have a formal community input process to formulate the overall plan for priority setting and resource allocations in TGAs.

This program letter clarifies HRSA HAB requirements and expectations for the PC/PB. Unless otherwise noted, the requirements and expectations apply to both PCs and PBs.

Roles and Responsibilities-Priority Setting and Resource Allocation

Priority Setting and Resource Allocations (PSRA) is the single most important legislative responsibility of a PC/PB, and greatly influences the system of HIV care in the EMA/TGA. The PSRA process must prioritize all RWHAP HIV core medical and support services annually. [2602(b)(4)(C)] and 2602(d)(1)]

PC Membership

The PC must include a representative from each of the 13 legislatively required membership categories. The PC must also include at least one member to separately represent each of the designated membership categories (unless no entity from that category exists in the EMA/TGA). Separate representation means each PC member can fill only one legislatively required membership category at any given time, even if qualified to fill more than one. There are only three situations that allow one person to represent two membership categories. PC members must reflect the demographics of the population of individuals with HIV in the jurisdiction. Additionally, no less than 33 percent of PC membership must be comprised of unaffiliated clients receiving RWHAP Part A services in the jurisdiction. [2602(b)(2)]

PB Membership	At a minimum, the PB must include representatives of the various stakeholders in the TGA, and must reflect the demographics of the population of individuals with HIV in the jurisdiction. Additionally, no less than 33 percent of PB membership must be comprised of unaffiliated clients receiving RWHAP Part A services in the jurisdiction.
Term Limits	To ensure the PC/PB are reflective of the demographics of the population of individuals with HIV in the jurisdiction, HRSA HAB expects the PC/PB to establish term limits and membership rotations.
Separation of PC/PB and Recipient Roles	A separation of PC/PB and recipient roles is necessary to avoid conflicts of interest. The legislation prohibits PC public deliberations from being "chaired solely by an employee of the grantee." [2602(b)(7)(A)]. A recipient representative, whose position is funded with RWHAP Part A funds, provides in-kind services, or has significant involvement in the RWHAP Part A grant, shall not occupy a voting seat in the PC/PB. A recipient representative may serve as a non-voting co-chair of the PC/PB.

If you have any questions regarding the information outlined in this letter, please consult your project officer.

Sincerely,

/s/ Chrissy Abrahms Woodland, MBA

Chrissy Abrahms Woodland, MBA
Director
Division of Metropolitan HIV/AIDS Programs

Frequently Asked Questions (FAQs)

Planning Council and Planning Body Requirements and Expectations Ryan White HIV/AIDS Program (RWHAP) Part A (April 6, 2022)
HIV Emergency Relief Grant Program

1. What flexibility does the Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) provide to address challenges with Planning Councils (PC) and Planning Body (PB) for meeting the legislatively mandated representation categories, as applicable.

   RESPONSE: Per the Ryan White HIV/AIDS Program (RWHAP) Part A Manual, the HRSA expects that the PC must include at least one member to separately represent each of the designated membership categories listed in section 2602(b)(2) of the RWHAP statute (unless no entity from that category exists in the EMA/TGA). Separate representation means each PC member can fill only one legislatively required membership category at any given time, even if qualified to fill more than one.

   Furthermore, it is a HRSA HAB expectation that, at a minimum, the PB must include representatives of each of the various stakeholders in the TGA. HRSA HAB defines stakeholder representation based on the 13 membership categories required for a PC outlined in RWHAP statute.

   There are only three situations that allow one person to represent two membership categories:

   1. One person may represent both the substance use disorder provider and the mental health provider categories if their agency provides both types of services and the person is familiar with both programs.
   2. A single PC member may represent both the RWHAP Part B and the state Medicaid agency if that person is in a position of responsibility for both programs.
   3. One person may represent any combination of RWHAP Part F grant recipients (SPNS, AETCs, and dental programs) and Housing Opportunities for Persons with HIV/AIDS (HOPWA), if the agency represented by the member receives grants from some combination of those four funding streams (e.g., a provider that receives both HOPWA and SPNS funding), and the individual is familiar with all these programs.

   In the event a jurisdiction does not have or is unable to fill a required membership category, documentation of efforts to fill the category, including annual certification by the Chief Elected Official (CEO) or designee, must be submitted to HRSA with the Program Submission Report in the electronic handbooks (EHB).

2. How can jurisdictions support meaningful engagement of people with lived experience in PC/PBs? Such guidance would also help to standardize and ensure equity for community PC/PB members among all jurisdictions.

   RESPONSE: Per HAB Policy Clarification Notice (PCN) 16-02, RWHAP Part A recipients can support the meaningful engagement of clients attending PC or PB meetings by providing gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity. Please note that 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. Additional considerations can include adjusting PC or PB meeting times to occur after business hours or on weekends to reduce conflict with client work schedules. Lastly, non-RWHAP funding sources (e.g., general revenue funds) can be utilized to compensate clients for attending PC or PB meetings.

3. The language in the letter indicates that people with lived experience serving on the PC/PB should be "receiving RWHAP Part A services"; however, meeting the legislative requirement of thirty-three percent (33%) of the PC membership being comprised of people with lived experience is more achievable if the language in the letter instead stated that membership for people with lived experience is based on them being "eligible for RWHAP Part A services." Is there any flexibility on this issue?

   RESPONSE: The RWHAP Part A statute, section 2602(b)(5)(C)(i) of the RWHAP statute, requires that "not less than 33 percent of the council shall be individuals who are receiving HIV-related services pursuant to a grant" under RWHAP Part A. Moreover, individuals receiving HIV-related services may include caregivers of people receiving RWHAP services or people receiving RWHAP services that are paid for by a third party payer, such as Medicaid.

4. What is the intent of imposing term limits for PC/PB membership categories? Are term limits specific to leadership positions only, or unaligned people with lived experience participation?

   RESPONSE: The intent of term limits is to ensure compliance with the RWHAP statute that requires the PC/PB to be reflective of the demographics of the population of individuals with HIV in the jurisdiction. Therefore, HRSA HAB expects the PC/PB to establish term limits and membership rotations for the required membership categories (Section 2602(b)(1) of the RWHAP statute) and unaligned persons with lived experience (i.e., persons receiving RWHAP Part A services and are not affiliated with funded RWHAP Part A providers as staff, board members, or consultants (Section 2602(b)(5)(C)(1) of the RWHAP statute). Per the RWHAP Part A Manual, HRSA expects that jurisdictions determine term limits and rotations that are in alignment with legislative and programmatic requirements, such as the integrated planning efforts, the comprehensive needs assessment, and the three-year period of performance. Jurisdictions should implement a predetermined period of time, where outgoing members cannot reapply to allow other community members the opportunity to serve. In addition, jurisdictions can include additional members that include representation for long-term survivors to maintain input.

5. Why can't recipient staff have a voting role in the PC or PB?

   RESPONSE: In order to preserve the independence of the PC/PB, a separation of PC/PB and recipient roles is necessary to avoid conflicts of interest (see section 2602(b)(5)(A) of the RWHAP statute). Per statute, recipient staff administer the RWHAP Part A grant in their jurisdiction, including selection of subrecipients to provide services. The PC/PB is prohibited from administering the RWHAP Part A grant, including the designation or selection of subrecipients. As such, recipient staff cannot have a voting role in the PC/PB to avoid this conflict of interest.

6. Please provide clarification for merged prevention and care planning bodies, specifically on the parity between care-recipient staff serving as co-chair, which is disallowed based on the HRSA HAB Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and

Expectations Letter (April 6, 2022), and prevention-recipient staff serving as co-chair, which is mandated by the Centers for Disease Control and Prevention (CDC).

RESPONSE: The requirements are not in conflict, and there are various methods to resolve any perceived conflicts. For example, a jurisdiction could implement multiple co-chairs that allows for a care-recipient staff, a prevention-recipient staff, and an unaligned person with lived experience to serve as PC/PB co-chairs. Doing this would support the CDC mandate and the RWHAP Part A legislative mandate prohibiting care-recipient staff from solely chairing the PC (section 2602(7)(A) of the RWHAP statute). For additional technical assistance, you may contact your project officer.

7. Can recipient staff fill an ex-officio role and not count towards quorum, or have a vote?

   RESPONSE: An ex-officio member has all the rights and privileges of membership, including the right to vote. Recipient staff who are directly involved in the administration of the grant should not fill an ex-officio role on the PC/PB unless the bylaws specifically restrict an ex officio member from voting. HRSA HAB recommends that jurisdictions address the Ex-Officio role and responsibility on the PC/PB in the PC/PB bylaws.

8. Is there a restriction for recipient staff not funded by HRSA or RWHAP Part A to serve as governmental co-chairs of PCs/PBs, especially if PC/PB at the local level also has a prevention mandate?

   RESPONSE: Per section 2602(b)(7) of the RWHAP statute, the legislation prohibits PC public deliberations from being "chaired solely by an employee of the grantee." A recipient representative, whose position is funded with RWHAP Part A funds, provides in-kind services, or has significant involvement in the RWHAP Part A grant, shall not occupy a seat in the PC nor have a vote in the deliberations of the PC. Therefore, an employee of the recipient, who is not directly involved in the administration of the grant, may serve as a co-chair, provided the bylaws of the PC/PB permit or specify that arrangement. An acknowledged best practice is to have bylaws require that one co-chair be a person with HIV.

9. RWHAP Part A recipients would like more information on the requirements for the new three-year period of performance. Will the three-year period of performance "lock" funding for jurisdictions when increased support and resources may be needed to address the changes on the ground?

   RESPONSE: Effective FY 2022, HRSA HAB has transitioned the RWHAP Part A from an annual competitive award with a one-year period of performance, to an annual funded award with a three-year period of performance. As required by law, the non-discretionary Part A formula award is calculated annually based on the number of living HIV and AIDS reported to and confirmed by CDC. Likewise, the Minority AIDS Initiative (MAI) award is calculated annually based on the number of living minority HIV and AIDS cases reported to and confirmed by the CDC.

   As fully explained in the notice of funding opportunity (Funding Opportunity Number: HRSA-22-018), one-third of funding available is for discretionary supplemental awards and is distributed based on demonstrated need. The normalized score assigned to the competitive application during the first year (i.e., FY 2022) of the three-year period of performance will be utilized to calculate

the discretionary supplemental award in the second and third years (i.e., FY 2023 and FY 2024, respectively).

Additional information on the transition of the RWHAP Part A award from an annual to a multi-year period of performance is located on TargetHIV.

10. Many jurisdictions experience challenges attaining and remaining in compliance with PC/PB guidance because of state public-meeting laws requiring in-person meetings to make quorum and/or by county-level public health COVID-19 requirements. These jurisdictions want to ensure that HRSA HAB is aware of these issues.

    RESPONSE: HRSA HAB is aware that many jurisdictions are required to comply with state and local sunshine laws requiring in-person meetings and understands the challenges this imposes on PCs/PBs in establishing quorum for their meetings. HRSA HAB also understands the impact COVID-19 has had on PCs'/PBs' ability to meet quorum for meetings.

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LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT FOR PLANNING AND DISCUSSION PURPOSES ONLY **ANNUAL CONFERENCE AGENDA OUTLINE** **NOVEMBER 9, 2023** **Vermont Corridor Terrace Level (510 S. Vermont Ave, LA CA 90020)**	
AGENDA ITEM	**WHO/TOPIC**
Call to Order and Roll Call (9:00-9:15)	Co-Chairs and Executive Director
Welcome, Opening Remarks, Meeting Objectives, and Recognition of Service 9:15-9:30am	Co-Chairs
Los Angeles County State of HIV/STDs 9:30-10:30am	**Mario Pérez and DHSP staff (Confirmed)** • Successes • Challenges • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support DHSP's efforts to address HIV/STDs in the County.
The County's Response to the Intersection of HIV and Substance Use | Harm Reduction and Other Services, DPH, Substance Abuse Prevention and Control (SAPC) 10:30am-11:15am	**Dr. Sid Puri, Associate Medical Director of Prevention, SAPC (Confirmed)** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support substance use/harm reduction efforts in the County.
BREAK **11:15-11:30am**	
PrEP, Long-acting PrEP, Doxy PEP | Strategies for Increasing Access and Utilization among Priority Populations 11:30 – 12:30pm	**Dr. Ardis Moe – (Confirmed)** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support increasing access and utilization of PrEP, LAI PrEP, and Doxy PEP in the County.
LUNCH w/ Speakers Housing and People Living	~~Supervisor Kathryn Barger~~ ~~***(Invited, awaiting response)***~~ Dr. Va Lecia Adams Kellum, CEO Los Angeles Homeless Services Authority

with HIV **12:30 – 1:30pm**	***(Invited, awaiting response)*** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to help address or support affordable housing for PLWH and priority populations.
Then & Now: Where We Were & Where We Are Now **Community Discussion** **Intergenerational Perspectives on Community Building and Resilience** **1:30-2:30pm**	• Facilitated session with audience participation • Address topics such as stigma, fear, life expectancy, stigma, PrEP/PEP & U=U, and community support • Panel ▪ Folx of varying generations, ranging from youth/young adults to LTS (20-30 years living with HIV) ▪ 2-3 Youth/Young Adults & 2-3 Older Adults ▪ Include HIV negative folx • Provide historical context • Elicit stories of strength & resilience • Include a Call to Action, i.e., provide tools on building intergenerational relationships • Encourage folx to interact with each other; create an interactive, fun and engaging presentation/conversation • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to help build a united community across generations to end HIV.
BREAK 2:30-2:45pm	
Enhancing Access to Mental Health Services for PLWH **2:45-3:30pm**	**Dr. Curley Bonds**, Los Angeles County Department of Mental Health **(Confirmed)** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support mental health services for PLWH and priority populations.
Public Comments **3:30 pm to 3:45pm**	
Closing remarks and by co-chairs/Adjourn **3:45-4pm**	
RECEPTION, AWARDS/RECOGNITIIONS, NETWORKING, RAFFLE PRIZES **4pm to 5pm**	

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

Derek Murray

Application on file at Commission office

LOS ANGELES COUNTY
COMMISSION ON HIV

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Dr. Mikhaela Cielo

Application on file at Commission office

Part D representative (Seat #9) | MOTION #3

LOS ANGELES COUNTY COMMISSION ON HIV

2023 MEMBERSHIP ROSTER| UPDATED 9.25.23

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2022	June 30, 2024	
3	City of Long Beach representative	1	EXC|OPS	Everardo Alvizo, LCSW	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2022	June 30, 2024	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2022	June 30, 2024	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2022	June 30, 2024	
8	Part C representative	1	PP	Leon Maultsby, MHA	Charles R. Drew University	July 1, 2022	June 30, 2024	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2023	June 30, 2025	
10	Part F representative	1	PP	Sandra Cuevas	Pacific AIDS Education and Training - Los Angeles Area	July 1, 2022	June 30, 2024	
11	Provider representative #1	1	OPS	Jose Magana	The Wall Las Memorias	July 1, 2023	June 30, 2025	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2022	June 30, 2024	
13	Provider representative #3	1	PP&A	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2023	June 30, 2025	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2022	June 30, 2024	
15	Provider representative #5	1	SBP	Byron Patel, RN, ACRN	Los Angeles LGBT Center	July 1, 2023	June 30, 2025	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2022	June 30, 2024	
17	Provider representative #7	1	EXC	Alexander Luckie Fuller ***(LOA)***	Invisible Men	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2022	June 30, 2024	
19	Unaffiliated consumer, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	
20	Unaffiliated consumer, SPA 2	1	SBP	Russell Ybarra	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
21	Unaffiliated consumer, SPA 3	1	PP&A	Ish Herrera	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2022	June 30, 2024	Lambert Talley (PP&A)
23	Unaffiliated consumer, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
24	Unaffiliated consumer, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2023	June 30, 2025	Ronnie Osorio (PP)
26	Unaffiliated consumer, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2023	June 30, 2025	Dechelle Richardson (PP&A)
28	Unaffiliated consumer, Supervisorial District 2	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2022	June 30, 2024	Juan Solis (SBP)
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
32	Unaffiliated consumer, at-large #1	1	PP&A	Lilieth Conolly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
33	Unaffiliated consumer, at-large #2	1	OPS	Shonte Daniels ***(LOA)***	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	Erica Robinson (OPS)
34	Unaffiliated consumer, at-large #3			***Vacant***		July 1, 2022	June 30, 2024	David Hardy (SBP)
35	Unaffiliated consumer, at-large #4	1	EXEC	Joseph Green	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2022	June 30, 2024	
37	Representative, Board Office 2	1	EXC|OPS	Danielle Campbell, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2022	June 30, 2024	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2022	June 30, 2024	
41	Representative, HOPWA	1	PP&A	Jesus Orozco	City of Los Angeles, HOPWA	July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	PP	Alasdair Burton	No affiliation	July 1, 2022	June 30, 2024	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3	1	PP	Pearl Doan	No affiliation	July 1, 2022	June 30, 2024	
47	HIV stakeholder representative #4	1	PP&A	Redeem Robinson ***(LOA)***	No affiliation	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2022	June 30, 2024	
49	HIV stakeholder representative #6	1	PP	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2022	June 30, 2024	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2022	June 30, 2024	
	TOTAL:	**43**						

LEGEND: EXC=EXECUTIVE COMM | OPS=OPERATIONS COMM | PP&A=PLANNING, PRIORITIES & ALLOCATIONS COMM | PPC=PUBLIC POLICY COMM | SBP=STANDARDS & BEST PRACTICES COMM

LOA: Leave of Absence

Overall total: 49

Planning Council/Planning Body Reflectiveness Table

(Use most recent HIV Prevalence data)

HIV Prevalence data source and year of data: 2022

Race/Ethnicity	HIV Prevalence in EMA/TGA		Total Members of the PC/PB		Unaffiliated RWHAP Part A Clients on PC/PB	
	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
White, not Hispanic	13,320	24.86%	10	23.26%	4	40.00%
Black, not Hispanic	10,758	20.08%	14	32.56%	5	50.00%
Hispanic	24,961	46.59%	11	25.58%	1	10.00%
Asian/Pacific Islander	2,127	3.97%	4	9.30%	0	0.00%
American Indian/Alaska Native	316	0.59%	0	0.00%	0	0.00%
Multi-Race	1,980	3.70%	4	9.30%	0	0.00%
Other/Not Specified	115	0.21%	0	0.00%	0	0.00%
Total	53,577	100%	43	100%	10	100%

Gender	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
Male	46,509	86.81%	27	62.79%	5	50.00%
Female	5,947	11.10%	13	30.23%	5	50.00%
Transgender: male-to-female	1,079	2.01%	1	2.33%	0	0.00%
Transgender: female-to-male	42	0.08%	1	2.33%	0	0.00%
Other gender identity	-	0.00%	1	2.33%	0	0.00%
Total	53,577	100%	43	100%	10	100%

Age	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
13-19 years	94	0.18%	0	0.00%	0	0.00%
20-29 years	3,465	6.47%	2	4.65%	0	0.00%
30-39 years	10,648	19.87%	12	27.91%	0	0.00%
40-49 years	11,038	20.60%	11	25.58%	2	20.00%
50-59 years	14,905	27.82%	11	25.58%	5	50.00%
60+ years	13,427	25.06%	7	16.28%	3	30.00%
Total	53,577	100%	43	100%	10	100%

Percentages may not equal 100% due to rounding.
(Includes alternates)

Non-Aligned Consumers = 23% of total PC/PB

*Multi-Race: 4 commissioners indicated multi-race but did not specify their exact races/ethnicities.

LOS ANGELES COUNTY
COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV (COH)
FY 2022-2023 ASSESMENT OF MECHANISM (AAM)
APPROACH AND FOCUS PROPOSAL
DRAFT 8.8.23; 9.21.23

FOR DISCUSSION PURPOSES ONLY

BACKGROUND

The federal Health Resources and Services Administration (HRSA) requires all Part A planning councils (the Commission on HIV is Los Angeles County's Ryan White Part A planning council) to conduct annual "Assessments of the Administrative Mechanism" (AAMs). The AAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in LA County.

The most commonly cited key systemic weakness in the County's administrative mechanism is the protracted contracting period to executive a contract. It generally takes 12-18 months from solicitation development to contract execution.

It is recommended that the FY 2022-2023 AAM focus on identifying challenges to and identifying strategies to shorten and fast-track the contracting process. Furthermore, the Division of HIV and STD Programs (DHSP) suggested the following:

- Consider a very specific service category assessment.
- Tailor questions on how the County is responding to homelessness among PLWH and those at risk.
- The County demonstrated during the COVID response that a fast-track contracting process is possible, however the willingness by DPH and the CEO to allow expedited contracting for HIV and STD services remains very elusive for DHSP. This continues to be a problem with new grants.

METHODOLOGY

Key informant interviews and focus groups facilitated by a consultant.

Conduct key informant interviews with staff from the following County Departments and units:

Division of HIV and STD Programs (DHSP)

1. Senior management staff
2. Contracts and procurement staff
3. Finance staff
4. Contract monitoring/audit staff

Department of Public Health

1. Office of the Director
2. Contracts and Grants

Board of Supervisors

1. Health Deputies
2. Administrative Deputies

3. Chiefs of Staff

Chief Executive Office

- Administrative Services Division, Contracts and Procurement team

Contracted Agency Perspectives

- Interview a representative sample from DHSP-funded agencies.

Consumer Focus Group

- Consumers of HIV prevention and care services

Opportunity to Leverage the Board of Supervisor's Motion on Procurement Modernization and Transformation

On June 14, 2022 the Board approved a motion authored by Supervisor Kathryn Barger and co-authored by Supervisor Janice Hahn to modernize and transform the County's approach to purchasing and contracting. This motion supports past appeals made by the COH to the Board to remedy the outdated and protracted contracting and procurement process across the County. Some of the key goals of the motion is to streamline cycle times, move to paperless system, and implement a strategic, equitable, accessible, and transparent online procurement process.

The County Chief Executive Office (CEO), Internal Services Division (ISD), Quality and Productivity Commission (QPC) and other Departments are in the process of hiring an independent consultant to test and validate initial analyses and recommendations made by ISD and QPC and develop key recommendations to the Board for implementation across the County.

It is recommended that the COH's AAM for FY 2022-2023 leverage the activities underway as a result of the Board motion and develop assessment questions that would enhance the results of the study.

OVERVIEW OF THE CONTRACTING AND SOLICITATIONS PROCESS AT DPH/DHSP (EXCERPTS FROM FY 2014, 2015, 2016 AAM)

In November of 2016 Dr. Michael Green, Chief of the Planning Section of DHSP made a presentation to the PP&A Committee describing the contracting and solicitations process currently in place at DPH/DHSP. In order to place the process in context, we summarize his presentation here (based on approved minutes):

The process is designed to ensure County programs do not enter into contractual agreements without a full, unbiased review and that community-based organizations (CBOs) receiving contracts meet requirements and are fully accountable to the County.

- The Commission and DHSP coordinate on planning services. DHSP then plans and releases solicitations. Requests for Proposals (RFPs) are the most common while Requests for Statements of Qualifications (RFSQs) are used occasionally. Invitations for Bid (IFBs) are price-based solicitations generally insufficient to reflect the complexity [that] services require.

- It generally takes 12-18 months from solicitation development to contract execution. That does not include time at the Commission and DHSP to develop the service concept and Standards of Care which add at least six months.
- Proposal evaluation is in phases: first, to ensure they meet minimum requirements; second, an external review panel convened by Contracts and Grants (C&G), DPH; third, final funding recommendations; fourth, departmental reviews; fifth, contracts go to the Board for approval. Once approved, contract negotiations occur with the CBOs, then a Board Letter is submitted for contract approval. Once approved, the CBOs sign the contracts and then they can be executed.
- C&G is charged with managing the contracting process and solicitations for DPH overall but, for DHSP, C&G manages solicitation while DHSP manages programmatic content and contracting. In 2015, C&G staff was assigned to DHSP. That increased solicitations from zero in the prior three years with up to six in the last 12-14 months and more in progress.
- C&G's role includes responding to questions on a solicitation and releases an addendum that may clarify or change some solicitation language and answer specific questions. C&G will host a proposer's conference if the solicitation warrants one. Such conferences are not required by the County, but are helpful for complex solicitations.
- Proposers must meet minimum contract requirements as well as appear to be able to sustain services for 90 days without County funds to demonstrate financial stability. Proposers passing those tests go on to further evaluation.

  DHSP is responsible for identifying unbiased, non-conflicted evaluators for review panels. That is difficult, e.g., there were 36 proposals for one RFP. Serving requires significant time for no pay and evaluators must sign a statement of no conflict of interest so local providers are often ineligible. Evaluators have been recruited, e.g., from Las Vegas, San Diego and San Francisco, but often nonlocal people are not invested in participating. DHSP has recommended DPH leadership identify a list similar to a jury pool for a 12-month period. DPH showed interest, but has not acted.
- Contractors are selected and funding recommendations are developed based on evaluation scores as well as funding requirements, geographic distribution of services and targeted populations defined in the solicitation. Proposers may request a debriefing after the recommendations to review their proposals. They may appeal decisions.
- Services are solicited for a variety of reasons, e.g., to meet emerging need, redefine services, replace expiring contracts, [or] utilize new grant funding. DHSP tends not to apply for short-term grants, e.g., 24-36 months, because the time is too short to contract services within the grant term. For longer term grants, DHSP typically begins solicitation at the same time it applies for the grant to facilitate service implementation. Delegated authority allows DHSP to increase or decrease funds for a service by a certain percentage or time, but eventually services will need to be resolicited.
- Prior to applying for funding, DHSP must receive DPH approval by showing: purpose of funding, why it is needed, specifically how it will be used and how services will be implemented in the community.
- Concurrently, DHSP begins work on a Board Letter for approval to receive grant funds which includes: the amount of funds to be received in response to an application submitted on a certain date requesting a certain amount; how funds will be used and a proposed list of contractors. The Board Letter is required even for the annual Ryan White grant. DHSP cannot technically contract any services if the Health Resources Services Administration (HRSA) or

another grantor delays its Notice of Grant Award. HRSA often has delayed its Notice of Grant Award from one to six months.

- A sole source solicitation allows DHSP to identify an agency or agencies that it knows can do the work in the way it needs to be performed without putting the contract out to bid. DHSP has to prove to the Board that no other contractors can provide the needed service or that sole source is needed to expedite the work and the identified provider(s) are well-qualified to do the work.
- Generally, the Board does not approve sole source contracting. It did approve DHSP to use sole source for Medical Care Coordination (MCC) expansion after the Commission advocated for it and data supported the beneficial impact of MCC.
- Other solicitation forms theoretically save time, but rarely do so in practice. The RFP process takes the most time, but offers more clarity about what is wanted and proposer submittal requirements are more stringent so results are better.
- Dr. Green said the County's process is determined by the Board, Chief Executive Office and Auditor-Controller. Multiple attempts to persuade the Board to streamline the process were met with opposition but, as noted with MCC, the Board allows adjustments if need is demonstrated.

PROPOSED TENTATIVE TIMELINE

Secure feedback and approval from Operations, Executive and full Commission on AAM focus and approach for FY 2022-2023	August-September 2023 No feedback received from Ops as of 9.
Secure project consultant	September-November 2023
Selected project consultant to review interview questions and study approach with Operations, Executive, and COH.	December 2023-January 2024
Conduct assessment	February-April 2024
Develop report	April-May 2024
Present draft, findings, to Operations and Executive Committees	May- June 2024
Present final report to full Commission for adoption	July 2024

AGN. NO.

MOTION BY SUPERVISORS KATHRYN BARGER AND JANICE HAHN

June 14, 2022

County of Los Angeles Procurement Modernization and Transformation

The County of Los Angeles spends approximately $6-8 billion annually for many different types of goods and services. Approximately fifteen percent (15%) are commodities or low-dollar services purchased via the Internal Services Department's (ISD) Purchasing Agent authority, in which County departments determine their needs and ISD centrally manages the sourcing and purchase order process. The vast majority of the County's total procurement expenditure, eighty-five percent (85%), is for services contracted by and through County departments. Each department determines the services that it needs and, in many cases, manages the entire procurement process from solicitation to contract execution.

The Los Angeles County Quality and Productivity Commission (Commission) was formed to provide the Board, the Chief Executive Officer and County departments with advice, information and recommendations relating to productivity, work measurements and quality of services in the County [County Ordinance 3.51]. The core mission of the Commission is to increase productivity and improve the efficiency of County operations, programs, and public services for the more than 10 million residents and businesses who make their home in Los Angeles County. As such, the Commission has identified procurement modernization and transparency as a goal in its efforts to best serve the County.

On September 29, 2020, the Board of Supervisors (Board) adopted a motion that directed the County to review and provide recommendations on several digital and streamlined contracting and auditing activities. On November 25, 2020, ISD submitted a report with a number of recommendations, most of which are in progress or have been implemented. Among the most impactful long-term recommendations in the report was to implement an end-to-end e-Procurement technology solution and to develop procurement process standardization across the whole County. The benefits of an end-to-end procurement solution include greater transparency and visibility, improved speed and efficiency, enhanced modern user experience, increased participation of local, small and diverse businesses, and cost savings. The goal is to modernize and transform the County's existing purchasing and contracting processes to streamline cycle times, move to a paperless system, and implement a strategic, equitable, accessible, and transparent online procurement process.

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MOTION

SOLIS	_____
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BARGER	_____
MITCHELL	_____

In support of the Board and the Commission's goals related to procurement modernization and transparency, ISD issued a request for proposals (RFP) for a new end-to-end e-Procurement technology solution in 2021 and is currently evaluating proposals from various vendors.

The Commission cites the City of New York's Blueprint for Procurement Transformation and Cook County (Illinois) as examples of governments who successfully underwent a procurement transformation and implemented the use of modern technological systems. The support of procurement technology and process experts and consultants is necessary to identify best practices and review, analyze, and consider similar cases that would modernize and transform Los Angeles County's purchasing and contracting system, process, and practices, to be efficient, effective, and equitable, and to be transparent, auditable, and standardized across all County departments.

WE, THEREFORE, MOVE that the Board of Supervisors direct the Quality and Productivity Commission, in consultation with the Internal Services Department (ISD), Chief Executive Office, Auditor-Controller, and any related County departments, take the following actions (in full coordination and collaboration with the County's end to end e-Procurement solution) and report back in writing to the Board of Supervisors in 180 days.

1. Complete a review and analysis of the current state of the County's procurement systems, process, and practices with the goal to modernize and transform the County's purchasing and contracting system.

2. Delegate authority to the Executive Officer of the Board of Supervisors to execute consultant service agreement(s) with subject matter experts to assist in this endeavor.

3. Based on the completed analysis, provide recommendations using emerging technical and business process improvements and innovations to make the County's procurement of all goods and services more efficient, effective, and equitable across all departments. The recommendations should include a standardized process that ensures transparency and accountability for all County procurement efforts.

# # #

KB:mvs

LOS ANGELES COUNTY COMMISSION ON HIV (COH) ASSESSMENT OF THE ADMINISTRATIVE MECHANISM (AAM) RYAN WHITE PROGRAM YEARS 24, 25, 26 (FY 2014, 2015 and 2016)

RECOMMENDATIONS MATRIX-DISCUSSION WORKSHEET FOR OPERATIONS COMMITTEE

(UPDATED 3.19.19; 08.03.23); UPDATES IN RED IN 3RD COLUMN. Updates made on 8-3-23 reflects updates provided by DHSP on 7/27/23 Operations Committee meeting.

In general terms, the 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. A number of recommendations were offered by representatives of each level comprising the administrative mechanism as to possible improvements to the system, but the overarching assessment is that a mature and competent system has been developed. While the overall assessment included recommendations for improvement, the following positive attributes were noted: 1) the Commission on HIV (which is the Ryan White Planning Council) has highly committed staff that provide excellent support to its members, and their deliberations are thoughtful and result in allocations of resources that are responsive to community needs; 2) the administrative entity (DHSP) also is given high marks for competence, dedication and responsiveness to Commission allocations and directives; 3) the provider community has long experience in delivering quality and comprehensive services.

Recommended focus of the 2022-2023 AAM:

- Focus on identifying challenges to and identifying strategies to shorten and fast-track the contracting process.
- Consider a very specific service category assessment.
- Tailor questions on how the County is responding to homelessness among PLWH and those at risk.
- The County demonstrated during the COVID response that a fast-track contracting process is possible, however the willingness by DPH and the CEO to allow expedited contracting for HIV and STD services remains very elusive for DHSP. This continues to be a problem with new grants.

#	Recommendation	Priority Level: High, Medium, Low	Target Deadline/Notes/Comments
Focus Area 1: Commission on HIV Perspectives			
1	Survey of the entire membership. In addition to the Key Informant Interviews (of those most involved in service procurement processes) it is recommended that there be a survey tool to assess the perceptions of efficiency that are held by the entire body.	**High Main deliverable for 2019**.	• COMPLETED. PART OF 2020 AND 2021 AAM. • Combine with item #2. • Expand survey to all Commissioners is not hard, reflects interest in views, and can inform training, e.g., one question was, "Do you recall getting trained on the planning and priority-setting process?" (Operations Committee Meeting 10/25/18 minutes). • 2/21/1 - Start review of questionnaire and solicit DHSP feedback. • 3/29/19 - Finalize updated questionnaire. Review list of survey participants.

			April-May 2019 - Release survey via SurveyMonkey to all COH members, DPH/DHSP staff and providers.
2	Future AAM processes should include tools to elicit perceptions of other components of the "administrative mechanism" as to the efficiency of the COH. While it is helpful to compile the collective perception of some of the most involved members of the COH regarding the body's efficiency, it would be a more robust assessment to include the perceptions of other partners in the administrative mechanism, such as DPH/DHSP staff and Providers.	**Medium Main deliverable for 2019.**	• Combine with item #1. • Pertains to additional broadening of perspectives." (Operations Committee Meeting 10/25/18 minutes). • Main deliverable for 2019. • 2/21/1 - Start review of questionnaire and solicit DHSP feedback. • 3/29/19 - Finalize updated questionnaire. • April-May 2019 - Release survey via SurveyMonkey to all COH members, DPH/DHSP staff and providers. • Questions could help with an evaluation of the COH (AAM Workgroup Meeting 3/7/19). • Include other parts of the County such as DPH Contracts and Grants (C&G) Unit, CEO, DHSP, DPH, CBO staff and seek their input on how to speed up the contracting process. What is their thinking around the County's contracting process?
Focus Area 2: Key Division of HIV and STD Programs (DHSP) and Department of Public Health (DPH) Stakeholder Perspectives			
3	The next assessment of the administrative mechanism (or some other interim administrative review) should include an assessment of the HR and Finance systems of the County and how they are impacting the ability of DHSP and DPH to efficiently employ appropriate processes to support HIV service delivery.	**Medium 2021**	• Ongoing conversation with DHSP to determine how the COH can best support their efforts to improve internal operational and administrative efficiency. • May be focus of next AAM. Possible Health Agency changes may impact. (Operations Committee Meeting 10/25/18 minutes). • Assessment of the DPH HR and Finance systems could be the focus of the AAM slated for 2021/2022 (AAM Workgroup Meeting 3/7/19). • Related to #7. The absorption of the DHSP Finance Unit into the DPH Finance Dept did not take place and the idea is no longer under consideration. Having its own Finance Unit is advantageous to DHSP.

4	Encourage the Executive Office or DPH to explore the impact of the consolidation of Contracts and Grants at the DPH level, as compared to the previous placement of Contracts and Grants within DHSP.	**Low**	• Ongoing conversation with DHSP to determine how the COH can best support their efforts to improve internal operational and administrative efficiency. • Tied to ongoing organizational changes within DPH and process oriented. (Operations Committee Meeting 10/25/18 minutes). • RESOLVED. DHSP continues to retain its own solicitations staff and unit. DHSP works independently of the DPH Contracts and Grants unit.
5	Encourage the relevant components of the County to explore compensation for reviewers as many other governmental levels offer. A companion suggestion was made to assemble	**Low**	• Ongoing conversation with DHSP to determine how the COH can best support their efforts to improve internal operational and

	a “pool” of qualified reviewers (as HRSA does), and this suggestion should be revisited.		administrative efficiency. • Impact low now. Few new Requests For Proposals (RFPs) due to expansion of services for existing RFPs. (Operations Committee Meeting 10/25/18 minutes). • This is outside of COH’s purview, however, DHSP engages in ongoing conversations with the COH and the community on raising awareness regarding the RFP opportunities from DHSP. • DHSP continues to advocate for DPH C&G Unit to provide ongoing trainings to the community on the contracting process. • DHSP has used a third-party administrator (TPA) for some contracts which has been a faster contracting process. The TPA route is helpful for smaller contracts to smaller agencies that would not otherwise meet the County’s minimum requirements. The TPA mechanism may be used for all funding sources.
6	The DPH/DHSP should collaborate with ISD or undertake its own well-promoted community education sessions to educate providers who are not current county contractors about the steps, requirements and competencies necessary to do business with the County so as to potentially become HIV service delivery providers. Special outreach should be made to providers with competency in minority communities and in the HIV “hot spots” identified in the county’s HIV epidemiology reports.	**High 2020**	• Ongoing conversation with DHSP to determine how the COH can best support their efforts to improve internal operational and administrative efficiency. DHSP is the appropriate lead. • Supports adding providers with special focus on those serving minority communities and HIV "hot spots." (Operations Committee Meeting 10/25/18 minutes). • DHSP is approaching the solicitations process in a different way to get more providers to apply for RFPs. They are looking at a broader distribution of RFP notices and will start a series of trainings in April 2019 for agencies on how to better respond to RFPs. The trainings will replace bidder’s conferences (AAM Workgroup Meeting 3/7/19). • Same as #5 updates. DHSP recommends including questions directed to C&G as part of the next round of AAM.

7	Given the reported variability among individual fiscal and programmatic monitors, DHSP should be encouraged to improve the quantity and frequency of its internal training of its contract monitoring staffs. While most staff members received high marks for their competency, there was sufficient commentary about variability among staff in their interaction with providers to warrant a review by DHSP senior staff.	**High 2020**	• conversation with DHSP to determine how the COH can best support their efforts to improve internal operational and administrative efficiency. DHSP is the appropriate lead. • Training for DHSP contract monitoring staff on consistent communication and collaboration with providers. (Operations Committee Meeting 10/25/18 minutes). • DHSP is currently looking into doing internal training for DPH Contracts and Grants unit staff to ensure uniformity of messages and information given to contractors. DHSP staff have regular communications and training to ensure uniformity of information given to agencies. Dr. Green's unit is in the process of revising monthly reporting tools for each service category to get more accurate and specific information from providers. Dr.

			Green will lead the training for DHSP program monitors on how to use the updated monthly reporting tool and how to give better and consistent guidance and information to contractors (AAM Workgroup Meeting 3/7/19). • This function is now handled under Dr. M. Green's division. DHSP no longer relies on C&G to train DHSP staff, resulting in a much more timely and faster internal training process.
Focus Area 3: Contracted Agency Perspectives			
8	There is clearly a great deal of variability among providers in terms of their own internal processes that ensure efficient delivery of funded services. A recommendation for COH to consider would be to participate with DHSP to convene a "best practice roundtable where more experienced provider agencies could share information on their systems and processes with less experienced providers. Various incentives could be explored such as compensation for staff time, or prizes for "best new practice," or other incentives that might be funded by COH or private funders.	**Medium 2021**	• Use frontline feedback, but focus on provider executives to effect change. (Operations Committee Meeting 10/25/18 minutes). • Frame the best practices roundtable in a way that is not looking at the procurement process. Traci Bivens-Davis suggested approaching the best practices roundtable by looking at impacts on clients (AAM Workgroup Meeting 3/7/19). • Dr. M. Green noted that this is still a good idea to pursue, perhaps via the Standards and Best Practices Committee. Look at the entire system across services and assess where we are seeing improvements and challenges. Use the HRSA HIV Target website for resources.

9	It was suggested that there could be improvements to provider efficiency if the current mandated data system were improved or another system implemented. If sufficient IT expertise were available or could be secured, a review of the collective data management system used by DHSP would be useful. Particular dimensions of the functionality of such a system that should be explored would be its use to avoid multiple eligibility processes across providers, and its ability to generate data so that monitoring of contract performance by providers could be partially automated and thereby both agency and DHSP staff would need less time on site.	**High** **2020**	• Related to CaseWatch. DHSP is the appropriate lead. • Focus on feasible improvements, e.g., renewing previous ability of providers to access CaseWatch to identify a client's prior provider to minimize paperwork burden on client and ensure coordination (not duplication) of care. (Operations Committee Meeting 10/25/18 minutes). • DHSP is looking at a possible replacement to Casewatch for care related services and a system called IRIS for prevention services. In the past, a provider could see if a patient has been seen in another agency. That feature has been made active again. One issue is that most providers do not go into Casewatch before seeing the patient to check if they are already in the Ryan White care system. Providers are not accessing Casewatch in real time while with the client. DHSP is continuing to look into an eligibility card for clients (AAM Workgroup Meeting 3/7/19). • DHSP is still in the process of replacing Casewatch; they anticipate to go live with the new system by March 2025. Data management challenges will continue to be a challenge even with newer systems in place. There is a need to continually map out multiple data systems, including those used at the agency level to reduce data entry duplication. •

General Recommendations			
10	It is recommended that a task force be convened (by the Executive Office or whatever level deemed appropriate) to do a comprehensive review of all the steps involved in procuring HIV related services. Given that it is reported by multiple sources that the overall timeline from identifying a need to getting reimbursable services on the street is around 24 months, and that timeline has not changed for over a decade, it is clear that this complicated and sometimes redundant system could be "tested" for efficiencies.	**High 2019 Policy and County-wide issue**	• REVISIT • Related to 2019 Co-Chairs' Priorities to work with the BOS to address the County's long contracting process and cycle. • Discuss with DHSP to develop a time study of procurement steps to test for efficiencies. (Operations Committee Meeting 10/25/18 minutes). • Since the contracting and procurement process is a countywide issue that requires a policy change from the Board of Supervisors, she asked if there are other advocacy work that the Commission should consider. Dr. Green noted he is exploring some possible options within DPH. He recommending working with health deputies first and Commissioners should focus on how the delays in contracting are impacting clients. Explore a fast track process for grant funded programs. Consider giving examples of how the delays in the contracting process impact access to services and clients. DHSP could help provide examples (AAM Workgroup Meeting 3/7/19).
11	It was noted by various informants that ISD (the Internal Services Department) is exploring its procurement processes and looking for improved efficiencies. It was also reported that the Interim Health Officer at DPH has noted that the department is moving on a fiscal and administrative function reorganization that could have an impact on HIV related service contracting. It appears timely to intensively study the procurement process for RWCA funded services as a part of the preparation for this reorganization.	**High 2021**	• REVISIT • Assess, watch, track, and monitor possible impact of single budget code consolidation for DPH • Include in scope of next AAM • Dr. Green noted that there has not been a consolidation of budget functions at DPH so far. Cheryl Barrit recommended that the Operations Committee track the issue for any potential impact on service delivery (AAM Workgroup Meeting 3/7/19).
Procedural Recommendations Regarding Future AAMs			
12	A procedural recommendation (that had been made in previous AAMs) reemerged in the process of conducting the current AAM. There seems to be no readily available database or information on the specific dates of each of the steps in the	**Low 2021**	• REVISIT • Discuss with DHSP to develop a time study of contracting steps with a provider to inform future AAMs.

POLICY/PROCEDURE #09.4205	Commission Membership Evaluation, Nomination and Approval Process	Page 1 of 8

SUBJECT: **The submission, evaluation, scoring, selection, and nomination of applications/ candidates for seats on the Los Angeles County Commission on HIV.**

PURPOSE: **To outline consistent method for evaluating, scoring and selecting candidates to fill Commission seats, and for appropriate communication with those applicants before and after evaluation of the application.**

PROCEDURE(S):

1. **Membership Applications**: There are two Commission membership application forms:
   a) **New/Renewal Member Application**: for first-time applicants for Commission membership and renewing members, refer to electronic Membership Application found at https://www.surveymonkey.com/r/2023CommissiononHIVMemberApplication .
   b) **Non-Commission Committee Member Application(s)**: for applicants who are applying for membership on one of the Commission's standing committees, but not for the Commission, see Policy/Procedure #09.1007 (Non-Commission Committee Membership) for details regarding the process for evaluating and nominating non-Commission Committee member candidates.

2. **Application Submission**: All candidates for Commission or Committee membership must complete and submit a Commission or Committee-only membership application. Once the application is submitted and received by staff:
   a) Staff will review the application for member eligibility, completeness, and accuracy, and will verify with the candidate, via telephone and email, to ensure all eligibility requirements are met and/or to seek clarification on incomplete sections or confirm information not understandable/ accurate. Additionally, staff will review with the applicant the Commission's requirements, commitment expectations, and onboarding process for membership.
   b) Once the application has been completed and verified by staff, staff will coordinate interview and/or next steps with the Operations Co Chairs.

3. **Application Evaluation Timeline**: Provided all conditions for a Commission membership application are met, the Operations Committee, via a designated interview panel, will evaluate and score the application within 60 days of its receipt. Necessary conditions include, but are not limited to:
   a) Candidate meets or will meet by time of appointment, the Board of Supervisor's COVID-19 vaccination requirement.
   b) All sections of the application are complete,
   c) Original or electronic signatures have been provided,
   d) The applicant is willing and available to sit for an interview when appropriate.
   e) Current Commissioners or Alternates who are seeking to continue their membership on the Commission are required to complete an application prior to the expiration of their membership terms. The renewal application focuses on the member's past performance, strengths and weaknesses, and methods for improving any gaps in service and/or participation.
   f) Candidates for institutional seats will not be required to sit for an interview but may be assessed for strengths and skill sets for training opportunities and placement in the appropriate committee, task force, caucus, or workgroup.
   g) Candidates who are employed by organizations who receive Ryan White Program Part A funding through the Division of HIV and STD Programs (DHSP) must provide a written letter of support from their employer and provide to staff prior to interview. This requirement ensures that the employer is not only aware of their staff's participation on the Commission but confirms their support given the nature of the Commission's work and member expectation.

4. **Candidate Interviews**: All new member candidates must sit for an interview with a panel composed of at least two Commission members or alternates in good standing with at least one member assigned to the Operations Committee. To maintain transparency and integrity of the nomination process, should an interview panelist be assigned to an interview of an applicant with which the panelist has a personal relationship, working relationship while employed by same employer, used as reference by the applicant, and/or other conflict of interest as identified by the Operations Co-Chairs and Executive Director, the panelist will be removed from the interview panel and a qualified Commission member will be selected in their stead.

   The Operations Committee, in consultation with the Commission Co-Chairs, may request an interview with a member seeking to renew his/her Commission membership. Likewise, a renewal membership candidate may request an interview with the Operations Committee. .

5. **Interview/Scoring Sequence**: Applications are always evaluated and scored following the interview. At its discretion, the interview panel may request a second interview after it has scored an application, and re-score the application following the interview to incorporate any new information learned at subsequently and/or at the interview. Point scores may or may not change when an application is re-scored following an interview.

6. **Score(ing)**: The interview panel evaluates the applicant according to the appropriate "Los Angeles County Commission on HIV New Member Application Evaluation & Scoring."
   a) Each member of the interview panel participating in the evaluation assigns a point value to each factor of criteria.
   b) All interview panel members' scores are totaled and averaged. The final point value is the applicant's final score.

7. **Scoring Forms**: The Commission's Operations Committee is responsible for the development and revision of the Membership Candidate Evaluation/Scoring Forms. The Committee develops separate scoring forms for new member candidates and renewal candidates:
   a) Scoring criteria is based on essential skills and abilities, qualities and characteristics, experience, and past performance (for renewal candidates) that the Committee determines is necessary for effective Commission member participation.
   b) The Operations Committee determines those factors and their relative importance through annual membership assessments.
   c) The Operations Committee is authorized to revise the scoring form as needed. To the degree that revisions are substantial, or criteria are altered, the revised scoring form must be approved by the Commission.

8. **Qualification Status**: By virtue of their application scores, candidates' application will be determined to be "Qualified" or "Not Qualified" for nomination to a Commission membership seat. A minimum of 60 points qualifies the candidate for nomination consideration ("Qualified"); a score of less than 60 indicates that a candidate is "Not Qualified".
   a) If the applicant earns a "Not Qualified" score, the Operations Co-Chairs will inform the applicant accordingly and suggest opportunities of other HIV/AIDS planning or volunteer involvement as further preparation for future Commission service.

9. **New Member Candidate Eligibility**: New member candidates must also be "eligible" for Commission membership nomination. New member candidates are considered eligible if they meet the following conditions:
   a) The application score qualifies ("Qualified") the candidate for Commission membership.
   b) There is not purposefully misleading, untruthful, or inaccurate information on the application.
   c) The applicant has fully participated in the evaluation/scoring process, as appropriate.
   d) The applicant does not violate the Commission's "two persons per agency" rule. *To avoid potential influence and to preserve the integrity of the Commission's decision-making and planning process, the Commission's membership cannot consist of more than two agency representatives from the same agency*.

10. **Renewal Candidate Eligibility**: Current Commissioners seeking re-appointment to the Commission must be "eligible" for continued Commission membership. Renewal candidates are considered eligible if they meet the following conditions:
    a) There is not purposefully misleading, untruthful or inaccurate information on the application.
    d) The applicant does not violate the Commission's "two persons per agency" rule.
    e) The candidate has fulfilled Commission member requirements in his/her prior term of service, including, but not limited to:
        - ***Commission Meeting Attendance***: unless the reason for the absence falls within Policy #08.3204 Excused Absences, members cannot miss three sequential, regularly scheduled Commission or primary assignment committee meetings in a year, or six of either type of meeting in a single year. Policy 08.3204 dictate that excused absences can be claimed for the following reasons:
            - personal sickness, personal emergency and/or family emergency;
            - vacation; and/or
            - out-of-town travel
        - ***Primary Committee Assignment***: members have actively participated in the committee to which they have been assigned, including compliance with meeting attendance requirements.
        - ***Training Requirements***: members are required to participate in designated trainings as a condition of their memberships.
        - ***Plan of Corrective Action (PCA)***: the member must fulfill the terms of any PCA required of him/her by the Operations and/or Executive Committee(s).

11. **Nominations Matrix**: If the applicant is eligible for Commission membership, the Operations Committee will place the candidate among those that can be nominated for available and appropriate seats on the Commission on its upcoming agenda for Committee approval. The candidate's name is entered on the "Nominations Matrix" which lists candidates in order of scores, alongside available Commission seats and vacancies.

12. **Seat Determination**: At the recommendation of the interview panel, the Committee will then determine the individual seats, if any, that are most appropriate for the available qualified candidates—based on the seats the candidates indicated in their applications, and any other seat(s) identified by Committee members that the candidate(s) are qualified to fill.
    a) Duty Statements for each seat dictate requirements for each membership seat on the Commission.

13. **Multiple Application Requirement**: In accordance with HRSA guidance, there should be multiple candidates for membership seats when possible. All consumer and provider representative seats, along with other seats designated by the Operations Committee, require two or more applications. The Operations Committee may exempt a seat previously designated to require multiple applications from that requirement under the following circumstances:

a) There has been a vacancy in the seat for six or more months,
b) The pool of available, possible candidates is limited, and
c) The Committee is convinced that every effort has been made and exhausted by the appropriate stakeholders to identify additional membership candidates.

14. **"Representation" Requirement**: Ryan White legislation and HRSA guidance require the Part A planning council membership to include specific categories of representation. The Commission's membership seats have been structured to fulfill that requirement. As specified in the COH Bylaws (Policy/Procedure #06.1000), Commission membership shall include individuals from areas with high HIV and STD incidence and prevalence. The Commission endeavors to ensure those categories are always represented by planning council membership.

15. **"Unaffiliated Consumer" Requirement**: Ryan White legislation and HRSA guidance require one-third or 33% of the voting membership of the Ryan White Part A planning council to be "unaffiliated" or "non-aligned" consumers. "Unaffiliated" consumers are patients/clients who use Ryan White Part A-funded services **and** who are not employees or contractors of a Ryan White Part A-funded agency **and** do not have a decision-making role at any Ryan White Part A-funded agency. (Policy/Procedure #08.3107 contains information on Consumer Definitions and Related Rules and Requirements). In addition, the Commission defines "Unaffiliated Consumer" as someone using Ryan White Part A-funded services within the last year and who is "unaffiliated" or "non-aligned," consistent with Ryan White legislative and HRSA definitions.

    Following the updated ordinance of the Commission as an integrated HIV prevention and care planning body, a "Consumer" is defined as an HIV-positive and/or AIDS-diagnosed individual who uses Ryan White-funded services or is the caretaker of a minor with HIV/AIDS who receives those services, or an HIV-negative prevention services client.

16. **"Reflectiveness" Requirement**: Ryan White legislation and HRSA guidance require both the entire Commission membership and the subset of unaffiliated consumer members to "reflect" the gender and ethnic/racial distribution of the local HIV epidemic. The Commission endeavors to always reflect the gender and ethnic/racial demographic distribution of Los Angeles County's HIV epidemic among its membership and consumer members. Furthermore, the CDC HIV Planning Guidance notes that planning bodies place special emphasis on identifying representatives of at-risk, affected, HIV-positive, and socioeconomically marginalized populations.

17. **Committee Nominations**: All factors being equal among two or more applications that meet the requirements of a particular open seat, the Committee will forward the candidate with the highest application score to the Commission for nomination to the Board of Supervisors for appointment to the Commission.

18. **Special Considerations**: There are several "special considerations" that may preclude the Committee from nominating the candidate with the highest score, resulting in the nomination of a candidate with a lower score to a seat. Those factors may include, but are not limited to:
    a) the necessity of maintaining "reflectiveness",
    b) an adequate proportion of consumer members,
    c) the need to fill certain "representative" categories,
    d) Board of Supervisors interest or feedback,
    e) over-representation of a particular stakeholder/constituency, otherwise known as the "two persons per agency" rule.
    f) potential appointment challenges.
    g) candidate would violate the COH's two person/per agency rule

19. **Conditional Nomination(s)**: The Operations Committee may nominate candidates "conditionally." Conditional nominations require candidates to fulfill certain obligations from the Executive and/or Operations Committee prior to or following the nomination. Conditions are detailed in a "Plan of Corrective Action (PCA)" imposed to correct past Commission performance issues or to enhance certain skills and abilities of the candidate/ member.
    a) The PCA is written with expected timelines and objectives, and must be agreed to and signed by the candidate, the Executive Director and an Executive or Operations Committee co-chair, as appropriate.
    b) The candidate must agree to the PCA by the subsequent regularly scheduled committee meeting following the development of the PCA. A candidate's refusal to accept a PCA may render his/her application ineligible.
    c) If the PCA obligates the candidate to certain conditions prior to nomination, the nomination will not proceed until the candidate has fulfilled those obligations.
    d) If the candidate/member has not fulfilled the conditions of the PCA, he/she will not be eligible for future re-nomination to the Commission.
    e) Terms of the PCA may be modified at any time upon agreement from all three parties (candidate/member, Executive Director, committee).
    f) The Operations Committee is responsible for monitoring a candidate's progress and fulfillment of any PCA obligations and requirements.

20. **Candidate Communication**: At the conclusion of a candidate's evaluation (interview, scoring, qualification and eligibility designation, seat determination, nomination), the Committee shall notify the candidate in written communication of the results of the evaluation and scoring process. The notification will detail one of the three possible results:
    a) The Committee has nominated the candidate for a particular Commission seat;
    b) The Committee has judged that there are no specific seats available concurrent with the candidate's qualifications, but the Committee will keep the candidate's application and evaluation scores for ongoing consideration for up to a year from the date of application submission; or
    c) The candidate's application and/or evaluation has been placed on hold temporarily.

21. Temporary Hold: A candidate's application may be held temporarily for up to a year under certain conditions that preclude an otherwise eligible nomination to proceed, including but not limited to:

a) Multiple candidates have not applied for a seat that requires multiple applications,
b) Appointment of the candidate to a seat would interfere with the Commission's capacity to meet representation, consumer and/or reflectiveness requirements, and/or
c) The Committee intends to nominate the candidate to a seat that is expected to be vacated soon.

The Operations Committee will provide the reason(s) for a temporary hold when it notifies the candidate of his/her application status. Once a candidate's application has been released from the hold, the candidate must agree to the nomination before it proceeds. If the hold is not released within the year, the candidate must submit a new application for Commission membership.

22. Withdrawal/Declination: At any time after a candidate has submitted an application up until the appointment is approved by the Board of Supervisors, a candidate is entitled to withdraw his/her application and/or decline a proposed nomination.

23. Training Requirements: Commissioners and Alternates are required to fulfill all training requirements, as indicated in the Commission's approved comprehensive training plan, including, but not limited to, the New Member Orientation(s), and Los Angeles County Ethics and Sexual Harassment trainings. Failure to fulfill training requirements as a Commission member may render the member's subsequent renewal applications ineligible.

24. Nomination and Approval: Once the Operations Committee has nominated a candidate for Commission membership, the Committee forwards the nomination(s) to the Commission for approval at its next scheduled meeting. When a candidate's nomination has been approved by the Commission, the candidate's Statement of Qualifications shall be forwarded within two weeks to the Executive Office of the Board of Supervisors.

a) Candidates are advised to attend the Commission meeting at which their nomination will be considered.
b) Upon Commission approval, the candidate is encouraged to attend all committees to learn how they operate and assess the best fit for a committee assignment.
c) Upon Commission approval, the candidate is asked to select its preferred primary Committee assignment. In most instances, the candidate will be asked to review the Committee Description and select their preferred committee in advance of approval to allow staff to review committee membership assignments to ensure parity, inclusion and reflectiveness.

25. Appointment: The Executive Office of the Board of Supervisors places the nomination on a subsequent Board of Supervisors agenda for appointment. Upon Board of Supervisors approval, the candidate is appointed to the Commission.

a) Candidates are not required to appear before the Board of Supervisors, although they may attend the designated meeting if so desired.
b) Candidates will be notified in writing when their nomination will appear before the Board of Supervisors and following appointment.
c) A newly appointed Commission member is expected to begin his/her service on the Commission at the next scheduled Commission meeting following Board appointment.
d) Each Commission seat has a pre-designated term of office in which the Commission member will serve until the term expires or he/she resigns from the seat. Should a member's seat change during their membership which prompts a change in their term of office, an updated signed SOQ must be resubmitted to the Executive Office to place the member on the BOS agenda for reappointment to formalize the change in term of office.

NOTED AND APPROVED: Cheryl A Barnit **EFFECTIVE DATE:** 5/10/18

Original Approval: 9/6/2004
Revision(s): 5/12/2011; 2013; 4/27/16; 4/12/16; 5/12/16; 5/2/17; 5/22/17; 9/14/17; 05/10/18; 2/9/23

	contracting process for each provider. It is recommended that the COH encourage the DHSP to track this information and to make it available for assessments in the future. This is one of HRSA's recommended practices, and it would augment future AAMs.		
13	Another procedural component that is very useful to quantitative analysis (and has been done in prior AAMs) is to conduct a survey of providers regarding their assessment of the efficiency of the overall administrative mechanism and in particular the procurement and fiscal/program monitoring procedures. COH should include a survey of all providers as component in the design of future AAM exercises. Incentives could be used to ensure high response rates, and the representativeness of the body of respondents could be analyzed as part of the process, and adjusted if needed.	**Low** **2021**	• COMPLETED. ALL CONTRACTED PROVIDERS WERE INVITED TO PARTICIPATE IN THE PY 31 AAM. • Expand survey to all providers to better supplement key informant interviews.

LOS ANGELES COUNTY
COMMISSION ON HIV

REVISED 2023 Training Schedule

- All trainings are open to the public.
- Click on the training topic to register.
- Recordings will be available on our website for those unable to join live trainings.
- Certifications of Completion will be provided.
- All trainings are virtual.

Topic	Date
General Orientation and Commission on HIV Overview *	March 29 3:00 - 4:30 PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 12 3:00 - 4:30 PM
Tips for Making Effective Written and Oral Public Comments	May 24 3:00 - 4:00 PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 19 3:00 - 4:30 PM
Public Health 101	August 16 3:00 - 4:30 PM
Sexual Health and Wellness	September 20 3:00 - 5:00 PM
Health Literacy and Self-Advocacy **Changed from Oct. 18 to 24th**	October ~~18~~ 24 3:00 - 4:30 PM
Policy Priorities and Legislative Docket Development Process *	November 15 3:00 - 4:30 PM
Co-Chair Roles and Responsibilities **Changed from Dec. 6 to Feb. 13, 2024**	FEB. 13, 2024 ~~December~~ 6 4:00 - 5:00 PM

Mandatory core trainings for all commissioners.

MENTAL HEALTH AND SUBSTANCE ABUSE (RESIDENTIAL) SERVICES

BACKGROUND

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

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

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

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

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[1] Ryan White HIV/AIDS Programs Parts & Initiatives. (2022). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/about/parts-and-initiatives

[2] Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026.(2021). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf

[3] Ending the HIV Epidemic Plan for Los Angeles. (2021). In lacounty.hiv. Retrieved July 19, 2023, from https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

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

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

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

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

Outcomes and Indicators

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

- HIV Care Continuum Outcomes (engagement in care, retention in care (RiC) and viral suppression (VS) among priority populations:
    - Engagement in HIV care =≤1 viral load or CD4 test in the contract year
    - Retention in HIV care =≤2 viral load or CD4 tests at least 90 days apart in the contract year
    - Viral suppression =Most recent viral load test <200 copies/mL in the contract year
- RWP service utilization and expenditure indicators by service category:
    - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
    - Service units per client=Total service units/Number of clients
    - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
    - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

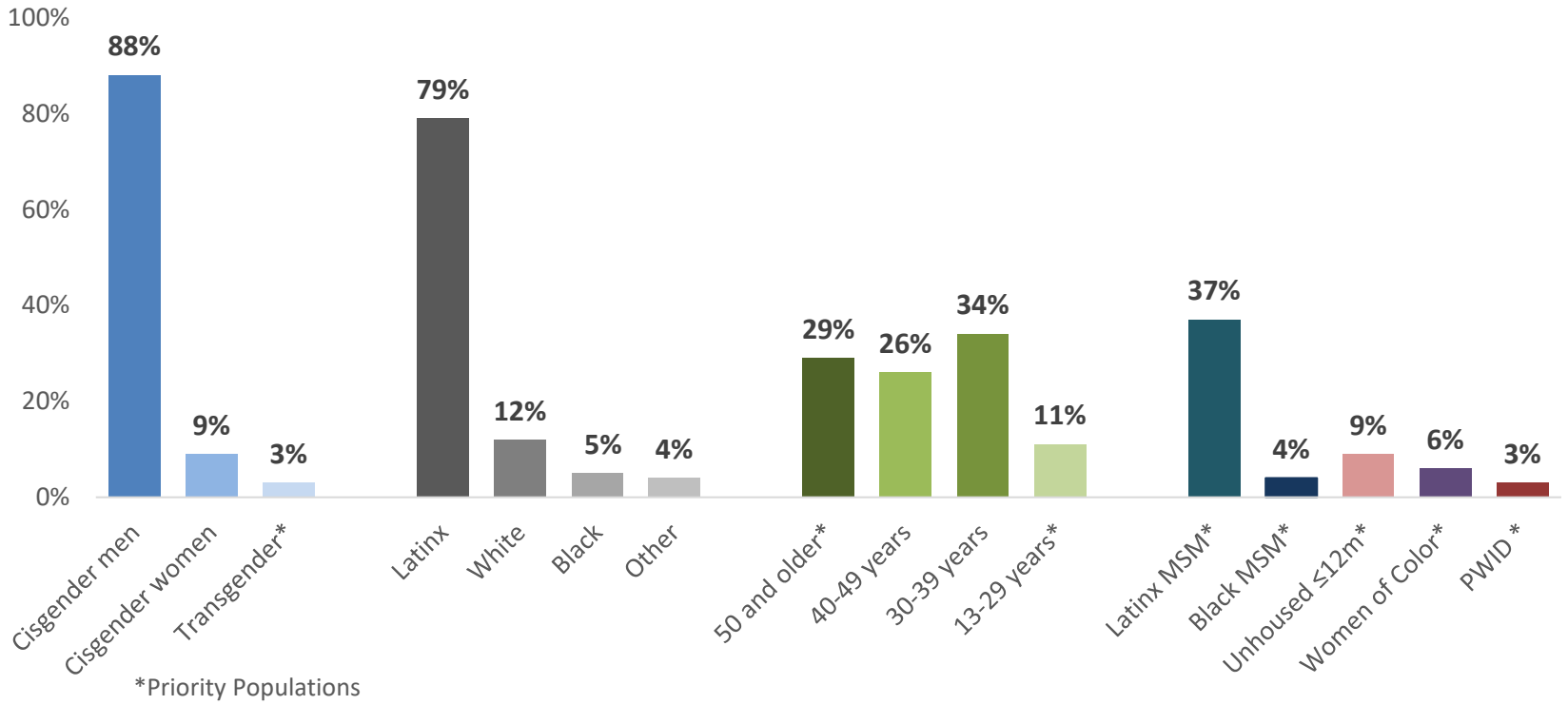
- HIV Casewatch (local RWP data reporting system)
    - Client characteristics and service utilization data reported by RWP contracted service agencies
    - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance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

MENTAL HEALTH (MH) SERVICES

Population Served:

- In Year 32, a total of 224 clients received MH services
- Most MH clients were cisgender men, Latinx, and aged 30-39 (Figure 1)
- Among the priority populations, the largest percent served were Latinx MSM

Figure 1. Key Characteristics of RWP Clients in Mental Health Services in LAC, Year 32

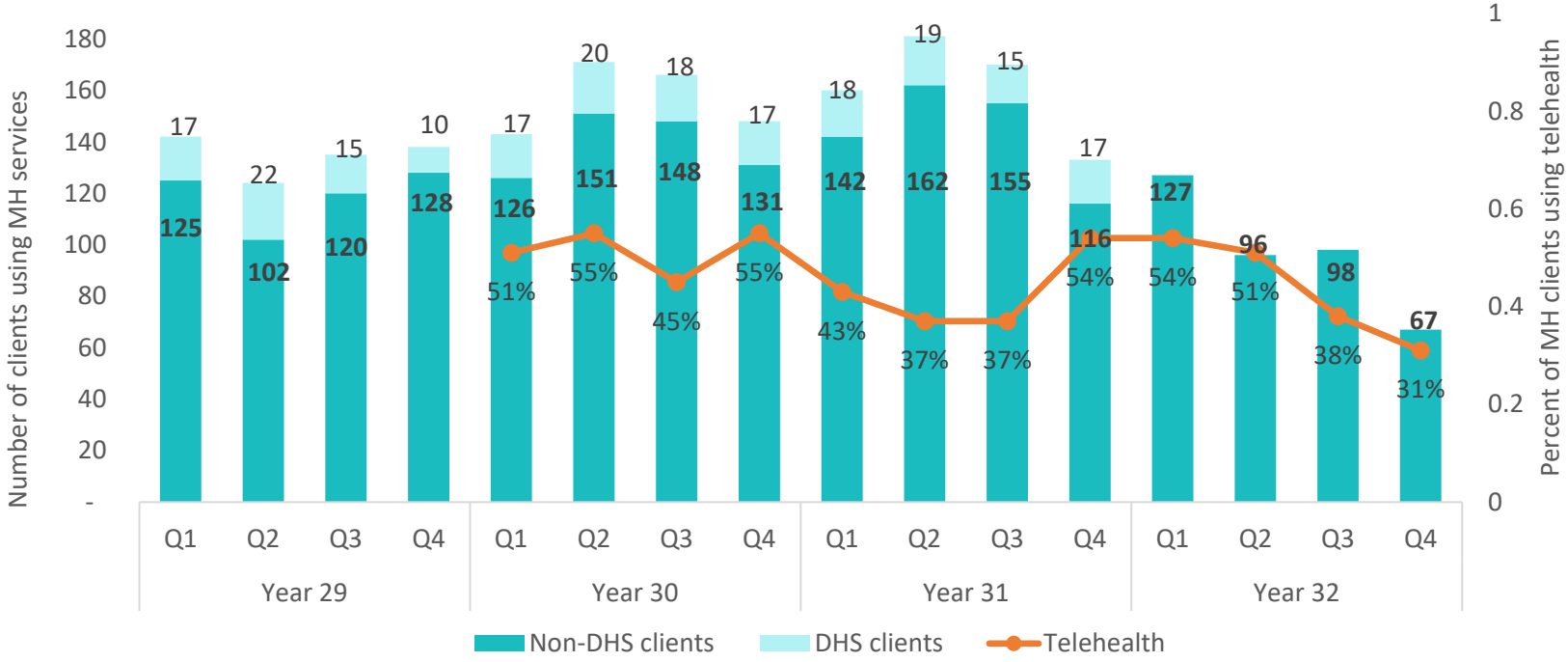


Service Utilization and Expenditures

Figure 2 below shows the number of RWP clients accessing Mental Health (MH) services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on service utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light turquoise part of the bar shows the number of DHS clients. The darker turquoise part of the bar shows the number of all other (non-DHS) clients. The total number of MH clients decreased in quarter 4 of Year 31 and has continued through Year 32. When looking at only non-DHS clients, we see a similar trend of decreasing utilization since the fourth quarter of Year 31.

The orange line shows the percent of MH clients who received at least one telehealth service. While the percent of clients using MH services via telehealth decreased in Year 32, it was critical to maintaining service continuing through the pandemic and continues to provide expanded service access. Within populations, Latinx clients (57%) and those ≥ age 50 (68%) were those with the largest percent of clients using telehealth for MH.

Figure 2. Number of Department of Health Services (DHS) and Non-DHS MH Clients by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
- Percentage of RWP Clients Accessing MH in Year 32: **1.5%**
- Unit of Service: **Sessions**

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

Priority Populations	Unique Clients	% of Clients	Total sessions	% of sessions	Sessions per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total MH clients	***224***	***100%***	***1,572***	***100%***	***7***	***$965***	***$216,060***
Latinx MSM	140	63%	961	61%	6.9	$941	$131,797
PLWH ≥ Age 50	65	**29%**	655	**42%**	**10.1**	**$1,396**	$90,745
Youth Age 13-29	24	11%	137	9%	5.7	$810	$19,445
Unhoused < 12 m	20	**9%**	226	**14%**	**11.3**	**$1,512**	$30,248
Women of Color	17	**8%**	50	**3%**	**2.9**	**$381**	$6,482
Black MSM	10	4%	64	4%	6.4	$864	$8,642
Transgender Persons	7	3%	39	2%	5.6	$617	$4,321
Persons who inject drugs (PWID)	7	3%	37	2%	5.3	$617	$4,321

Table 1 Highlights

- *Population Served:* The largest number and percent of MH clients were Latinx MSM (63%).
- *Service Utilization:*
  - The majority MH sessions were attended by Latinx MSM (61%).
  - Utilization by sessions per client were highest among unhoused clients (11.3/client) and clients ≥ age 50 (10.1/client) compared to all MH clients and other subpopulations. While sessions per client were lowest among transgender clients and PWID, they also represented the smallest numbers of MH clients.
  - The percent of MH sessions was higher relative to their population size among clients ≥ age 50 (29% vs 42%) and unhoused in the past 12m people (9% vs 14%).
  - The percent of MH sessions among women of color (8% vs 3%) was lower relative to their population size however this is based on a small number of clients.
- *Expenditures:*
  - Expenditure per client were highest among clients ≥ age 50 and unhoused clients and the lowest among women of color.

HIV Care Continuum (HCC) Outcomes

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

Table 2. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use MH Services in LAC, Year 32

HCC Measures	MH clients		Non-MH clients	
	N=224	%	N=14,548	%
Engaged in HIV Care [a]	*223*	100%	13,623	94%
Retained in HIV Care[b]	*191*	85%	10,190	70%
Suppressed Viral Load at Recent Test[c]	*203*	91%	12,074	91%

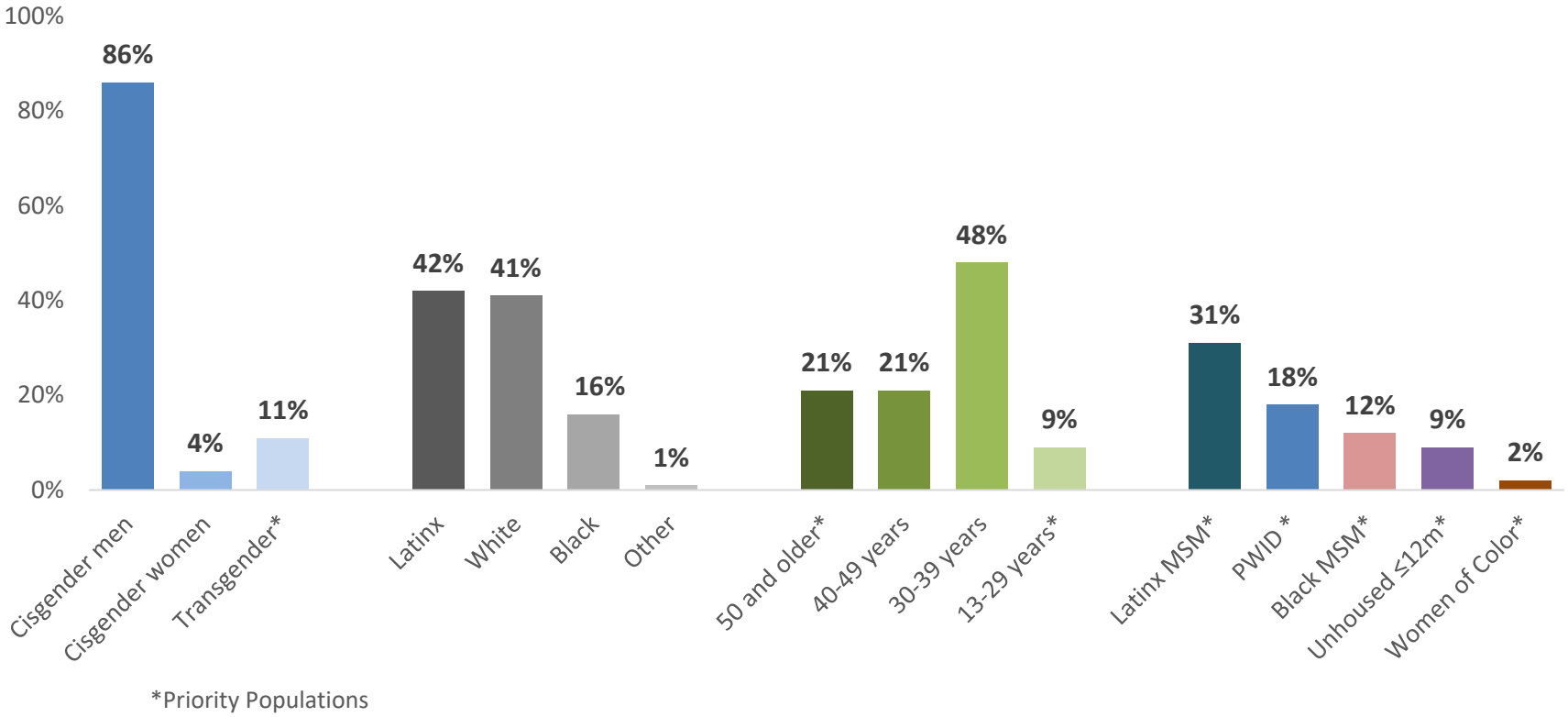
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period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

SUBSTANCE ABUSE RESIDENTIAL (SAR) SERVICES

Population Served:

- In Year 32, a total of 85 clients received SAR services
- Most SAR clients were cisgender men, Latinx and Black, and were age 30-39 as shown in Figure 3.
- Latinx MSM represented the largest percent among priority populations. A larger percent of SAR clients was PWID (18%) compared to RWP clients overall (4%).

Figure 3. Demographic Characteristics and Priority Populations among SAR Clients in LAC, Year 32



Service Utilization and Expenditures:

Since Year 29, the number of clients accessing SAR services has decreased each year. This has progressed from 115 clients in Year 29 to 112 in Year 30, 90 in Year 31 and 85 in Year 32. All SAR services are delivered in-person, there are no telehealth modalities.

- Year 32 Funding Sources: **RWP Part B (100%)**
- Percentage of RWP Clients Accessing SAR in Year 32: **<1% (0.6%)**
- Unit of Service: **Days**

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

Priority Populations	Unique Clients	% of Clients	Total Days	Percent of Days	Days per Client	Expenditures per Client	Estimated Expenditures by subpopulation
Total SAR clients	***85***	***100%***	***9,395***	***100%***	***110.5***	***$7,722***	***$656,363***
Unhoused < 12 m	42	49%	**4,597**	49%	109.5	$7,647	$321,160
Latinx MSM	26	31%	**2,651**	28%	102.0	$7,123	$185,207
PLWH ≥ Age 50	18	21%	1,948	21%	108.2	$7,561	$136,093
Persons who inject drugs (PWID)	15	18%	1,762	19%	**117.5**	**$8,207**	$123,099
Black MSM	10	**12%**	832	**9%**	83.2	$5,813	$58,126
Transgender Persons	9	**11%**	601	**6%**	66.8	$4,665	$41,988
Youth Age 13-29	8	9%	998	11%	**124.8**	**$8,715**	$69,723
Women of Color	<5	**2%**	29	**0.3%**	**14.5**	**$1,013**	$2,026

Table 3 Highlights

- *Population Served:* Clients who were unhoused < 12 m (49%) made up nearly half of all SAR clients, followed by Latinx MSM (29%) in Year 32
- *Service Utilization:*
  - Days per client were the highest among youth aged 13-29 and PWID compared to total MH clients and other subpopulations. While days per client was lowest among women of color, this represented use by fewer than 5 clients.
  - The percent of SAR hours was lower relative to their population size among Black MSM, women of color and transgender people.
- *Expenditures:*
  - Youth aged 13-29 had the highest expenditures per client ($8,715), followed by PWID ($8,207).
  - Women of color had the lowest expenditures per client however, the number of clients is very small.

HIV Care Continuum (HCC) Outcomes

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

Table 4. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use SAR Services in LAC, Year 32

HCC Measures	SAR clients		Non-SAR clients	
	N=85	Percent	N=14,687	Percent
Engaged in HIV Care[a]	84	99%	13,762	94%
Retained in HIV Care[b]	72	85%	10,309	70%
Suppressed Viral Load at Recent Test [c]	76	89%	12,201	83%

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

SUMMARY OF FINDINGS

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

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

	RWP	Mental Health	Substance Abuse Residential
Clients Characteristics	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 and ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to exit of DHS from RWP. • From Year 29-32, however, number of clients at remaining agencies was steady.	• Decrease in total clients due to DHS departure in Year 32 compared to Year 31 • Decrease in clients at remaining agencies possibly due to Medi-Cal expansion, provider shortages or other reason - further analysis needed	• Steady decrease in number of clients since Year 29
Telehealth	• Approximately 1 in 4 clients received a service via telehealth in Year 32 – a decrease from 46% in Year 30.	• Nearly half of MH clients continued to access services via telehealth in Year 32	• Not applicable
Service Units per Client	N/A (units vary)	• Seven sessions per client	111 days per client
Total Expenditures	$45.9 million	• Total $216,060 (Part A) • $965 per client	• $656,363 (Part B) • $7,722 per client
HCC outcomes	• Engagement in care was lowest among unhoused clients and Black MSM • RiC was lowest among youth aged 13-29, Black MSM and unhoused clients • VS was lowest among unhoused clients	• Engagement and retention in care were higher among MH clients compared to clients not accessing MH services but no difference in VS	• Engagement and retention in care and VS were higher among SAR clients compared to clients not accessing SAR

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

	RWP	Mental Health	Substance Abuse Residential
Latinx MSM	• Largest RWP population • About 25% of Latinx MSM received RWP services via telehealth • Largest percentage of uninsured clients	• Majority of MH clients (63%) and accounted for about 61% of services provided • Expenditure per clients were slightly lower than the average for all MH clients	• Represented 31% of clients and accounted for about 28% of services provided • The total days for SAR were the second highest among priority populations • Average number of days and expenditures per client were slightly lower than the average for all SAR clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• Represented a small number and percent of MH clients and services provided • Average number of sessions and expenditures were lower than respective average numbers for all MH clients	• Represented small number and percent of SAR services provided • Average number of days and expenditures were lower than respective average numbers for all SAR clients •
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The lowest percentage of RiC among priority populations	• 11% of all MH clients but accounted for 9% of MH services • Lower per client sessions and expenditures than average for all MH clients • Reasons for low MH service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• Represented small number and percent of SAR services provided • Highest per client service days and expenditures among priority populations • Highest utilizers of SAR services as demonstrated by the average days per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • Second highest percentage of engagement in care among priority populations	• 68% received services via telehealth • 29% of all MH clients and accounted for 42% of MH services • Second highest utilizers of MH services as demonstrated by the percentage of total sessions as well	• 21% of all SAR clients and accounted for the same percentage of services provided • Number of service days provided and expenditures per client were slightly below the average for all SAR clients

	• The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • Second highest percentage of uninsured, Spanish-speaking, and unhoused people	as sessions per client among priority populations • Second highest per client and overall expenditures among priority populations	
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • Second highest percentage of RiC among priority populations	• Represented a small number and percent of MH clients and services provided • Lowest use of MH services as demonstrated by the number of sessions and expenditures per client among priority populations	• Represented small number and percent of SAR services provided • Lowest utilizers of SAR services as demonstrated by the number of sessions and expenditures per client among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • Highest percentage of unhoused people • Second highest percentage of people living ≤ FPL	• Represented a small number and percent of MH clients and services provided • Lower per client visits and expenditures than respective averages for all MH clients	• Represented small number and percent of SAR services provided • Average number of days and expenditures were considerably lower than respective average numbers for all SAR clients • Second lowest average of expenditures and days of SAR service per client among priority populations
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• Second highest percent of MH clients who used services via telehealth (75%) • The highest average number of visits and expenditures among priority populations • High utilization of MH services by unhoused people may be reflective of complexity of social and behavioral needs in this subpopulation	• Half of SAR clients and accounted half of SAR days • High utilization of SAR services by unhoused people may be reflective of complexity of social and behavioral needs in this subpopulation.

PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • Second highest percent of clients unhoused in past 12m	• Represented a small number and percent of MH clients and services provided • Lower per client sessions and expenditures than respective averages for all MH clients	• 18% of clients receiving SAR service and accounted for 19% of services provided • Average number of days and expenditures were considerably higher than respective average numbers for all SAR clients • High utilization of SAR services by PWID may reflect complex of social and behavioral needs in this subpopulation

Save The Date

November 2, 2023

8 AM - 4 PM

TGI HEALTH SUMMIT

Increasing awareness of the health disparities and strategies surrounding Transgender, Gender-Nonconforming, and Intersex (TGI) communities. This Summit will support to mobilize information about community resources available, improving knowledge and awareness of HIV care and prevention services in LA, and offer community building initiatives centering healing for TGI Populations.

Village At Ed Gould Plaza

1125 N McCadden Pl, Los Angeles, CA 90038

REGISTRATION COMING SOON

REACH LA · LOS ANGELES LGBT CENTER · LOS ANGELES COUNTY COMMISSION ON HIV · trans* lounge · Keck School of Medicine of USC