LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, March 15, 2022
1:00PM-3:00PM (PST)

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

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/4uf8wyuk

**Link is for non-Committee members only*

JOIN VIA WEBEX ON YOUR PHONE:

1-415-655-0001 US Toll
Access code: 2598 580 1018

For a brief tutorial on how to use WebEx, please check out this video:
https://www.youtube.com/watch?v=iQSSJYcrgIk

For those using Apple iOS devices - a new version of the WebEx app is now available and is optimized for mobile devices. Visit your Apple App store to download or click here for WebEx updates.

PUBLIC COMMENTS

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.

LIKE WHAT WE DO?

Apply to become a Commissioner at http://tinyurl.com/HIVCommApplication

LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, MARCH 15, 2022 | 1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/4uf8wyuk
**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001
Access code: 2598 580 1018

Planning, Priorities and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA	Frankie Darling Palacios, (LOA)	Felipe Gonzalez
Joseph Green	Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray	Jesus "Chuy" Orozco	LaShonda Spencer, MD
Damone Thomas	Michael Green, PhD		
QUORUM:	8		

AGENDA POSTED: March 11, 2022

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

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

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

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these

services, please contact Commission on HIV at (213) 738-2816 or via email at hivcomm@lachiv.org.

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

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located 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 – 1:14 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 1:14 P.M. – 1:19 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 1:19 P.M. – 1:25 P.M.
   a. Committee Updates
   b. Comprehensive HIV Plan

6. CO-CHAIR REPORT 1:25 P.M. – 1:30 P.M.
   a. Co-Chair Nominations/Elections

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:30 P.M. – 1:50 P.M.
   a. The Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32 Status Updates

8. PREVENTION PLANNING WORKGROUP 1:50 P.M. – 2:00 P.M.
   a. Meeting Update

V. DISCUSSION 2:00 P.M. – 2:40 P.M.

9. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP
   a. Ryan White Part A, MAI, and Prevention Programs 2:40 P.M. – 2:55 P.M.

VI. NEXT STEPS 2:55 P.M. – 2:58 P.M.

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting

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

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

VIII. ADJOURNMENT 3:00 P.M.

14. Adjournment for the Meeting of March 15, 2022.

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

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

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

February 15, 2022

COMMITTEE MEMBERS P = Present | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	A	Anthony M. Mills, MD	P
Frankie Darling Palacios	A	Derek Murray	P
Felipe Gonzalez	P	Jesus "Chuy" Orozco	A
Joseph Green	P	LaShonda Spencer, MD	P
Michael Green, PhD, MHSA	P	Damone Thomas	A
Karl T. Halfman, MS	EA	Guadalupe Velasquez (Leave of Absence)	EA
William King, MD, JD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Carolyn Echols-Watson, AJ King, Next-Level Consulting, Jose Rangel-Garibay and Sonja Wright			
DHSP STAFF			
True Beck, Pamela Ogata, Victor Scott and Jane Rohde Bowers			

*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/5y5a9b9c

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Kevin Donnelly Committee Co-Chair, called the meeting to order at approximately 1:06 PM. Members introduced themselves.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

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

K. Donnelly amended the agenda. The first was to remove Frankie Darling-Palacio as Co-Chair. Second, move the Comprehensive HIV Plan (CHP) discussion to item 5 of the agenda under the Executive Director/Staff Report.

- Staff will make the Co-Chair correction on the meeting minutes and future agendas.

2. APPROVAL OF MEETING MINUTES

MOTION #2: The Committee approved the January 18, 2022, meeting minutes. 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. Committee Updates

C. Barrit highlighted the upcoming Public Policy Committee (PPC) Public Policy Priorities Stakeholder Community Consultation scheduled for March 7, 2022. This special meeting will invite public comments and selected speakers to help shape the Commission's policy platform for 2022 and beyond. The Committee was encouraged to invite colleagues that do not normally attend Commission meetings to provide public comment and hear about key issues around social determinants of health PPC is interested in pursuing. An event notification will be distributed soon.

Comprehensive HIV Plan (CHP)

AJ King provided an update on CHP progress. Currently, the first section of the plan is being drafted. It addresses data sets and assessments. A "snapshot" of Los Angeles County's (LAC) HIV prevention and care services will be included identifying inventory of current available resources and identify gaps and/or barriers to service delivery.

A survey to capture workforce capacity is planned. Possible topics for the survey include and again workforce, racial/ethnic diversity, cultural competence/humility, training, proficiency, consumer representation and value in the workforce. AJ King encouraged those in attendance to participate in the development of the survey and urged members to invite varying groups to expand the representation contributing to the tool. A meeting will take place in the next couple of weeks. Julie Tolentino, End the Epidemic (EHE) program director, will be invited to contribute to the creation of the survey since the EHE plan acknowledges the need to assess workforce capacity issues.

AJ King provided his contact information and encouraged meeting attendees to provide additional comments after the meeting. A. King e-mail is ajking@next-levelconsulting.org.

6. CO-CHAIR REPORT

a. Co-Chair Nominations/Elections

K. Donnelly opened the floor to Co-Chair nominations and provided information on some Co-Chair duties which include sitting on the Executive Committee. Those interested in co-chairing were encouraged to reach out to the Co-Chair for further information.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. FY 2021 (PY31) Fiscal Report

Pamela Ogata reviewed the DHSP fiscal report for Program Year (PY) 31. (The report is included in the meeting packet.) The following are some highlights.

- Emergency Financial Assistance (EFA) expenditures will be billed to the Health Resource and Services Administration (HRSA) Part A grant to maximize funding.
- Outreach/Linkage and Reengagement Program (LRP) will be funded by HRSA Part A funds.
- The total HRSA grant award is $43.9 million.
- Based on estimated expenditures for the Minority AIDS Initiative (MAI) grant $300,000 will be carried over from FY 2021 (PY31) to fiscal year 2022 (PY32).
- The Part B grant is anticipated to be fully expended. The grant award is $5 million and funds housing services.
- Housing for Health provides two services: housing services and emergency financial assistance.
- DHSP anticipates no substantial reallocation of PY 31 funds. However, 2 new service categories are included in the fiscal report. They are EFA and outreach services also known LRP.
- C. Barrit noted the Commission Allocation column of the fiscal report indicates no allocation for EFA. However, the Commission did approve an allocation, but because EFA services were previously funded outside of HRSA Part A and/or MAI it does not appear on this report.

➢ P. Ogata will include a footnote regarding the EFA allocation on the next fiscal report for PY 31.

- The next fiscal report will be provided in July 2022. The PY ends February 2022, and the County fiscal year ends June 30, 2022.
- The Committee requested information on the solicitation schedule as it relates to the delivery of services. DHSP noted it shares the solicitation schedule with the Standard and Best Practices Committees.

➢ The Committee requested an update on the solicitation status. DHSP will provide the schedule to PP&A.

V. DISCUSSION

8. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. Ryan White Part A, MAI and Prevention Programs

K. Donnelly opened the discussion by reviewing the Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32 Status Updates from the Division of HIV and STD Programs (DHSP) to determine what has been addressed before creating the next set of directives.

DHSP reported each solicitation differs based on the service category solicitated, Commission directives, surveillance data, targeted populations and/or service planning areas.

DHSP is working with the Black African American Community (BAAC) Task Force (TF) as subject area experts in the development of training materials and curriculum. They were unable to provide a status on the progress of this effort.

- DHSP will provide an update on the development of BAAC TF recommendations for provider training material and curriculum.

There was discussion regarding an assessment of needs for the Black, African American community. It was recommended a needs assessment be conducted as part of the development of the CHP.

AJ King indicated a willingness to include instruments to assess BAAC needs. Suggestions on how to measure need was requested. System issues are planned for assessment. Issues such as the method of gathering information (i.e., by health districts or high prevalence areas)

- It was recommended this issue is put before the BAAC TF to provide direction on what instruments would provide the information sought.

The Committee discussed available needs assessment information. The most recent report is the 2015-16 Los Angeles County Coordinated HIV Needs Assessment (LACHNA) report which identified out of care individuals and populations who do not access to service. This information will be a source for the formulation of recommendations for inclusion in the CHP. DHSP does not currently have staff to implement a new LACHNA report due to staff reassignment.

- DHSP to implement a LACHNA report once staff levels are restored. The division will notify the Committee when the study is implemented.

There was discussion regarding African American women's health needs particularly mental health. Issues of tailoring mental health services, and failures of mainstream mental health services serving the Black/African Americans community was discussed. Utilizing providers with lived experience was discussed.

DHSP is implementing a comprehensive mental health services assessment to attempt to identify deficits in existing agency capacity and community need.

The provider and delivery of services are significant issues in healthcare services. Having someone that looks like you and understands what you're going through in terms of administering care, particularly mental health services are needed. Providers have clients that request mental health services from Black/African American and/or a woman provider, but they are difficult to find. Further, finding local mental health services in general are difficult and many local mental health providers only take cash.

- The Committee recommended mental health providers of color, specifically Black/African American, be identified, encouraged to provide services, and advocated for through special programs to increase providers of color.

- DHSP recommended Committee collaborate with the Standards and Best Practices (SBP) Committee to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally appropriate.

DHSP has Psychosocial Support Services on the RFP list. DHSP noted services recommended by the BAAC TF include peer support and non-medical case management services. DHSP suggested looking at how to address specific disparities among varied populations and defining specific kinds of nonmedical case management services to allocate resources.

It was noted, the SBP Committee is developing best practices document across various, highly impacted population. They are working with each of the caucuses to refine the documents.

- C. Barrit ensured the Committee that as part of the SBP Committee workplan, mental health and psychosocial services will be included in the pipeline of standards for review.

- The Committee requested DHSP prioritize specific communities in RFPs for Psychosocial Support Services.

- Dr. King has agreed to bring the mental health issues to the Mental Health Task Force.

- The Committee requested COH staff to update to the directives status document to include highlights of today's discussion.

DHSP limited contract staff (due to COVID-19 reassignment) have had to focus on re-establishing expired contracts as opposed to adding new service contracts which is why the Psychosocial Support Services RFP has not been sent out for solicitation.

The Committee noted nutrition and food bank services have received positive comments about the quality of food and delivery services. There are less canned goods and more fresh and healthier foods.

DHSP noted housing efforts should be coordinated between the County and city programs. The housing funds received by DHSP are limited and a fraction of the funding provided to the County and local cities. DHSP is working on how to effectively use funding to reduce homelessness for PLWH. One recommendation is improving resource referrals and clearing house structure/services as a method of increased coordination. Additional training for housing specialist was discussed as well.

Consumers expressed the need for educating people about care and prevention as well as providing flexible services. They recommended as part of planning include future economic changes in the delivery of services. For example, what will be the basic needs such as food and housing if inflation or unemployment increase. Trauma and stigma were discussed as barrier to services. Aging and employment opportunities for People Living with HIV (PLWH) were discussed.

Consumers noted, training housing specialist should include compassion, the ability to identify multiple client needs and referring them accordingly. This would include screening for mental health and employment services.

Medical transportation services were expanded to include ridesharing services. Taxi and Metro services are still provided as well. Providers administer the program. DHSP noted, during the pandemic there was a decrease in the use of public transportation, but ridesharing usage increased. Increase in use of telehealth services also impacted the use of transportation.

DHSP has a solicitation in development to contract with an agency to develop Ryan White eligibility cards.

DHSP is working on augmenting contracts to include childcare and transportation services to facilitate consistent engagement in care and support services. This strategy would avoid releasing a standalone RFP for childcare and transportation and gives service providers flexibility in provided services.

There was some discussion on Emergency Financial Assistance and DHSP's effort to increase the use of this service. DHSP noted the State programs are more robust and ongoing. The EFA program is limited to $5,000 per client per year. DHSP is unable to eliminate documentation requirements because the federal grants have constraints. The identification of resources that do not require extensive documentation to qualify for services was noted as possibility.

The Committee requested clarification on the services provided by EFA, specifically, childcare services. DHSP has not included childcare services. Currently, funding for rental assistance, assistance with rent deposits, moving costs and utilities services are provided. To expand services, DHSP indicated the Commission would need to define specific services and which resources would support those services.

The Commission hoped the childcare solicitation will address the concerns expressed by the Women's Caucus when requesting this service. If the childcare service is provided by a neighbor or family member, is that reimbursable? The Caucus stressed the need for flexibility. There was concern that the Women's Caucus was not aware nor reviewed the solicitation. DHSP was asked to clarify the types of childcare services requested through the solicitation.

DHSP cannot reimburse a client directly for childcare costs in the current solicitation. Payments must go directly to the provider. County Counsel limited services to licensed childcare provider agencies and/or existing contracted provider sites. Dr. L. Spencer expressed concerns about the narrow focus of the childcare solicitation. She noted there are only a few sites that can provide childcare, and it is unlikely that other sites would be willing to set up the service due to costs. She emphasized the need to find a way to support informal childcare.

The Committee proposed the establishment of a phone service for clients to call for access to licensed childcare providers in their area. This could increase childcare providers who could receive direct payments and bypass client reimbursement. DHSP needs to determine if such a service already exist. It would be possible for this to be a Medical Care Coordination teams' responsibility.

The Committee requested DHSP consider the use of Net County Costs (NCC). DHSP noted the

NCC funding could be redirected but are currently fully allocated. DHSP requested the Committee provide direction on what services funded through NCC should be reduced to support childcare services.

The Committee clarified the Commission's role does not include allocating NCC funds but provides allocation percentages for RW services. DHSP identifies funding sources for services. DHSP confirmed a review of the funding portfolio would need to be reviewed and decisions made on funding sources for services.

The Committee suggested reallocating NCC-supported services to RW funding where appropriate to free up funds for childcare services requiring flexible funding. DHSP noted there is an internal discussion about using NCC for EFA services which could include childcare services.

K. Donnelly noted the Committee had two more points to review on the directives, but due to the time constraints it was suggested the Committee discussed those items at the March 2022 meeting which should lead the committee into updating or creating new program directives.

- It was noted number 9 on the directive's status sheet requires more information for the Committee to adequately develop new directives or refine existing ones

- Commission staff will include the HRSA Directives guide in the March 2022 meeting packet.

9. COMPREHENSIVE HIV PLAN (CHP)

a. Ryan White Part A, MAI and Prevention Programs
Discussed during Executive Director's Report.

VI. NEXT STEPS

10. Task/Assignment Recap
Tasks and assignments are included in meeting notes indicated with a red arrow.

11. Agenda Development for the Next Meeting

- Co-Chair Nominations/Elections
- The agenda will include continued discussion of the Comprehensive Program Directives to DHSP
- Comprehensive HIV Plan

VII. ANNOUNCEMENTS

12. Opportunity for Members of the Public and the Committee to Make Announcements
There were no announcements.

VIII. ADJOURNMENT

a. Adjournment:
The meeting was adjourned by K. Donnelly at approximately 3:02PM.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • 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 misogyny, 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; 3/3/22)**

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/1/22

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
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)
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
GARTH	**Gerald**	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
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
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
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
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**	We Can Stop STDs LA	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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
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**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	Unaffiliated consumer	No Ryan White or prevention contracts
VEGA	**Rene**	Unaffiliated consumer	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

From: Michael Green <mgreen@ph.lacounty.gov>
Sent: Monday, January 3, 2022 9:39 AM
To: Barrit, Cheryl <CBarrit@lachiv.org>; Echols-Watson, Carolyn <CEchols-Watson@lachiv.org>
Cc: Pamela Ogata <pogata@ph.lacounty.gov>; Roberto Melendrez <RMelendrez@ph.lacounty.gov>
Subject: Solicitations priorities

Good morning.
Here's the current list of upcoming solicitations in order of release for guidance for your SBP
committee:
Biomedical
Media services
Evaluation services
Transitional Case Management (jails; possibly youth)
Childcare
Home-based case management
Health Education/Risk Reduction
Upcoming will be AOM, MCC, Residential/expanded housing, benefits specialty services.

Best,

Michael Green, Ph.D, MHSA
Chief of Planning, Development and Research
Division of HIV and STD Programs
Los Angeles County Department of Public Health
600 South Commonwealth Avenue, Fl 10
Los Angeles, CA 90005
213.351.8002 (office)
Pronouns: he/him/his

Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32
Status Updates from the Division of HIV and STD Programs (DHSP)

DIRECTIVE	DHSP RESPONSE/STATUS UPDATE
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.	Solicitations are composed using the latest data, which reflect the geography and other demographics of target populations
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.	In progress. Some training resources still need to be identified and tested. *DHSP will provide an update on the development of B/AAC Caucus recommendations for provider training material and/or curriculum.* This should be included in the needs assessments conducted as part of the formative work for the development of the comprehensive plan. *It was recommended the B/AAC Caucus be consulted on measurement tools to use for a comprehensive needs assessment of the Black/African American Community. The information will be included in the CHP.* *DHSP to implement a LACHNA report once staff levels are restored. The division will notify the Committee when the study is implemented.* *The Committee recommended mental health providers of color, specifically Black/African American providers are identified and encourage to provide services. Special programs to increase the number of providers of color was recommended.* Is there a different standard of care for these services for this population?

• Earmark 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.	Must be allocated by PP&A. *The Commission allocated funding for Psychosocial Support Services in PY 34.* DHSP relies on SBP for guidance. *The SBP Committee workplan includes mental health and psychosocial services standards review.* *The Committee requested DHSP prioritize specific communities in RFPs for Psychosocial Support Services.*
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 (over 50 yrs).	Commission must allocate funds for these programs.
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.	DHSP has used EHE and HRSA CARES funds to improve capacity to store perishable, nutritious foods, and increase variety and quality of food available consistently.
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.	The entire housing portfolio needs to be examined to determine where DHSP's limited housing resources can have the most impact. *DHSP is review methods of increased coordination and improvement of resource referrals and clearing house structure/services.* *Training for housing specialist was recommended to improve services.* *Consumers noted the training should include an emphasis on compassion and the ability to screen for multiple client's needs.*
6. Continue to support the expansion of medical transportation services.	In progress *Medical transportation services were expanded to include ridesharing services. The program is provider administered.*
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	In progress *A solicitation is in development to contract with an agency to develop Ryan White eligibility cards.*

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.	Childcare solicitation is nearly complete. *DHSP is working on augmenting contracts to include childcare and transportation services. The current solicitation cannot reimburse a client directly for childcare costs. Payments must go directly to childcare providers.* *The Committee express concerns about the narrow focus of the solicitation. DHSP was encouraged to find a way to support informal childcare. The Committee requested DHSP consider the use of Net County Costs (NCC) which has fewer funding restrictions. DHSP noted the NCC funding could be redirected but are currently fully allocated.* *The Committee suggested reallocating NCC-supported services to RW funding where appropriate to free up funds for childcare services that require greater funding flexibility.* *DHSP noted there is an internal discussion about using NCC for EFA services which could include childcare services.* EFA program is in place. *EFA provides client funding for rental assistance, rent deposits, moving costs and utilities services. To expand services, DHSP requested the Commission define specific services and resources*.
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.	Need more information on what this would look like.
10. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support to build a stronger sense of community, empowerment and resilience among women living with HIV.	Commission should allocate funds accordingly.

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.

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

Endnotes

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

Quick Reference Handout 5.2: Directives

RWHAP Legislative Requirements

One of the duties of a Ryan White HIV/AIDS program (RWHAP) Part A planning council (PC)* is 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" [Legislation, Section 2602(b)(4)(C)]*

Directives address *how best to meet* the priorities established by the planning council.

**Planning bodies provide recommendations rather than serving as decision makers, but sound practice is for both PCs and PBs to develop directives.*

Purpose and Focus of Directives

Directives help strengthen the system of care. They provide written guidance to the recipient from the PC/PB regarding how best to meet specific service priorities established as part of the priority setting and resource allocation (PSRA) process, and other factors the recipient should consider in arranging for services. Often, directives address identified barriers to care or disappointing health care system performance on measures and clinical outcomes such as linkage to care, retention in care, adherence to medications, and viral suppression, overall or for particular PLWH populations or geographic areas.

Most directives focus on one or more of the following:

1. **Geographic targeting:** ensuring availability of services in all parts of the EMA/TGA or in a particular county or area

   Examples of directives:
   - *RWHAP-funded outpatient ambulatory health services (HIV-related medical care) must be available within each county in the EMA/TGA, either through facilities located in the county or through other methods such as use of mobile vans or out-stationing of personnel.*
   - *Oral health care must be accessible to PLWH in the EMA/TGA regardless of where they live.*
   - *Mental health and outpatient substance abuse treatment services must be available to PLWH within County X at least 2 days a week.*

2. **Population targeting:** ensuring services appropriate for specific target PLWH populations

   Examples of directives:
   - *Core medical service providers must have bilingual Spanish-English staff in positions with direct client contact, including clinical staff.*
   - *Each of the three counties in the EMA/TGA must have at least one service provider qualified to provide culturally appropriate services to young MSM of color.*
   - *At least one outpatient substance abuse treatment provider must offer services appropriate for and accessible to women, including women who are pregnant or have small children.*

3. **Access to care:** overcoming barriers that reduce access to care

   Examples of directives:
   - *Every funded outpatient ambulatory health services (OAHS) provider and every medical case management provider must offer services at least one evening a week and/or one weekend day a month.*
   - *Transportation must be made available to PLWH who are unwilling to seek care in their own communities due to fear of exposure and stigma, and who require such assistance so they can access care in another location within the EMA or TGA.*
   - *PLWH with a history of unmet need must have access to peer navigator services or other targeted assistance for at least the first six months after they return to care.*

4. **Service models:** requiring the testing or broader use of a particular service model

   Examples of directives:
   - *At least two medical providers will receive funds to test the use of a Rapid Response linkage to care model, designed to ensure that newly diagnosed clients have their first medical visit within 72 hours after receiving a positive test result.*
   - *All medical case management providers will ensure that at least one case manager completes recipient-approved geriatric training on a refined case management model for older PLWH.*
   - *The EMA/TGA will pilot test an Early Intervention Services (EIS) model designed to reach young MSM of color who are newly diagnosed or out of care, link them to care, and help ensure that they become fully connected to medical care.*

Directives are one way of strengthening the system of care. There are other ways, as well, such as adding requirements to universal or service category-specific Service Standards. Sometimes a directive will call for testing a new service model or approach. If it proves successful in addressing the identified need, it may be added to Service Standards and implemented throughout the system of care.

Identifying the Need for a Directive

The PC/PB may identify needs and issues leading to directives at any time of the year through many sources, among them review and discussion of data from the following sources:

- **Needs assessment**—service gaps, barriers to care, or issues identified by consumers, service providers, or PLWH who are out of care, or through a review of epidemiologic data trends
- **Town hall meetings or public hearings** that are part of the PSRA process—identified service needs, gaps, services strengths or weaknesses
- **HIV care continuum**—disparities in linkage to care, retention, and/or viral suppression among specific PLWH populations
- **Service utilization**—disparities in use of particular service categories by different PLWH populations based on such characteristics as race/ethnicity, age, gender/gender identity, sexual orientation, risk factor, or place of residence
- **Clinical Quality Management (CQM)**—identified performance issues or changes in service models that improve patient care, health outcomes, and patient satisfaction

Often, review of such information will help to identify issues such as the following:

- ***Poor service access,*** limited use of services, poor retention, or low rates of viral suppression for PLWH populations, especially those who are traditionally marginalized and/or have co-morbidities
- ***Lack of culturally and linguistically appropriate services*** overall or in particular locations or specific service categories
- ***Too few providers in outlying areas*** of the EMA or TGA
- ***A need for new models or strategies*** to better address the changing local epidemic

HRSA/HAB Expectations

PC/PBs have a great deal of flexibility in the development and use of directives. Directives can be developed whenever available data indicate the need for action to provide parity in access to high quality care for all PLWH, regardless of who they are or where they live within the service area.

HRSA/HAB expects directives to be:

- **Based on an identified need,** determined through review of data from needs assessment, town hall or other community meetings, service utilization data, CQM activities, or other sources
- **Explored and developed as needed throughout the year**—often with the involvement of several committees, such as the following (Committee structures and names vary by jurisdiction):
  - *Needs Assessment and Planning*
  - *Care Strategy/System of Care*
  - *Consumer/Community Access*
  - *Priority Setting and Resource Allocation*
- **Presented in relation to the PSRA process,** since they often have financial implications and may require changes in how services are delivered—and are best addressed through discussion with the recipient before allocations have been made
- **Approved by the full PC/PB,** along with or separate from resource allocation
- **Consistent with an open procurement process.** Directives should not have the effect of limiting open procurement by making only 1-2 providers eligible, since the PC/PB should have no involvement in the selection of specific entities to serve as subrecipients.

  For example, consider the following possible directives:

  > *Mental health services must be provided by clinicians that can demonstrate expertise in serving people living with HIV*
  >
  > *Mental health services must be provided by organizations with prior RWHAP experience*

  The first is an acceptable directive, requiring that mental health clinicians have appropriate expertise to serve PLWH—which can be obtained through training and/or prior experience, regardless of funding source. The second suggested directive is not acceptable, because it limits possible subrecipients to those that have received RWHAP funding in the past. There might be only one or two entities that meet that requirement, which would prevent an open procurement process.

Tips for Preparing Sound Directives

The following approaches support the development of sound directives:

1. **Provide a limited number of carefully thought-out directives.** If the PC/PB proposes too many directives, they may not receive the individual attention or resources needed for successful implementation.
2. **Review current directives,** to retire those that no longer apply and to avoid duplication where appropriate by refining an existing directive rather than developing a new one. Directives only rarely need to be maintained over many years. If the approach in the directive proves effective, it can be made permanent through other means, such as inclusion in Service Standards.
3. **Base directives on data and be prepared to present the underlying data** when proposing a new or revised directive to the PC/PB.
4. **Identify and research possible directives throughout the year,** as part of your ongoing efforts to improve the continuum of care. This provides time to explore service models used by other jurisdictions, determine costs, and have a well-considered directive to present as part of PSRA —and ensure allocation of resources needed for implementation.
5. **Refer to but don't duplicate requirements in existing Service Standards.** If aggregate monitoring or CQM data show that Service Standards are not being met, the PC/PB should explore with the recipient why this is happening—and may want to consider a directive that offers a refined approach.
6. **Use plain, direct language** so that the directive is easy to understand and implement.

Role of the Recipient

The recipient is *responsible for implementing* directives. Beyond that, the PC/PB should collaborate with the recipient as it formulates directives, particularly with regard to assessing the costs, feasibility, and timing of implementing a potential directive.

COSTS

Suppose the PC/PB has developed the following proposed directive to improve retention in care for employed PLWH:

> *All RWHAP Part A-funded OAHS and medical case management providers must provide services at least one evening a week or one weekend day a month .*

Adding evening or weekend hours may improve care, access and retention, but it also adds costs for staff and for keeping the facility open longer. Before time for resource allocation, the PC/PB needs to ask the recipient to estimate the added costs per year for evening hours and for weekend hours. That will allow the PC/PB to refine the directive if necessary. For example, if it would be much less expensive to use evening rather than weekend hours, it might remove the weekend option. That will also give the PC/PB the information needed to add dollars to the OAHS and medical case management allocation to permit implementation of this directive—unless it is willing to serve fewer PLWH in these service categories.

FEASIBILITY

The PC/PB should consult with the recipient regarding such issues as whether a similar strategy or service model has been tried before, and if so, with what results; and whether the directive can be implemented or perhaps needs to be revised or restated. For example, a directive that calls for use of telemedicine in providing mental health services is feasible only if state law allows such use of telemedicine. Strategies must be

consistent with RWHAP service definitions and other HHS guidance. Incentives for keeping medical appointments must meet federal guidelines or be funded out of non-federal funds.

TIMING

It is not always possible for a directive to be implemented quickly. While some jurisdictions may be able to modify the scope of work for a multi-year subrecipient contract, others will not be able to change requirements or specify a new service model until the service category goes out for competitive bid, which may happen only every 2-4 years. It is sometimes possible to state a directive so that parts can be implemented immediately. For example, the directive below will probably be implemented only after these service categories go out for bid, since it is likely to require hiring of staff with specific skills and experience:

> *All OAHS and medical case management providers must ensure transgender PLWH and African immigrants receive services only from clinicians and case managers with both training and experience in serving these populations.*

As an interim measure, the following directive could be implemented quickly, with assistance from the recipient, or the PC/PB could instead decide to add it as a requirement in its Service Standards:

> *All OAHS and medical case management staff serving transgender PLWH and African immigrants must first complete in-depth, recipient-approved cultural competence training to prepare them to serve these populations.*

Discussion with the recipient can help in addressing these cost, feasibility and timing challenges.

Assessing Implementation and Results

Directives are generally implemented by the recipient through procurement and contracting, and/or program monitoring and clinical quality management (CQM) efforts, including quality improvement projects. The recipient must follow directives in procurement and contracting but cannot always guarantee full success. For example, the recipient might put out a request for proposals (RFP) to implement a new service model but receive no qualified responses. The recipient may want to suggest revisions in the directive to make responses more likely.

Once a directive has become a requirement for subrecipients, its implementation can be followed through program monitoring, reviewed as part of CQM, or assessed in terms of changes in performance measures or clinical outcomes for affected PLWH. The recipient should always be asked to provide updates on implementation of directives, ideally at least quarterly. The PC/PB and recipient should work together to assess the results of directives and to decide when a pilot project should be expanded, refined, or ended.