LOS ANGELES COUNTY
COMMISSION ON HIV

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Get in touch: hivcomm@lachiv.org

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, November 16, 2021
1:00PM-3:00PM (PST)

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http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

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

To Join by Computer: https://tinyurl.com/b9txjvw
**Link is for non-committee members only*
To Join by Phone: 1-415-655-0001
Access code: 2593 351 5744

Planning, Priorities and Allocations Committee Members:			
Frankie Darling Palacios, Co-Chair	Kevin Donnelly, Co-Chair	Everardo Alvizo, LCSW	Al Ballesteros, MBA
Felipe Gonzalez	Joseph Green	Karl T. Halfman, MS	William King, MD, JD
Miguel Martinez, MPH, MSW	Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD
Damone Thomas	Guadalupe Velasquez, (LOA)	DHSP Staff	
QUORUM:	8		

AGENDA POSTED: November 10, 2021

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

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

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

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

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

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

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

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

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

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

II. PUBLIC COMMENT 1:04 P.M – 1:15 P.M.

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

III. COMMITTEE NEW BUSINESS 1:15 P.M. – 1:20 P.M.

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:20 P.M. – 1:30 P.M.

a. Operational Updates

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

a. Co-Chair Nominations/Elections
b. Holiday Meeting Schedule (December 21, 2021)
c. "So, You Want to Talk about Race" by I. Oluo Reading Activity
Excerpts only from Chapters 16 or 17

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

a. Minority AIDS Initiative (MAI)
i. Three years of MAI Expenditures and Demographics by Service Category
b. Emergency Financial Assistance (EFA) Expenditure and Client Demographics
ii. EFA Expenditures and Demographics

V. DISCUSSION 2:00 P.M. – 2:30 P.M.

8. PLANNING TASKS

a. Proposed Ryan White Part A and MAI Program Year (PY) 33 and 34 Service Category Rankings **MOTION #3**
b. Proposed Ryan White Part A and MAI PY 33 and 34 Service Category Funding Allocations **MOTION #4**

9. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. Ryan White Part A, MAI, and Prevention Programs

10. COMPREHENSIVE HIV PLAN (CHP) 2:30 P.M. – 2:50 P.M.

a. Address Integrated Plan Questions, Activities for Completing the Plan, Ways to Reduce Duplication of Effort and Steps for Plan Alignment

VI. NEXT STEPS 2:50 P.M. – 2:55 P.M.

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

VII. ANNOUNCEMENTS 2:55 P.M. – 3:00 P.M.

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

VIII. ADJOURNMENT 3:00 P.M.

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

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve Meeting Minutes as presented.
MOTION #3:	Approve Proposed Ryan White Part A and MAI PY 33 and 34 Service Category Rankings, as presented, or revised, and move to the Executive Committee for Approval.
MOTION #4:	Approve Proposed Ryan White Part A and MAI PY 33 and 34 Service Category Funding Allocations, as presented, or revised, and move to the Executive Committee for Approval.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

October 19, 2021

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Frankie Darling Palacios, Co-Chair	A	William King, MD, JD	A
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Everardo Alvizo, LCSW	P	Anthony M. Mills, MD	P
Al Ballesteros, MBA	P	Derek Murray	P
Felipe Gonzalez	P	Mario Perez, MPH	P
Joseph Green	A	LaShonda Spencer, MD	A
Michael Green, PhD, MHSA	P	Damone Thomas	P
Karl T. Halfman, MS	P	Guadalupe Velasquez	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Carolyn Echols-Watson, AJ King (consultant), Catherine LaPointe, Jose Rangel-Garibay and Sonja Wright			
DHSP STAFF			
True Beck, Jane Bowers, Wendy Garland, Pamela Ogata, Victor Scott and Julie Tolentino			

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

Meeting agenda and materials can be found on the Commission's website at https://tinyurl.com/35zjnnmb

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Kevin Donnelly, Committee Co-Chair, called the meeting to order at approximately 1:05 PM. Members introduced themselves and stated their conflicts of interest.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

Motion #1: Approved the Agenda Order. (**Passed by Consensus**)

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approved September 21, 2021 meeting minutes. The Committee was reminded meeting minutes can be amended up to 1 year after approval. **(Passed by Consensus)**

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

There were no new business items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Commission and Committee Updates

Cheryl Barrit reminded the Committee of the virtual annual meeting on November 18, 2021. Staff distributed the flyer to all Commissioners via email. An appeal was made for members to share meeting information to encourage consumer participation. Any members who did not receive the flyer were encouraged to notify staff.

b. Primer On allowable Services for Ryan White (RW) Part A and MAI Funding

C. Barrit reviewed the RW Unallowable and Allowable Costs summary prepared by staff at the request of the Committee Co-Chairs. The document summarizes Health Resources and Service Administration (HRSA) Program Clarification Notice (PCN) 16-02 which describes allowable and unallowable RW services.

The summary includes service categories and general allowable and unallowable expenditures for each category. The document is to assist in identifying permitted RW expenditures for planning purposes.

C. Barrit reminded the Committee remaining Commission meetings will be held virtually through the end of this calendar year as allowed by Assembly Bill 361. If things change, staff will notify Commissioners. The Commission will follow the direction and lead of the Board of Supervisors (BOS).

6. CO-CHAIR REPORT

a. Holiday Meeting Schedule (November 16, 2021 and December 21, 2021)

The Committee agreed to meet on November 16th and December 21, 2021.

b. "So, You Want to Talk about Race" by I. Oluo Reading Activity – Excerpts only from Chapters 14 or 15

Kevin Donnelly read excerpts from Chapter 15 of the book.

K. Donnelly expressed gratitude to DHSP for facilitating the RW Part A grant application review which included Co-Chair Frankie Darling Palacios, Al Ballesteros, and Commission staff (C. Barrit and J. Rangel-Garibay) as reviewers. K. Donnelly requested a report back from DHSP on the application.

Pamela Ogata noted this was the first application that covers a 3-year time period and a new focus area highlighting geographic areas of greatest need. Areas were identified based on the number of persons living with HIV (PLWH).

DHSP will share the application with the Committee and/or Commission once funding is awarded in 2022.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Minority AIDS Initiative (MAI) Expenditure and Client Demographics

i. Three years of MAI Expenditures and Demographics by Service Category

Mario Perez provided the following presentation highlights.

- The report focuses on MAI sub populations.
- MAI funding is approximately 8% of the RW program funding.
- MAI funding is to decrease disparities.
- MAI supplements core and support services by approximately $3.6 million in PY 31.
- PY 31 funding total was approximately $43.9 million.

Wendy Garland presented the Ryan White Program and Minority AIDS Initiative Subpopulations of Focus in Los Angeles County (LAC) Report. The report is intended to present information that is not easily captured in slides but requires documentation. The information is preliminary data and will require additional review before sharing with the full Commission.

The following are highlights of the report. (The revised report is included in meeting packet, revised 10/28/2021)

- MAI funding is to improve access to HIV care, reduce disparities and improve health outcomes by providing services specifically designed to address unique barriers and challenges faced by individuals disproportionately impacted by HIV.
- Jurisdictions/planning bodies identify populations disproportionately impacted by HIV. Those populations are included in the Part A HRSA grant application.
- Los Angeles County identified three populations disproportionally impacted by HIV.
    - Cisgender men of color aged 30 or older who have sex with men (MSM of color)
    - Cisgender men of color aged 18-29 years who have sex with men (YMSM of color)
    - Transgender persons of color
- Sixty percent (60%) of those receiving RW services are members of one the sub populations identified.
- In PY 30, persons of color represented 4 out of 5 Ryan White HIV/AIDS Program (RWP) clients.
- Eighty (80%) of clients served are from communities of color. Latinx were the largest percentage of RWP clients. Latinx were the largest percentage of MAI subpopulation served followed by Black/African American clients at 22%

- Poverty and lack of insurance were highest among RWP clients and all MAI subpopulations.
- The highest levels of poverty, recent incarceration and homelessness were among transgenders clients followed by YMSM.
- The transgender population served includes white clients. DHSP was unable to breakout ethnicities served.
- MAI subpopulations have represented more than half of RWP clients over the past five years.
- The top three services most utilized by MAI subpopulations in PY 30 were Mental Health, Medical Outpatient and Medical Care Coordination (MCC).
- Less than half of clients utilizing Transitional Case Management (TCM), or Housing Assistance were MAI subpopulations
    - Transgender clients used the largest percentage of Housing Assistance and were disproportionately impacted by homelessness.
- Low percentages of transgender clients and YMSM of color use of TCM services does not correspond to levels of incarceration for these populations. The impact of COVID-19 on contracted providers restricted access to the jails, which may have influenced the usage of TCM in in PY 30.
- The number of clients using the service does not necessarily correlate with expenditures, nor does it reflect how clients are utilizing the service. Additional analysis is needed to determine whether MAI subpopulations are receiving more or fewer service units per client (i.e., visits, hours, procedures)
- MAI funded services include
    - Transitional Case Management – Jails
    - Housing services for permanent housing
- In 2020, approximately 1 out of 3 PLWH were also RWP clients.
    - With higher percentages of PLWH engaged in care, retained in care, and virally suppressed RWP clients had better HIV care continuum (HCC) outcomes than PLWH in LAC not receiving RW services.
- Black/African American clients across all subpopulation groups have the highest unsuppressed viral load.
- Interventions that promote receipt of services, retention in care and ART adherence such as rapid linkage and MCC need to be strengthened. Key social determinants of health experienced by MAI subpopulations should be considered to reduce HCC disparities.
- Committee members wanted to know why women are not a sub population
    - Women are 1% of PLWH in Los Angeles County.
        - 40% Black/African American
        - 40% Latina
        - 20% White/API/Other
- HRSA application request jurisdictions to identify 2 or 3 sub populations.
- M. Perez addressed California Advancing and Innovating Medi-Cal (CalAIM)and its impact on the RW portfolio of services currently provided in LAC.
    - The expanded Medi-cal program proposes all low-income persons 50 and over become Medicaid (Medi-Cal) eligible regardless of documentation status. Which could cause a large migration of clients from RW services. (RW being the payer of last resort.)
    - An opportunity to finance new/other service categories that may more effectively decrease disparities might be necessary.

- M. Perez provided some recommendations to the Committee based on the information provided in the MAI presentation.
    - Analyze the frequency of client visits for services funded by MAI. It is possible, the targeted populations are being served at a higher frequency than are currently being reflected for some services.
    - Think about the current service categories and determine if they are consistent with the spirit of MAI funding which was to make additional investments to aid in achieving better health outcomes.
- The Committee requested clarity on the clients that utilize services funded by MAI funds. Are the clients served only the targeted populations are all people of color?
    - This question was related to information provided to the Committee regarding the use of MAI funds for housing and transitional case management services. DHSP reported approximately 13% to 17% of MAI funds in PY 30 were expended on non-people of color.
- M. Perez addressed the use of MAI funds. The question was asked if MAI funds only support services provided to people of color. The answer was no. The following explanation was provided.
    - Non-people of color do benefit from MAI funding if they are eligible for services funded through MAI. The example given was a white woman receiving transitional case management services which is funded through MAI. Providers bill for services rendered. If their contract is funded using MAI funds, then the non-person of color benefits from the MAI investment.
- Dr. Green stated there is no requirement for MAI funding to be spent exclusively on "target MAI populations".
- DHSP stated utilizing 100% of MAI funds for people of color is probably not realistic because clients are not screened for services on the basis of a funding source. Clients are not turned away based on funding sources or because they do not fit into the MAI categories.
- DHSP recommended identifying a percent of clients by service category to provide a benchmark of clients of color that must be served. Further, it was recommended when the Committee reviews PY data, review service categories to ensure intended populations are being reached and determine if changes are needed to the services categories provided.
- The Committee requested further clarification on requirements for the use of MAI funds and targeted MAI populations. Committee questions include: Are there any other HRSA perimeters that require a percentage of funds to be spent on MAI targeted populations? Was it permissible to spend 90% of the funds on non-targeted MAI populations? It was noted that among Black/African Americans the unsuppressed viral rate was the lowest among all populations served.
- DHSP confirmed there is no HRSA guideline for the percentage of targeted MAI populations to be served with the MAI funds. Further, it was stated it is up to each jurisdiction to determine how the funding is allocated.
- The Committee discussed previous MAI guidelines provided to DHSP separate from Part A directives. The plan had specific services included that were thought to be the most utilized by people of color.
- It was recommended the Committee review the last MAI plan approved by the Commission.
- It was recommended the plan be updated. The Committee thought additional guidance to DHSP is needed.
- The Committee discussed having an in-depth conversation about establishing a new service category(ies) that may enhance services needed by targeted MAI populations. This would be part of the 3-year planning cycle that the Committee has now adopted.

- DHSP provided some recommendations to address the Committee's MAI directive planning efforts for MAI funds.
    - Review unmet need and unsuppressed viral load data to determine MAI sub-populations should continue to be targeted.
    - Redefine the service categories that should be part of the RW service network to decrease disparities for the target populations
    - Review existing service categories currently in place and determine if refinements are needed. (MCC was provided as example of a service that may need some refinement such as the retention navigation component.)
    - See if there are new service categories that need to be added.
    - Review system capacity.
- The Committee noted agencies should be held accountable when they are not doing their due diligence and providers accountability should be part of the discussion when establishing MAI directives.
- DHSP noted the jurisdiction has the ability develop service categories as long as they fit within HRSA service categories.
- Committee members agreed to proceed with planning PY 33 and 34 service rankings and percentage allocations with the MAI information provided. It was noted recommendations can be modified when addition information is provided.
- DHSP provided an updated expenditure report on services currently supported by Los Angeles County (LAC). The current program year (PY) is 31 (3/1/21 – 2/28/22). The highlights reflect year end expenditures by service category.
    - MCC is largest expenditures at $11.3 million. In addition, $1.5 million was billed to Net County Costs (NCC). (County funds dedicated to HIV services) Making the estimated costs for this service over $12 million.
    - AOM anticipated to expend $7.6 million
    - Oral Health anticipated to expend $6.4 million
    - Mental Health anticipated to expend $350 thousand
    - Home and Community Based Health Services anticipated to expend $2.2 million
    - Non-Medical Case Management for Benefit Specialty Services anticipated to expend $1.4 million. This is separate from the Non-Medical Case Management services funded MAI funds which is for Transitional Jail services.
    - Housing Services has three types of services funded through Part A, B and MAI.
    - Housing services for permanent supportive services includes case management services and 22 units for those requiring mental health services. These services were reflected in the MAI report provided in this meeting.
    - Residential Care Facilities for Chronically Ill (RCFCI) and Transitional Residential Care Facilities (TRCF) which are funded through Part A funds. These are housing programs for those needing assisted living services.
        - $100 thousand is anticipated to be expended for mental health services
    - Medical Transportation anticipated to expend $413 thousand
    - Food Bank/Home-Delivered Meals anticipated to expend $2.4 million
    - Legal Services anticipated to expend $240 thousand

Part A direct services expenditures are anticipated to expend approximately $32 million
MAI expenditures are anticipated to expend approximately $3.4 million.
Part B funds approximately are anticipated to expend $4.3 million is for Housing services and approximately $800 thousand for Substance Abuse Treatment. The B expenditures exceed the award.

Part A is estimated to expend less than awarded. DHSP will shift MAI and Part B expenditures that exceed their awards to Part A. Additionally, expenses may be shifted from MAI funds to Part A. MAI funds can be rolled over for one program year. All Part A funds must be expended. The Committee was cautioned all invoices have not been received, but it is estimated $2 million in MAI expenditures will be shifted to Part A to expend all awarded funds. This could mean $2 million in MAI funds.

DHSP shifted $2 million in Part A funds to NCC earlier in the program year which impacted the underspending indicated in Part A.

b. Emergency Financial Assistance (EFA) Expenditure and Client Demographics

i. EFA Expenditures and Demographics

DHSP did not provide EFA information.

V. DISCUSSION

a. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Rankings

- Motion #3 will be put on the November agenda

b. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Funding Allocations

- Motion #4 will be put on the November agenda

- DHSP was requested to provide data on the frequency of client visits for services at the October meeting. They were unable to provide data for this meeting. *DHSP has committed to provide the information the December 21, 2021 PP&A meeting*.

The Committee agreed to postpone their discussion on motions 3 and 4. **(Passed by Consensus)**

8. COMPREHENSIVE HIV PLAN (CHP)

a. Overview and Federal Guidance (PowerPoint include in the packet)

AJ King, CHP consultant, provided a PowerPoint presentation on the 2022-26 CHP process. The following are some highlights from that presentation.

- This is the second plan CHP. The first was for the period of 2017-2021
- Guidance allows for the use of existing plans in the completion of the CHP. (i.e., EHE plan)
- The sections of the plan include Executive Summary, Community Engagement and Planning Process, Contributing Data Sets and Assessments, Situational Analysis, Goals and Objectives, Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up and Letters of Concurrence.

- The plan is due December 9, 2022. A timeline for completion was included in the presentation. Community engagement was emphasized as a key component throughout the plan.

b. Address Integrated plan Questions, Activities for Completing the Plan, Ways to Reduce Duplication of Effort and Steps for Plan Alignment.

The Committee identified they will need to; determine a system for obtaining feedback, how to engagement the community, identify issues that may have been omitted from previous plans, how to engage those disproportionately impacted by HIV and effective methods of implementing listening sessions.

Committee members were asked their ideas for developing the plan.

- It was pointed out cities represented on the Commission all have HIV plans that would be useful in informing the CHP.
- The Committee has some concerns regarding listening sessions participants and the ability to get varied voices to participate. There should be a concerted effort to get a wide range of consumer input.
- AJ King suggested taking the sessions to the people and provide incentives. In addition, provide feedback on how the information is used. The consultant noted over assessing the community could be an issue. The community has already been asked for their feedback several times but may not have experienced any service changes. The process should be transparent and ensure feedback is provided on what the information is being used to develop.
- It was recommended unbiased ways to obtain information are implemented.
- The Committee recommended planning ahead when presenting information from listening session. Invite consumers to PP&A meetings to get additional input and maintain transparency.
- The City of Long Beach made a request to host a listening session at their quarterly meeting. Providers and some consumers participate in the meeting. The participants administer HIV/STD and harm reduction services in the city. The next meeting is Wednesday January 12th 12-2pm. The meeting is virtual. It was also recommended a separate consumer meeting be scheduled and incentives offered.
- Additional Long Beach has a STD/HIV plan that can could contribute to the CHP. They are currently updating the plan.
- Committee members stressed consumers participation and making their ability to participate as easy as possible.
- The CHP will be a standing item for PP&A agenda and has all committee, caucus, task forces and workgroups within the Commission to carve out time for CHP discussions. This is in an effort to reduce duplication of effort.
- In addition, groups outside of the Commission such as We Can Stop STDs LA to may assist in creative ways to engage consumers.
- The Committee will utilize partner cities (Long Beach, Los Angeles, West Hollywood, and Pasadena) to look obtain data/input specific to their cities.
- It was noted the Committee Co-Chairs have attended various Commission entities (caucuses, taskforces, workgroups, other committees) informing them of the CHP process and encouraging their input. A consistent theme was noted during these visits. How is the plan different from the EHE? And which plan is going to be implemented in LAC? It was recommended the answers be consistent and plans will complement and align with one another.
- The Committee emphasized the need to simplify the process and eliminate miss information and

the lack of information. Make the process as easy as possible to understand and its purpose.

- AJ King was invited to the November 16, 2021 meeting.

VI. NEXT STEPS

a. Task/Assignment Recap

- The Executive Director will contact partner cities to discuss the CHP process and their possible contributions to completing the plan.
- The Executive Director will debrief with the CHP consultant to articulate a process moving forward
- Strategize on thoughtful questions for listening sessions and identify existing gaps that can be addressed in the CHP
- Discuss listening session locations, facilitators, and incentives.

b. Agenda Development for the Next Meeting

- Include CHP as an ongoing agenda item
- Motions #3 and #4 will be on the agenda.

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

a. Adjournment:

The meeting ended at approximately 4:00 PM.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 10/27/21

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	No Affiliation	No Ryan White or prevention contracts
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men’s Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
MORENO	**Carlos**	Children’s Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

The Ryan White Program and Minority AIDS Initiative Subpopulations of Focus in Los Angeles County

BACKGROUND

The goal of the Ryan White HIV/AIDS Program (RWP) Minority AIDS Initiative (MAI) is to improve access to HIV care and reduce disparities in health outcomes for people living with diagnosed HIV (PLWDH) through supplemental funding across all parts of the RWP. This will be achieved by providing services designed to address the unique barriers and challenges faced by individuals disproportionately impacted by HIV within the eligible metropolitan and transitional areas (EMA/TGA).

As a Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives supplemental MAI funding to increase access to core medical and related support services and reduce disparities in health outcomes among persons of color living with or at increased risk for HIV. The amount of the award is based on the number of PWLDH who are people of color within a jurisdiction. MAI funds represent approximately 8.3% of the $43.9 million combined MAI ($3.6 million) and Part A ($40.3 million) award for FY 2021.

The 2022-2024 MAI plan for HIV services in LAC is based on the principles of identifying and addressing unmet need, with the goals of improving and broadening access for underserved and disenfranchised communities of color who are not in care and improving retention and viral suppression among those in care.

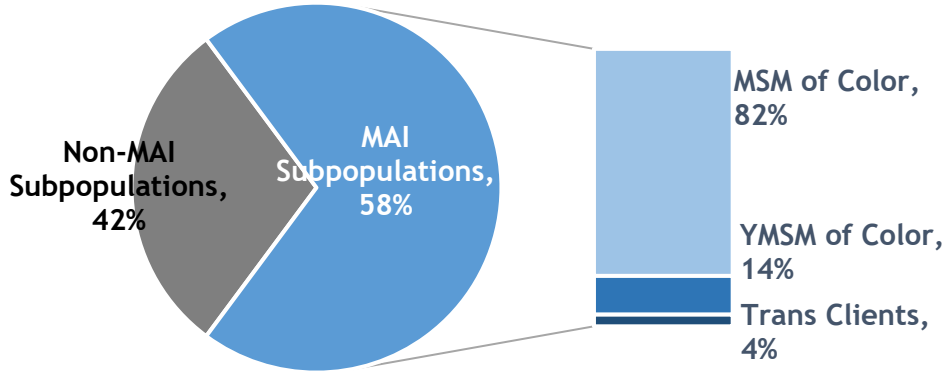
MINORITY AIDS INITIATIVE SUBPOPULATIONS OF FOCUS

HRSA requires that each EMA/TGA identify MAI subpopulations of focus based on local epidemiologic and programmatic data. For LAC, there are **three MAI subpopulations**:

1. Cisgender men of color aged 30 or older who have sex with men (**MSM of color**)
2. Cisgender men of color aged 18-29 years who have sex with men (**YMSM of color**), and
3. Transgender persons of color (**Trans clients**)

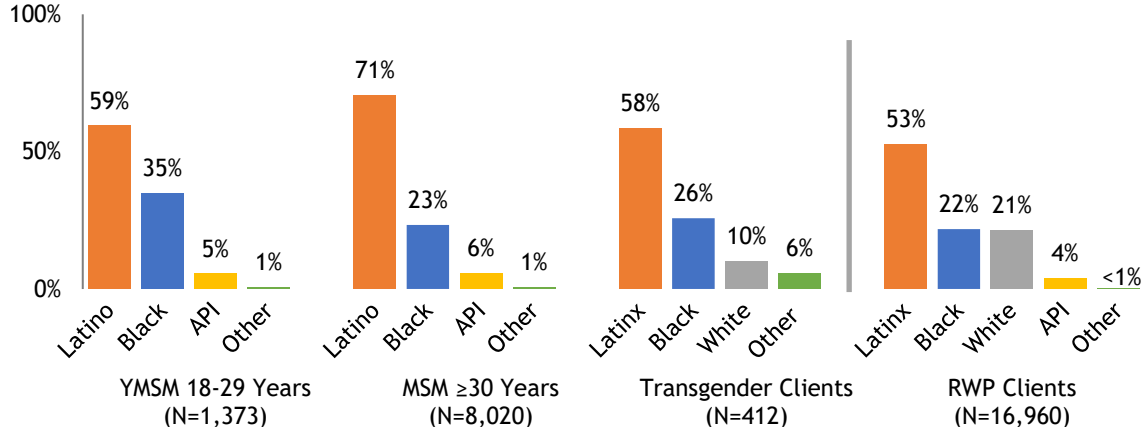
As shown in Figure 1, **MAI subpopulations represented 58% of clients** receiving at least one RWP service in Year 30. Largest MAI subpopulation was MSM of color followed by YMSM of color and transgender clients. **Non-MAI populations are RWP clients who do not meet the definition for the MAI subpopulations including cisgender women, heterosexual cisgender men, white MSM, and people who use injection drugs.**

Figure 1: Clients ≥ 13 and older living with diagnosed HIV utilizing Ryan White Program (RWP) services by MAI Subpopulation, Year 30 (March 1, 2020-February 28, 2021), LAC (N=16,960)



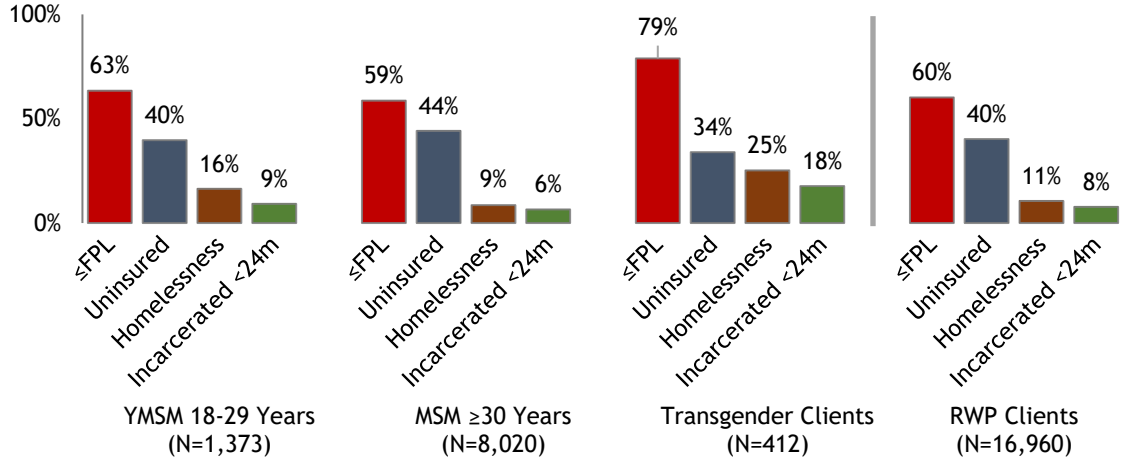
A comparison of the MAI subpopulations with all RWP clients by race/ethnicity is presented below to show the composition of each (Figure 2). Social determinants, such as poverty, health insurance coverage, housing status and experience with the justice system can all influence how, and whether, PLWDH access and utilize HIV care and support services. Understanding how these determinants impact the MAI subpopulations is important to effective service planning and delivery. Key determinants for all RWP clients compared to MAI subpopulations are presented in Figure 3.

Figure 2: Minority AIDS Initiative Subpopulations by Race/Ethnicity compared to Ryan White Clients aged ≥ 13 years, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,2]



In Year 30, persons of color represented 4 out of 5 RWP clients. Latinx were the largest percentage of RWP clients and within each MAI subpopulation followed by Blacks.

Figure 3: Key social determinants of health among Ryan White Program clients aged ≥ 13 years diagnosed compared to Minority AIDS Initiative Subpopulations, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,2]

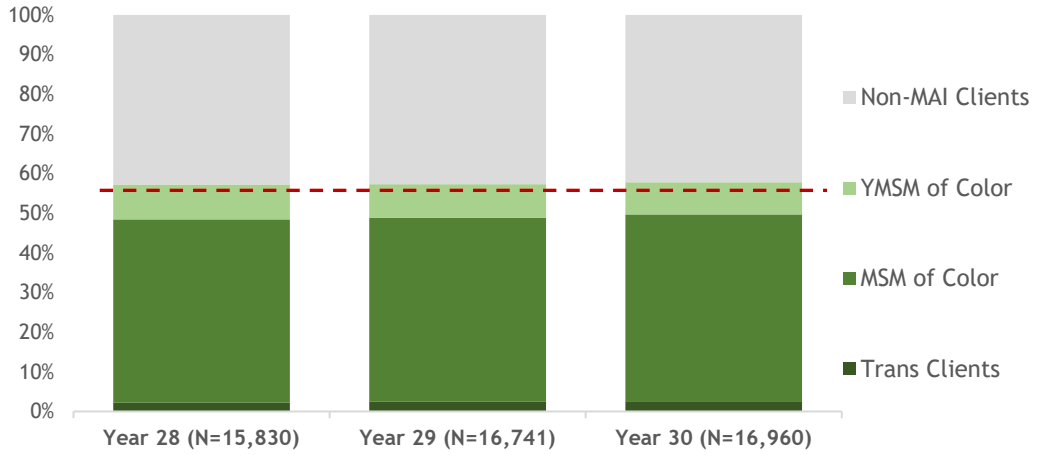


Poverty and lack of insurance was high among RWP clients and all MAI subpopulations. The highest levels of poverty, recent incarceration and homelessness were among transgender clients followed by YMSM.

[1]Other race/ethnicity includes American Indians, Alaskan Natives and persons of multiple race/ethnicities.
[2]Total percentage may exceed 100% due to rounding

Figure 4 presents trends in the percentage of MAI subpopulations receiving RWP services each year. The green shaded area represents the MAI subpopulations.

Figure 4: Ryan White Clients aged ≥ 13 years by Minority AIDS Initiative Subpopulation, LAC, Years 26-30 (March 1, 2016-February 28, 2021)[1]



MAI subpopulations have represented more than half of RWP clients over the past five years and have been slowly increasing.

MINORITY AIDS INITIATIVE SERVICES

MAI services are different from Part A services. **Part A services are intended to meet the needs of all low-income PLWDH while MAI services should be targeted to meet the specific needs of the MAI subpopulations to promote better health through distinct service interventions.** The 2022-2024 MAI Plan identifies key services crucial for LAC's comprehensive HIV care delivery system and will continue to support two services funded under MAI:

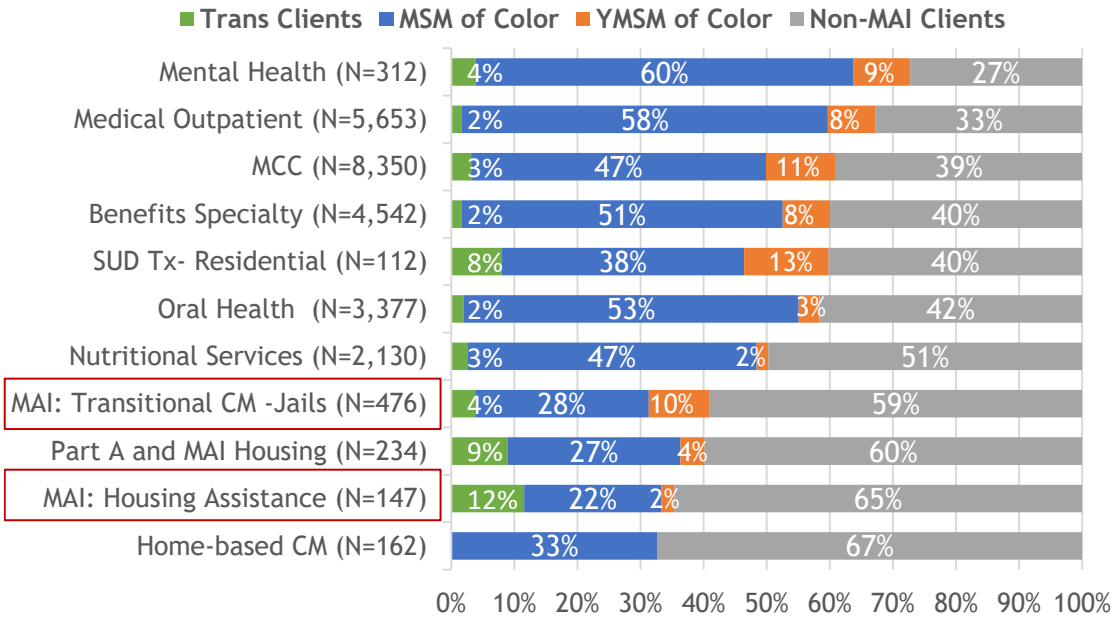
1. **Transitional Case Management – Jails**: This form of non-medical case management services provides additional support to PLWDH upon release from jail. Case managers assist these clients to secure medication, housing, follow-up care, and referrals to support programs. In addition, case managers facilitate navigation and linkage within the RWP to needed services including the MCC program, HIV medical home, nutritional support, transportation and housing.

2. **Housing Assistance:** This form of housing services provides rental subsidies and permanent supportive housing with case management services for PLWDH and and housing services for PLWDH who are also living with a diagnosed mental health disorder. This MAI service is intended to directly connect clients with permanent housing services in contrast to Part A housing services which provide residential care facilities for the chronically ill (RCFCI) and transitional residential care facilities (TRCF) as a transition to permanent housing.

SERVICE UTILIZATION AMONG MAI SUBPOPULATIONS

Use RWP services in for MAI subpopulations compared to non-MAI clients in Year 30 is presented below in Figure 5. These include the services for which data are reported in HIV Casewatch. Those services supported with MAI funding are indicated with a red box. The services are ordered by those used by the largest percent of MAI subpopulations.

Figure 5: Utilization of Ryan White Program Services among clients aged ≥ 13 years by Minority AIDS Initiative Subpopulation, LAC, Year 30 (March 1, 2020-February 28, 2021)[1]



The top three services most utilized by the MAI subpopulations in Year 30 were Mental Health, Medical Outpatient and MCC.

By number, less than half of clients utilizing Transitional CM or Housing Assistance were MAI subpopulations, however Housing Assistance was used by largest percentage of transgender clients. This is important as transgender clients were also disproportionately impacted by homelessness.

Low percentages of clients transgender and YMSM of color utilizing Transitional CM services do not correspond to higher levels of recent incarceration for these populations but may reflect the impact of COVID-19 on service continuity in Year 30 as contracted providers had restricted access to the jails.

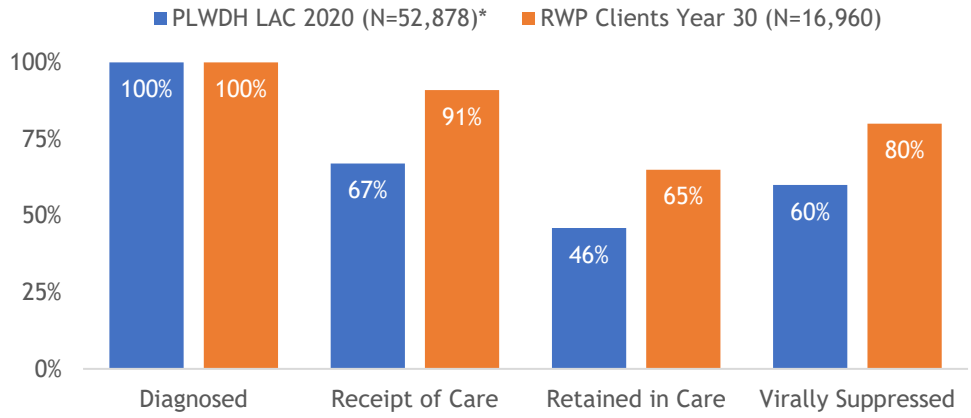
Number of clients using the service doesn't necessarily correlate with expenditures and does not reflect how clients are utilizing the service. Further analysis is needed to determine whether MAI subpopulations are receiving more or fewer service units per client (visits, hours, procedures) compared to non-MAI subpopulations.

HIV CARE INDICATORS FOR MINORITY AIDS INITIATIVE SUBPOPULATIONS

Entering and staying in HIV care is necessary to ensure that adherence to HIV treatment occurs and that viral suppression is achieved. HIV laboratory data (viral load [VL], CD4 or genotype tests) reported by providers to DHSP is used to estimated the HIV care continuum (HCC) indicators: receipt of care (≥ 1 laboratory test in the past 12 months), retention in care (≥2 laboratory test >90 days apart in the past 12 months), and viral suppression (VL<200 copies/mL at most recent test in the past 12 months).

The HCC indicators presented in Figure 6 show how RWP clients compare to PLWDH in LAC with respect to engagement in care, retention in care, and viral suppression in 2020. RWP clients represent a subset of PLWDH who received at least one RWP service in the past 12 months.

Figure 6: HIV Care Continuum for PLWDH age ≥ 13 in LAC compared to Ryan White Program Clients, LAC[1]



[1]LAC surveillance data is for Jan-Dec 2020 and RWP data is Mar 2020-Feb 2021)
*Source: Los Angeles County HIV Surveillance Program

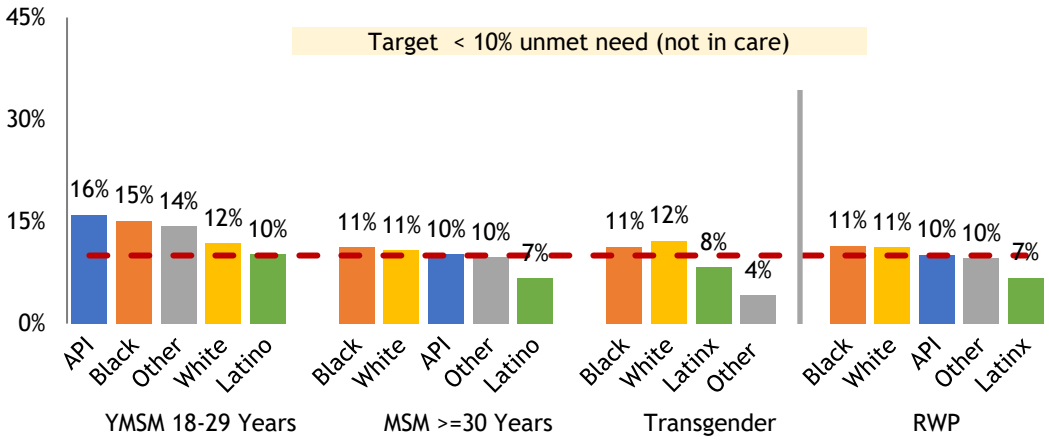
In 2020, approximately 1 out of 3 PLWDH were also RWP clients.

With higher percentages of PLWDH engaged in care, retained in care and virally suppressed RWP clients had better HCC outcomes than PLWDH in LAC.

The next figures show how MAI subpopulations compare by race/ethnicity with non-MAI subpopulations for unmet need for medical care (not in care) and unsuppressed viral load. Within each subpopulation a white comparison group is included in addition presenting the overall RWP population. The primary indicator of progress is viral suppression among RWP clients across racial/ethnic groups. It is important to note that non-MAI target populations include BIPOC who are not among the target populations.

Examining and identifying disparities allows us to determine whether changes to services needed to help PLWDH stay in care, get back in care, and ensure they are taking their medication as prescribed.

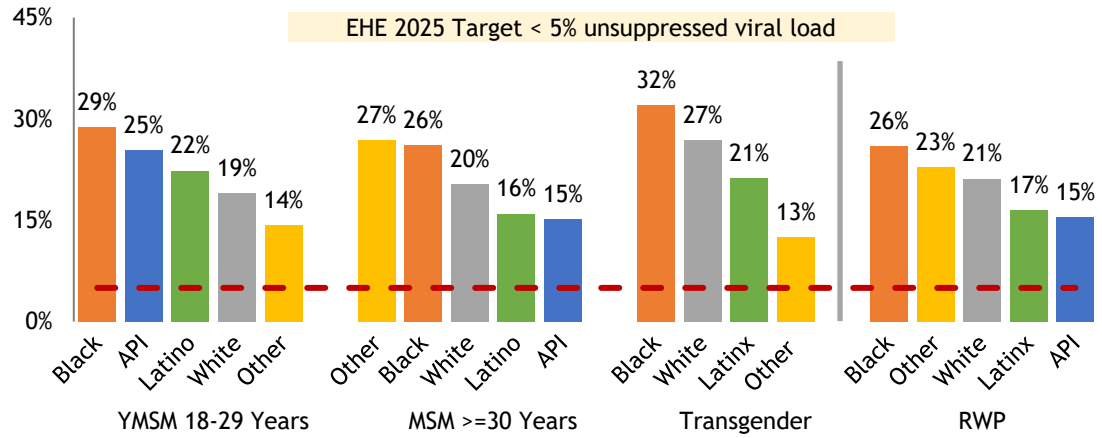
Figure 7: RWP Clients aged ≥ 13 years living with diagnosed HIV with unmet need (not in HIV medical care) compared to MAI Subpopulations by race/ethnicity, Year 30 (March 1, 2020-February 28, 2021), LAC[1,2]



Compared to other MAI subpopulations and RWP overall, unmet need was highest among YMSM.

Only Latinx across all subpopulations and transgender clients of other racial/ethnic groups met the target for unmet need.

Figure 8: Unsuppressed viral load among RWP Clients aged ≥ 13 years diagnosed compared to MAI Subpopulations, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,3]



None of the subpopulations or racial/ethnic groups met the EHE 2025 target for unsuppressed viral load. Within each subpopulation there is wide variation in unsuppressed viral load and was higher among Black clients across all subpopulation groups.

Interventions that promote receipt of and retention in care and ART adherence such as rapid linkage and MCC need to be strengthened to consider the key social determinants of health experienced by MAI subpopulations in order to reduce HCC disparities.

[1]Other race/ethnicity includes American Indians, Alaskan Natives and persons of multiple race/ethnicities. For transgender clients this API are also included. [2]Unmet need (not in care): numerator includes Year 30 clients with no CD4/VL/Genotype test reported in the 12-month period; denominator includes clients receiving ≥ 1 RWP service in the 12-month period in Year 30. [3]Not virally suppressed: numerator includes clients with VL >200 copies/mL at last test or no VL test reported within the 12-month period; denominator includes clients receiving ≥ 1 RWP service in the 12-month period.

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YR 31 AND PART B YR 31 EXPENDITURES BY RWP SERVICE CATEGORIES
Expenditures reported by October 6, 2021

1	2	3	4	5	6	7	8	9	10
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+7)	COH YR 31 ALLOCATIONS FOR HRSA PART A AND MAI
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 2,921,558	$ -	$ 2,921,558	$ 7,615,881	$ -	$ -	$ -	$ 2,921,558	$ 9,258,477
MEDICAL CASE MGMT (Medical Care Coordination)	$ 4,228,468	$ -	$ 4,228,468	$ 11,346,075	$ -	$ -	$ -	$ 4,228,468	$ 12,174,533
ORAL HEALTH CARE	$ 2,103,040	$ -	$ 2,103,040	$ 6,352,833	$ -	$ -	$ -	$ 2,103,040	$ 5,298,780
MENTAL HEALTH	$ 150,356	$ -	$ 150,356	$ 351,216	$ -	$ -	$ -	$ 150,356	$ 264,747
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 843,935	$ -	$ 843,935	$ 2,174,343	$ -	$ -	$ -	$ 843,935	$ 2,693,515
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 639,550	$ -	$ 639,550	$ 1,383,853	$ -	$ -	$ -	$ 639,550	$ 1,339,084
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 312,529	$ 312,529	$ -	$ 741,223	$ -	$ -	$ 312,529	$ 302,422
HOUSING-RCFCI, TRCF	$ 98,607	$ -	$ 98,607	$ 109,068	$ -	$ 1,825,692	$ 4,381,660	$ 1,924,299	$ 403,647 Part A portion
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,312,190	$ 1,312,190	$ -	$ 2,624,380	$ -	$ -	$ 1,312,190	$ 2,967,007
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ 356,400	$ 855,360	$ 356,400	Part B
MEDICAL TRANSPORTATION	$ 197,725	$ -	$ 197,725	$ 413,546	$ -	$ -	$ -	$ 197,725	$ 790,405
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 700,700	$ -	$ 700,700	$ 2,444,597	$ -	$ -	$ -	$ 700,700	$ 2,789,438
LEGAL	$ -	$ -	$ -	$ 240,282	$ -	$ -	$ -	$ -	$ 88,249
SUB-TOTAL DIRECT SERVICES	$ 11,883,939	$ 1,624,719	$ 13,508,658	$ 32,431,694	$ 3,365,603	$ 2,182,092	$ 5,237,020	$ 15,690,750	$ 38,369,155
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 2,893,664	$ 165,861	$ 3,059,525	$ 4,034,450	$ 363,270	$ 129,659	$ 361,518	$ 3,189,184	
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 280,188	$ -	$ 280,188	$ 1,082,954	$ -	$ -	$ -	$ 280,188	
TOTAL EXPENDITURES	$ 15,057,791	$ 1,790,580	$ 16,848,371	$ 37,549,098	$ 3,728,873	$ 2,311,751	$ 5,598,538	$ 19,160,122	
TOTAL GRANT AWARD				**$ 40,344,502**	**$ 3,632,709**		**$ 5,000,000**		
VARIANCE				(2,795,404)	96,164		598,538		
Estimated MAI Carryover from YR 21 to YR 22	**$**	**2,100,702**							

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PY 33 AND 34 MULTI-YEAR WORKSHEET

	FY 2022 RW Allocations (PY 32) (1)						FY 2023 RW Allocations (PY 33)				FY 2024 RW Allocation (PY 34)		
PY 32 Priority #	Core/ Support Services	Service Category	Part A %	MAI %	Total Part A/ MAI %		Part A %	MAI %	Total Part A/ MAI % (2)		Part A %	MAI %	Total Part A/ MAI % (2)
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%		0.00%	0.00%			0.00%	0.00%	
2	S	Non-MedicalCase Management - BSS/TCM/CM for new positives/RW clients	2.44%	12.61%	3.30%		0.00%	0.00%			0.00%	0.00%	
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%		0.00%	0.00%			0.00%	0.00%	
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%		0.00%	0.00%			0.00%	0.00%	
7	C	Mental Health Services	4.07%	0.00%	3.72%		0.00%	0.00%			0.00%	0.00%	
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
10	C	Early Intervention Services	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
11	S	Medical Transportation	2.17%	0.00%	1.99%		0.00%	0.00%			0.00%	0.00%	
12	S	Nutrition Support Food Bank/Home-delivered Meals	8.95%	0.00%	8.19%		0.00%	0.00%			0.00%	0.00%	
13	C	Oral Health Services	17.60%	0.00%	16.13%		0.00%	0.00%			0.00%	0.00%	
14	S	Child Care Services	0.95%	0.00%	0.87%		0.00%	0.00%			0.00%	0.00%	
15	S	Other Professional Services - Legal Services	1.00%	0.00%	0.92%		0.00%	0.00%			0.00%	0.00%	
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
18	C	Home Based Case Management	6.78%	0.00%	6.21%		0.00%	0.00%			0.00%	0.00%	
19	C	Home Health Care	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
20	S	Referral	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
22	S	Language	0.65%	0.00%	0.60%		0.00%	0.00%			0.00%	0.00%	
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
24	S	Rehabilitation	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
25	S	Respite Care	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
26	C	Local Pharmacy Assistance	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
27	C	Hospice	0.00%	0.00%	0.00%		0.00%	0.00%			0.00%	0.00%	
		Overall Total	**100.0%**	**100.00%**	**100%**		**0.00%**	**0.00%**	**0.00%**		**0.00%**	**0.00%**	**0.00%**

Footnotes:

1 - Service Category Rankings and Allocation Percentages Approved by the Commission on 09/09/2021

2 - The total column will not sum. To determine percentages, funding award amounts for Part A and MAI must be known.

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Service Category Rankings Worksheet
Program Year (PY) 33 and 34

Approved PY 32(1)	PY 33	PY 34	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1			Housing	S	Housing
			Permanent Support Housing		
			Transitional Housing		
			Emergency Shelters		
			Transitional Residential Care Facilities (TRCF)		
			Residential Care Facilities for the Chronically Ill (RCFCI)		
2			Non-Medical Case Management	S	Non-Medical Case Management Services
			Linkage Case Management		
			Benefit Specialty		
			Benefits Navigation		
			Transitional Case Management		
			Housing Case Management		
3			Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
			Medical Subspecialty Services		
			Therapeutic Monitoring Program		
4			Emergency Financial Assistance	S	Emergency Financial Assistance
5			Psychosocial Support Services	S	Psychosocial Support Services
6			Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
7			Mental Health Services	C	Mental Health Services
			MH, Psychiatry		
			MH, Psychotherapy		

Approved PY 32(1)	PY 33	PY 34	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
8			Outreach Services	S	Outreach Services
			Engaged/Retained in Care		
9			Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
10			Early Intervention Services	C	Early Intervention Services
11			Medical Transportation	S	Medical Transportation
12			Nutrition Support	S	Food Bank/Home Delivered Meals
13			Oral Health Services	C	Oral Health Care
14			Child Care Services	S	Child Care Services
15			Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
16			Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
17			Health Education/Risk Reduction	S	Health Education/Risk Reduction
18			Home Based Case Management	C	Home and Community Based Health Services
19			Home Health Care	C	Home Health Care
20			Referral	S	Referral for Health Care and Support Services
21			Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
22			Language	S	Linguistics Services

Approved PY 32(1)	PY 33	PY 34	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
23			Medical Nutrition Therapy	C	Medical Nutrition Therapy
24			Rehabilitation Services	S	Rehabilitation Services
25			Respite	S	Respite Care
26			Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27			Hospice	C	Hospice

Footnote:
1 – Service rankings approved 9/09/2021

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

July 17, 2015

To: Mario J. Pérez, MPH, Director
Division of HIV and STD Programs

From: Dawn Mc Clendon
Los Angeles County Commission on HIV

Subject: **RYAN WHITE PROGRAM YEAR (PY) 25 MINORITY AIDS INITIATIVE (MAI) PLAN**

At its meeting on July 9, 2015, the Commission on HIV (Commission) approved the following Minority AIDS Initiative (MAI) three-year plan, to include PY 24 carry-over allocations and PY 25 allocations, and is forwarding to the Division of HIV and STD Programs (DHSP) for implementation:

PROGRAM YEAR 24 CARRY-OVER MAI ALLOCATIONS:

As a result of the implementation of the Affordable Care Act (ACA) and other changes in healthcare, the number of people living with HIV/AIDS relying on core medical services supported by local Ryan White Programs (RWP) has decreased, *resulting in approximately $2.5 million in PY 24 MAI funds carried-over into PY 25*. The Commission has made it a priority to spend the carry-over funds first before accessing PY 25 MAI funds.

BACKGROUND

In Los Angeles County, populations most likely to not know their HIV status; not link to care, engage and remain in care, and if in care, fail to thrive are mostly young, 29 and under MSM (< 30) and transgender women of color. Social determinants of health having adverse impact on HIV positive individuals' linkage, engagement and retention in care include, but are not limited to: lack of knowledge about health status/options, behavioral health problems (mental health, addiction) unstable housing homelessness, and poverty among others.

The MAI plan is intended to be a three-year plan with the distinct focus to provide better access to care and improve health outcomes for MSM < 30 and transgender women of color.

PY 25 MAI PLAN

On July 9, 2015, the Commission approved MAI allocations for four service categories: (1) Housing, (2) Outreach, (3) Non-medical Case Management, and (4) Language Services. The Commission's primary objective for the MAI funds is to serve and initiate the improvement of outcomes along the HIV treatment cascade for young MSM < 30 and transgender women of color. Additionally, as a result of the implementation of the plan, the Commission intends to build capacity for targeted services, particularly those that help identify HIV positive individuals who are not linked, engaged or retained in care; and those addressing social determinants having an adverse impact on linkage, engagement and retention.

The following MAI allocation percentages were approved at the July 9, 2015 Commission meeting for PY 25 to address issues that compromise access to care and health outcomes for young MSM < 30 and transgender women of color:

HRSA Service Categories/ Commission-Approved Service Categories	PY 25 Priority Ranking	PY 25 MAI Allocations
Housing / Residential Services	9	**40.0%**
Outreach/ Linkage and Re-engagement	7	**30.0%**
Non-Medical Case Management/ Benefits Counseling and Transitional Case Management	6	**25.0%**
Linguistic Services / Language Services	19	**5%**

Residential services will initially focus on, in year one of the three year plan, increasing residential care facility services for the chronically ill (RCFCIs) MSM < 30 and transgender women of color population. The long-term strategy in years two and three is to expand housing services by increasing the availability of Transitional Residential Care Facilities (TRCFs); this will require a Request for Proposal (RFP) by DHSP.

Outreach will focus on linkage and re-engagement using DHSP's surveillance data to identify underserved people of color. The surveillance data will be used to link the identified population to care and increase efforts to promote available services in the community. Additionally, outreach activities that provide brief interventions to encourage the MAI's targeted underserved populations of color to obtain and maintain HIV medical care will be implemented by DHSP staff. This would include those diagnosed with HIV but have not sought care and those who do not maintain consistent HIV medical care. The goal is to increase the numbers of HIV positive underserved minorities who are out-of-care into HIV care and those who are inconsistent with their HIV care maintain consistency.

Non-Medical Case Management will focus on benefits counseling linking minority populations in and out of the Ryan White system to medical services. Assistance will be provided to navigate clients through the health care system to maximize benefits and services for those minorities living with HIV. Additionally, MSM < 30 and transgender women of color in youth group homes and jails will be provided transitional services.

Language Services will provide interpreting and translation services, both oral and written, for MSM < 30 and transgender women of color requiring linguistic assistance in navigating the health care system to obtain and maintain HIV health care services.

REPORTING/FOLLOW-UP

The Commission requests quarterly reports from DHSP on the progress of the MAI plan. This includes, but not limited to the number of clients served, units of service, and outcomes versus investment analysis.

As always, should you have any questions or need additional information, please do not hesitate to contact this office at 213.639.6716. Thank you.

c: Kyle Baker, Chief of Staff and Director, Government Relations, DHSP
Carlos A. Vega-Matos, MPA, Chief, Care Services, DHSP
Michael Green, Ph.D., MHSA, Chief of Planning, DHSP
Commission on HIV
File

LOS ANGELES COUNTY
COMMISSION ON HIV

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

October 9, 2020

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

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

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

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

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

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

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

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

The 2019 HIV Surveillance Report notes following areas of disparities:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

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

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

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

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

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

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

Black/African American Trans Women:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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Endnotes

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

AGING TASK FORCE RECOMMENDATIONS
(Final 12/10/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

**This is a living document and the recommendations will be refined as key papers such the State of California Master Plan on Aging and APLA's HIV and Aging Townhall Forums are finalized. **

Ongoing Research and Needs Assessment:

- Encourage the Division of HIV and STD Programs (DHSP) to collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:
    - Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
    - Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.
    - Conduct studies on the prevention and care needs of older adults.
    - Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status.

- Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
- Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.
- Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.
- Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.

Workforce and Community Education and Awareness:

- Educate the Commission on HIV, Department of Public Health, HIV workforce and community at large on ageism, stigma, and build a common understanding of definitions of older adults, elders, aging process and long-term survivors.
- Address ageism on the Commission on HIV and the community at large through trainings and by convening panels composed of Ryan White and prevention services clients and subject experts.
- Openly discuss and examine as part and parcel of HIV planning and implementation, the impediments to HIV prevention and care among aging populations posed by the historically embedded discrimination and bigotry institutionalized in mainstream US culture and society, as well as embedded in subcultural (ethnic, racial, social, religious, etc.) cultures and institutions that often goes unacknowledged: that is the interconnected/overlapping linkages between ageism (or what is expressed in ageism) and societal heteronormativity/homophobia (internalized and cultural), sexism, misogyny, racism, xenophobia, ableism, and all forms of discrimination and bigotry targeting "The Other."
- Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.
- Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.
- Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.
- Expand opportunities for employment among those over 50 who are able and willing to work.
- Provide training on the use of technology in managing and navigating their care among older adults.

- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.
- Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist patients affected by cognitive decline in navigating their care.
- Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.
- Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.
- Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.
- Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50 accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older
- Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.

- Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.

General Recommendations:

- Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.

Women's Caucus-Key Highlights and Ideas for Directives

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

Directives ideas:

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

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

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

4. Fund women and family focused housing specialist

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

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

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

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

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

10. Fund psychosocial services and support groups for women

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

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

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

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

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

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