LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE MEETING

Tuesday, April 16, 2024
1:00pm - 3:00pm (PST)

Vermont Corridor
510 S. Vermont Ave. Terrace Conference Room TK02
****Valet Parking: 523 Shatto Place, LA 90020****

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

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To Join by Telephone: +1-213-306-3056 United States Toll (Los Angeles)
Password: PLANNING **Access Code:** 2539 058 4641

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together.

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

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

PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, APRIL 16, 2024 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room, Los Angeles, CA 90020

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r84f83b3954f98098c53482ef4bdddae9
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2539 058 4641

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Felipe Gonzalez Co-Chair	Al Ballesteros, MBA	Lilieth Conolly
Michael Green, PhD	Ish Herrera	William King, MD, JD	Miguel Martinez, MPH, MSW
Derek Murray, MPH, MPA	Dechélle Richardson (Alternate)	Daryl Russell	Harold Glenn San Agustin, MD
LaShonda Spencer, MD	Lambert Talley (Alternate)	Jonathan Weedman	
QUORUM: 8			

AGENDA POSTED: April 11, 2024

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 mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. 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 the Commission Office 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 Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos setenta y dos 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, Los Angeles, CA 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

6. 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

7. Executive Director/Staff Report 1:15 PM – 1:20 PM
    a. Programmatic and Operational Updates

b. HRSA Technical Assistance Site Visit
c. Status Neutral Priority Setting and Resource Allocation (PSRA) Draft Framework Update

8. Co-Chair Report 1:20 PM – 1:30 PM
   a. 2024 Training Schedule
      - April 23rd - Priority Setting and Resource Allocation Process & Service Standards Development Virtual Training @ 3:00pm-4:30pm
   b. Women's Caucus

9. Division of HIV and STD Programs (DHSP) Report 1:30 PM – 1:50 PM
   a. Programmatic and Fiscal Updates

V. DISCUSSION ITEMS 1:50 PM—2:50 PM

10. Prevention Focused Planning: Priority Populations
    a. What does high-impact prevention look like?
    b. Identify at least 5 HIV/STI prevention strategies

VI. NEXT STEPS 2:50 PM – 2:55 PM

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting - Unmet Mental Health Needs of People Living With HIV

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the meeting of April 16, 2024.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 6.12.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Public comment is limited to 2 minutes per person. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/27/24

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts. ***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CONOLLY	**Lilieth**	No Affiliation	No Ryan White or prevention contracts
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FERGUSON	**Kerry**	ViiV Healthcare	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
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	Invisible Men	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
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
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MARTINEZ-REAL	**Leonardo**	Unaffiliated consumer	No Ryan White or prevention contracts
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MENDOZA	**Vilma**	Unaffiliated consumer	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLETTE	**Andre**	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
			Data to Care Services
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	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
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated consumer	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
March 19, 2024

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez, Co-Chair	P	Derek Murray	EA
Al Ballesteros, MBA	A	Dechelle Richardson	P
Lilieth Conolly	EA	Daryl Russell	P
Joseph Green	P	Harold Glenn San Agustin, MD	P
Michael Green, PhD, MHSA	A	LaShonda Spencer, MD	P
Ismael "Ishh" Herrera	EA	Lambert Talley	A
William King, MD, JD	EA	Jonathan Weedman	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Lizette Martinez			
DHSP STAFF			
Victor Scott, Paulina Zamudio			

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

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly and Felipe Gonzalez, Planning, Priorities and Allocations (PP&A) co-chairs, called the meeting to order at approximately 1:03pm. F. Gonzalez reviewed the hybrid meeting guidelines and code of conduct; see meeting packet for more details.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

C. Barrit conducted roll call vote and F. Gonzalez reminded committee members to state their conflicts.

ROLL CALL (PRESENT): J. Green, M. Martinez, D. Richardson, D. Russel, H. San Agustin, L. Spencer, K. Donnelly, F. Gonzalez

3. Approval of Agenda

MOTION #1: Approve the Agenda Order **(✓Passed by Consensus)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(✓Passed by Consensus)**

II. PUBLIC COMMENT

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

   There was no public comment.

III. COMMITTEE NEW BUSINESS

6. **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 was no committee new business.

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **2023 Annual Report**
      - C. Barrit, Commission on HIV (COH) Executive Director, reminded the Committee that the 2023 COH Annual Report was submitted to the Board of Supervisors (BOS) at the end of February. The report is posted on the COH website.
      - F. Gonzalez noted that the report highlights current service priorities and allocations and data used to determine rankings.
      - F. Gonzalez noted that the report highlights disruptions in services during 2019-2020 due to the COVID-19 pandemic and coupled with stigma, poverty, racism, and social determinants of health put marginalized populations at increased risk of HIV acquisition. He noted many women of color stating a lack of mental health support during the last full body Commission meeting and that the COH must work to address this unmet need.
      - P. Zamudio noted that DHSP currently does fund mental health services, but people may not be aware of the service.
      - L. Spencer noted that the current program is challenging because it is a fee-for-service model meaning that mental health providers only get paid if a client shows up for their appointment, but agencies must maintain/pay salaries for mental health providers regardless of clients show up or not. An agency typically cannot participate in the program if it does not have other funds to pay psychiatry staff noting that no show rates for mental health appointments are roughly 50%.
      - D. Richardson commented that A. Ballesteros previously made a recommendation to

restructure mental health services as a line item within a budget versus fee-for-service.

- D. Russell expressed concern if the mental health services being offered tailored to the needs of people living with HIV.
- P. Zamudio commented that providers have stated that many of their patients also receive Medi-Cal and since the Ryan White Program is a payor of last resort, many mental health services are covered under Medi-Cal and there are not enough clients to sustain the fee-for-service model. She added that Medi-Cal mental health providers are not trained in HIV and need to have a trauma-informed approach to care.
- K. Donnelly and F. Gonzalez requested adding addressing mental health provider capacity to serve people living with HIV to the April PP&A Committee meeting agenda.
- L. Spencer suggested advocating for specialized HIV mental health providers noting that they are not available through Medi-Cal and will be able to utilize RWP funds instead of Medi-Cal funds to pay for services.
- M. Martinez added that reimbursement rates under Medi-Cal are extremely low whereas reimbursement rates under the RWP come much closer to covering agencies costs for services. He noted using Medi-Cal to cover mental health services costs agencies money so many do not want to take on mental health services. He also noted a lack of providers, long wait times, lack of specialized providers and, due to the scarcity, providers charging high fees.
- R. Archuleta (member of the public; virtual attendance) asked how mental health providers are monitored.
- R. Garcia (member of the public) commented that peer support navigators are a crucial to keep clients engaged and prepare clients to engage in services.

b. General Orientation and Commission on HIV Overview March 26, 2024

- C. Barrit reminded the committee that COH mandatory trainings will start beginning with the General Orientation and Commission on HIV Overview training on Tuesday, March 26 from 3:00-4:30pm. The training will be held virtually, and the presentation slides and recording will be posted to the Commission website following the training. The training flyer can be found on the COH website and all trainings are open to the public.
- C. Barrit added that the Health Resources and Services Administration (HRSA) sunset the Planning CHATT technical assistance on July 1, 2023 and started an internal technical assistance program for planning councils. Our new program officer informed Commission staff and leadership that the technical assistance team will be conducting a site visit of the planning council from May 20th -23rd. The HRSA team will attend the Executive Committee meeting but may also attend any other meetings that are scheduled during this time. HRSA will be sending a letter with proposed agenda within the next few weeks and Commission staff will share the information with commissioners once received. Additionally, HRSA staff requested additional technical assistance requests ahead of the meeting. Commissioners can submit technical assistance requests to Commission staff who will forward to HRSA. C. Barrit noted that technical assistance on the revised COH bylaws and Status Neutral Priority Setting and Resource Allocation Framework has already been requested and are currently

under review with HRSA.

- J. Green asked if the co-chairs of the various caucuses can be invited to attend the May Executive Committee meeting as well.
- A. Burton requested a link to archived Planning CHATT resources.

8. Co-Chair Report

a. Prevention Standards Approval from Standards and Best Practices Committee

- K. Donnelly reported that the Prevention Standards has been reviewed and approved by the Standards and Best Practices Committee. The standards will go to the Executive Committee on March 28th for review and approval before going to the full COH for approval in April.

b. Approval of Status Neutral Priority Setting and Resource Allocation (PSRA) Framework

- K. Donnelly noted that the Status Neutral Priority Setting and Resource Allocation (PSRA) Framework was sent to HRSA program officers for review and feedback. HRSA staff noted that feedback on the framework is forthcoming. Feedback from HRSA will be shared with the committee when available.

c. Convening with Consumer Caucus

- K. Donnelly reported that co-chairs and Commission staff are working with the Consumer Caucus to determine the best time for group meeting to review the priority setting and resource allocation process.

9. Division of HIV and STD Programs (DHSP) Report

a. CDC Notice of Funding: High-Impact HIV Prevention and Surveillance Programs for Health Departments

- DHSP staff, Victor Scott, provided a brief overview of the new CDC High-Impact HIV Prevention and Surveillance Programs for Health Departments notice of funding announcement that was released in February, see meeting packet for more details.
- V. Scott noted that this new grant will replace the current PS18-802: Integrated HIV Surveillance and Prevention Programs grant that ends July 31, 2024. The new grant will begin on August 1, 2024, and the first budget period will be for 10 months through May 31, 2025, and the subsequent years 2 through 5 will be a 12-month budget period from June 1st through May 31st. Level funding is expected throughout the 5 year period. See meeting packet for more details on proposed funding amounts.
- The new grant will combine HIV surveillance, HIV prevention and Ending the HIV Epidemic activities into one funding opportunity with three separate pots of money. The new grant aims to strengthen community engagement, health equity, and whole person care while taking a syndemic approach to prevention. Approximately 10% of funds can be used toward a syndemic prevention activities.
- M. Martinez asked how the proposed funding compares to current HIV funding. V. Scott

noted that there was a reduction in funding in the new grant. CDC used 2021 HIV surveillance prevalence data to determine award amounts. He noted that 5-6 jurisdictions that saw a reduction in their award amounts.

- M. Martinez noted that traditional nonbiomedical prevention approaches, such as health education, were not outlined in the notice of funding and asked if these activities will no longer supported under the new grant. V. Scott confirmed that they are no longer supported. He added that the CDC has asked jurisdictions to use these types of approaches but does not fund them. DHSP continues to advocate for funding nonbiomedical prevention approaches and has asked CDC to outline what strategies can be used while focusing on a whole person approach.

b. Programmatic and Fiscal Updates

- V. Scott provided a response to a question raised at the February PP&A Committee meeting regarding where the bulk of Medical Care Coordination (MCC) dollars go. He noted that approximately 70% of MCC expenditures pay for staff salary. 18% toward benefits, 8% towards rent, telecommunications, and supplies, and approximately 4% of indirect costs. H. San Agustin reminded the group that he asked the questions because he noticed understaffing within the MCC program despite a large amount of money being allocated to this service.
- P. Zamudio noted that DHSP staff regularly meet with MCC staff and are aware of current challenges staff are facing. DHSP is in the process of revamping the program to address concerns. She also noted that flat funding prevents funding increases for contracted providers to increase salaries or add more staff. She added that staff retention has been a big challenge in the last 2-3 years due to salary competition, lack of training for various professions (e.g., nurses, social workers, etc.), and incompatibility with working in the HIV field creating increased workload for agencies. DHSP is also reviewing potential process challenges such as too much paperwork and data system issues and is also looking at agencies that are doing well to help offer technical assistance to agencies that are struggling.
- D. Russell asked how DHSP is addressing client concerns. P. Zamudio noted that clients can access the Customer Support Line to address issues and DHSP works with providers to remedy concerns. She noted DHSP is working with contracted providers to offer a trauma-informed care approach to build staff capacity to address and prevent potential challenges.
- P. Zamudio noted that DHSP will be releasing the revamped Ambulatory Outpatient Medical (AOM) care and MCC requests for proposals this year.
- B. Salcedo (member of the public) recommended a pilot project of using community members or organizations to link clients into clinics or other care coordination that is needed.
- M. Martinez commented that the committee had previous discussions around MCC and AOM services. He noted MCC would not have adequate resources due to flat funding and rates have gone up which means less staff to do the work. He noted that the committee

needs to remember that MCC will need more money when they go through the priority setting and resource allocation process. He also noted that the group needs to look beyond just MCC, to not invest completely into one model, and that adding prevention navigation is equally as important. Agencies need people linked to the community to help bring people into clinics and clinics need qualified staff to retain people in care. He noted this disconnect may be what clients are feeling.

V. DISCUSSION

10. Prevention Focused Planning: Overview of Available Prevention Data and Review of Key Highlights of Comprehensive HIV Plan Situational Analysis Section

- Former Prevention Planning Workgroup co-chair, Miguel Martinez, provided a presentation on current LA County prevention data. See meeting packet for details.
- A. Franklin (member of the public) asked what is being done to ensure equitability to ensure marginalized communities are receiving needed services. M. Martinez noted inequities exist due to systemic racism and the COH develops directives as part of the priority setting and resource allocation process that aim to address challenges. P. Zamudio noted DHSP makes it a priority to invest in areas with the most need and decisions are data-driven and priority areas may shift over time.
- D. Russel asked how progress on the implementation of the directives is communicated back to the COH. M. Martinez noted that Commission staff work with DHSP to provide regular updates to the COH. L. Spencer noted that gathering community input to inform the directives is very important as well as regular follow up on directives. She did note that follow up from DHSP needs to be more robust.
- L. Spencer asked if there was non-injection drug use data. P. Zamudio noted that the Substance Abuse and Prevention Control (SAPC) program would have data around non-injection drug use.
- D. Russel asked how prevention is addressing long-term survivors. M. Martinez noted treatment as prevention addresses long-term survivors to ensure engagement in care and viral suppression as well as peer support programs. P. Zamudio added that health education is also offered to create community and understand importance of medical care.
- D. Richardson asked if there was data around education as prevention. P. Zamudio noted DHSP currently does not have a data system to collection prevention education data. She noted DHSP can check monthly reports to track the number of people receiving education but there is not mechanism for collecting impact or outcome data to assess if an individual has learned anything or changed behaviors over time. M. Martinez added that individual agencies may collect this data on their own but that the measures are not uniform. L. Spencer noted that collecting this data is very challenging as patients may cycle on and off education and PrEP. She noted linkage to a peer navigator is successful but that there is a sharp drop off for clients who go on to receive medication. M. Martinez noted that outcome assessment and data collection is often cost prohibitive.
- R. Garcia (member of the public) requested more gender-diverse data in future presentations as transgender populations often share the highest burden of disease and poor health outcomes.

M. Martinez noted that the presentation was a general overview and highlight examples of existing data.

- Future discussions will include data from SAPC and will include information on priority populations which includes transgender individuals indicated in the Comprehensive HIV Plan.
- Other questions not addressed during the meeting include:
  - How are mental health vendors monitored? From R. Archuleta, a member of the public attending online.
  - How granular of data does DHSP have? Is the data as granular as zip codes or only health districts? From K. Nelson, a member of the public attending online.

VI. NEXT STEPS

11. Task/Assignments Recap

a. Commission staff will share the HRSA site visit letter once received.
b. Commission staff will follow up on any outstanding questions that were not answered during the meeting.
c. Commission staff will reach out to SAPC to gather additional data around substance use and HIV.

12. Agenda Development for the Next Meeting

a. Continue prevention data discussion.
b. Revisit and review DHSP Mental Health Needs Assessment report.

VII. ANNOUNCEMENTS

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

- *B. Salcedo announced that the TransLatin@ Coalition will be opening a new location in El Monte. A grand opening celebration will be held on Saturday, March 30th from 12pm – 4pm at 10715 Garvey Ave. El Monte, CA 91733. All are welcome to attend.*

VIII. ADJOURNMENT

14. Adjournment for the Meeting of March 19, 2024.

The meeting was adjourned by K. Donnelly at 2:58pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

POLICY/ PROCEDURE:	NO. 09.5203	Priority Setting and Resource Allocations (PSRA) Framework and Process

DRAFT 12.27.23

SUBJECT: The Commission's Priority Setting and Resource Allocations (PSRA) framework, process and specifics.

PURPOSE: To outline the Commission's service prioritization and resource allocations process, as mandated by the Ryan White Treatment Modernization Act (Ryan White) and Los Angeles County Charter Code 3.29.

BACKGROUND:

- Service prioritization and resource allocations are two of the Part A planning councils' chief responsibilities, detailed specifically in Ryan White legislation and confirmed in County Charter Code.

- In accordance with Health Resources and Services Administration (HRSA) guidance, the Commission sets service priorities based on consumer need and determines allocations from priorities and other factors such as service capacity, other sources of funding, service utilization and cost-effectiveness.

- As defined in its ordinance, the Commission establishes priorities and allocations of Ryan White Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee' s allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations and Comprehensive HIV plan, without the review of individual contracts; provide and monitor directives to the grantee on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the Board of Supervisors and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan.

POLICY:

- This policy outlines the Priority Setting and Resource Allocation (PSRA) process used to

- prioritize services and allocate resources—in accordance with governing Ryan White and County code legislation—encompassing the specific partners, responsibilities, steps, tasks and timelines associated with the process.

- The PSRA process is led by the Commission's Planning, Priorities and Allocations (PP&A) Committee. The Division of HIV and STD Programs (DHSP) provides critical information; consumer input is collected through the Comprehensive HIV Plan and other assessments; and provider input is collected through focus forums, surveys and Commission participation.

- The policy details the expectations and timing of stakeholder involvement in the multi-year Ryan White Part A funding cycle determined by the HRSA Ryan White HIV/AIDS Program (RWP). The process allows for ongoing stakeholder input at several key junctures. Multi-year allocations are intended to conclude prior to the submission of the RWP Part A application. Allocations are reviewed annually to ensure alignment with and responsiveness to community needs and funding requirements.

PRINCIPLES AND CRITERIA[1]:

A. **Priorities and allocations are data based**. Decisions are based on the data, not on personal preferences. Commissioners should avoid presenting anecdotal information or personal experiences during the decision making, focusing on needs assessments, and cost/service utilization data rather than a single person's experience.

B. **Conflicts of interest are stated and followed.** Commission members must state areas of conflict according to the approved Conflict of Interest Policy, and cannot participate in open discussions or vote on the related service categories in which they have a conflict. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s), and neither initiate discussion nor vote on priorities or allocations for those service categories. S/he can answer questions directed by other members, and can vote on priorities and allocations when they are presented as a whole list. (Model Priority Setting and Resource Allocation Process, Compendium of Materials for Planning Council Support Staff. EGM Consulting, LLC. 2018).

Commented [BC1]: Ask new HRSA PO for clarification.

[1] Model Priority Setting and Resource Allocation Process, Compendium of Materials for Planning Council Support Staff. EGM Consulting, LLC. 2018.

C. The data provide the basis for changes in **priorities or allocations from the previous year**. The data indicate changes in service needs/gaps and availability based on information from the various data sources.

D. **Needs of specific populations and geographic areas** are an integral part of the discussion in the data presentations and the decision making. They may also lead to recommendations to the Recipient on how best to meet the priorities.

E. **Final vote** on the complete priorities and allocations will be presented by the Planning, Priorities and Allocations Committee Co-Chairs to the full planning council for a roll-call vote.

F. **Paradigms and operating values** are selected and used by the PP&A Committee to help guide their decision-making in setting service priorities and resource allocations. The PP&A Committee reviews the paradigms and operating values selected and approved from the previous year as the foundation for current year PSRA process or reallocations. (Attach)

G. **The Commission's Status Neutral HIV and STI Delivery System framework** is used by the PP&A Committee to ensure that service priorities and resources allocations emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being. (Attach)

H. Decisions should help to ensure **parity in access to care**, for all Ryan White-eligible HIV/AIDS population groups and for PLWH/A regardless of where they live in the County.

I. Discussions and decisions should have a major focus on **improving performance on the HIV Care Continuum/Treatment Cascade,** focusing on areas of concern – such as linkage to care or retention in care. Reducing unmet need (the number of people who know they are HIV-positive but are not in care) requires deciding how many "new" or "lost to care" clients should be identified, estimating the mix of services they will need from RWHAP Part A, and allocating funds sufficient to meet those needs. Where a choice needs to be made between providing a wider range of services to more individuals and getting additional people into care, the Planning Council will give priority to getting more people key services (among them primary care and medications).

J. The Commission members will keep in mind current goals, objectives, and priorities from its **Comprehensive HIV Plan (CHP)** to be sure they receive appropriate attention in decision making.

Policy 09.5203 **:** Priority Setting and Resource Allocations (PSRA) Framework and Process
Last Revised: *May 12, 2011; (XX, XX 2024)*

PROCEDURE(S):

1. The priority setting process should consider services needed to provide and/or support a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services. Funding availability and unmet needs associated with these service priorities are considered during the resource allocation process.

2. The list of HRSA fundable service categories (core and support) and the definitions of these services will be presented by the Commission staff.

3. The list of HIV prevention categories from the most recently approved Prevention Service Standards will be presented by the Commission staff.

4. DHSP compiles service utilization reports (including, but not limited to, clients served, priority populations, expenditures per client), anticipated service delivery goals/objectives, expenditures reports, surveillance reports, prevention data (including, but not limited to, counseling and testing and PrEP and PEP utilization),and programmatic and fiscal challenges and opportunities for service improvements.

4. The PP&A Committee convenes a combined meeting with the Consumer Caucus during the first quarter of the year to:
   a) review process paradigms and operating values and provide feedback;
   b) review summary of findings from the most recent Ryan White Service Utilization Reports and HIV prevention data provided by DHSP;
   c) review most recent HIV prevention and care financial reports from DHSP; and
   d) review key goals, objectives and metrics from the Comprehensive HIV Plan, Ending the HIV Epidemic Plan, and other key pertinent documents; and
   e) harness feedback on service category priorities and allocations from consumers.

5. The PP&A Committee formally organizes focus groups at various provider stakeholder meetings or conducts provider surveys as needed to inform the PSRA process.

6. During July-August, the PP&A Committee deliberates and prioritizes services categories in rank order (highest need is #1 priority). The principal data and information used for priority-setting are the Comprehensive HIV Plan, relevant needs assessment, the HIV epidemiology report, fiscal and programmatic reports, and service utilization reports.
   a) The PP&A Committee only ranks service priorities once—regardless of funding scenario—as they indicate the services most needed regardless of changes in the funding picture or in which different resources available.
   b) The PP&A Committee compiles and/or reviews the data and feedback it has collected from DHSP, community listening sessions and/or surveys and reviews it in June, prior to service prioritization.

Commented [BC2]: For PP&A and Consumer Caucus discussion. Intended to engage consumers more in the PSRA process and increase knowledge/skills around using data, understanding the RWP/CDC-funded programs.

7. During July-August after the service categories have been ranked and prioritized, the PP&A Committee determines resource allocations for services:
   a) Allocations can be made by actual amounts or percentages based on specific expenditure proposals, although percentages allow more flexibility to respond to variances in the funding awards.
   b) Allocations may change in each of the selected funding scenarios.
   c) It is strongly encouraged that stakeholders who suggest funding allocations for specific service categories also present accompanying recommendations to advise how the continuum of care will accommodate those suggested modifications to funding levels.
   d) Additional streams of funding are identified in each service category, with amounts locally dedicated for HIV services where the information is available.
   e) The PP&A Committee, in collaboration with DHSP, compiles a resource inventory for allocation-setting, and uses it to help determine capacity and other resources when allocating funds.

8. The PP&A Committee recommends and secures approval for service priorities and funding allocations at the August or September Commission meeting, prior to the RWP Part A grant application submission deadline.

9. When a reallocation of funds is necessary, adequate data to support the movement of funds between service categories will be presented, considered, and fully documented in the minutes of the meeting during which the reallocation of funds is approved. Proposed re-allocations must be submitted to the Commission for approval. All changes in allocations must be accompanied with a written justification detailing the reasons for the modifications.

10. During the month (30 days) following the approval of resource allocations by Commission, the PP&A Committee will consider appeals regarding its PSRA process. Appeals must be presented to the PP&A Committee at its monthly meeting immediately following the Commission meeting in which the allocations were adopted. The following two types of appeals will be considered:
    a) new factual information that may have led to different decisions if the information had been available during the PSRA process, and/or
    b) questions or complaints about decision-making that did not conform to the process as outlined.

11. In October-November, the PP&A Committee compiles information and suggestions made throughout the PSRA process to further elaborate on its priority and allocation decisions by developing “directives.”
    a) These “directives” are framed as “guidance”, “recommendations”, and/or “expectations” and are intended to detail “how best to meet the need” or as “other factors to be considered” to be forwarded to DHSP the Commission and/or its various committees, and/or other stakeholders, as appropriate.

b) The guidance, recommendations and expectations further define minimum quality of care standards, implementation practices and/or mechanisms to respond to specific operational or system needs.
c) Once completed and approved by the PP&A Committee, the directives are forwarded to the Executive Committee and the Commission for approval.
d) The approved directives are transmitted to DHSP for consideration and implementation if deemed to be feasible by DHSP. DHSP will review the directives and report to the PP&A Committee which recommendations are feasible with a timeline for implementation.
e) DHSP shall provide periodic updates at PP&A Committee meetings.

12. In addition to its other business, the PP&A Committee devotes the intervening months between each year's PSRA process to further study identified service categories, populations and/or related planning issues, and implements committee activities accordingly to compile the necessary data.

NOTED AND APPROVED: _____ **EFFECTIVE DATE:** _____

Original Approval: May 1, 2011 *Revision(s): XX*

Policy 09.5203 **:** Priority Setting and Resource Allocations (PSRA) Framework and Process
Last Revised: *May 12, 2011; (XX, XX 2024)*

ATTACHMENTS
Paradigms and Operating Values
Status Neutral HIV and STI Service Delivery System Framework

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATING VALUES
(Amended Draft - PP&A 04/20/2021)

PARADIGMS (Decision-Making)

- Equity: Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically. (1)
- ***Compassion: response to suffering of others that motivates a desire to help.*** (2)

OPERATING VALUES

- Efficiency: accomplishing the desired operational outcomes with the least use of resources
- Quality: the highest level of competence in the decision-making process
- Advocacy: addressing the asymmetrical power relationships of stakeholders in the process
- Representation: ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process
- Humility: Acknowledging that we do not know everything and ***willingness to listen carefully to others***. (3)

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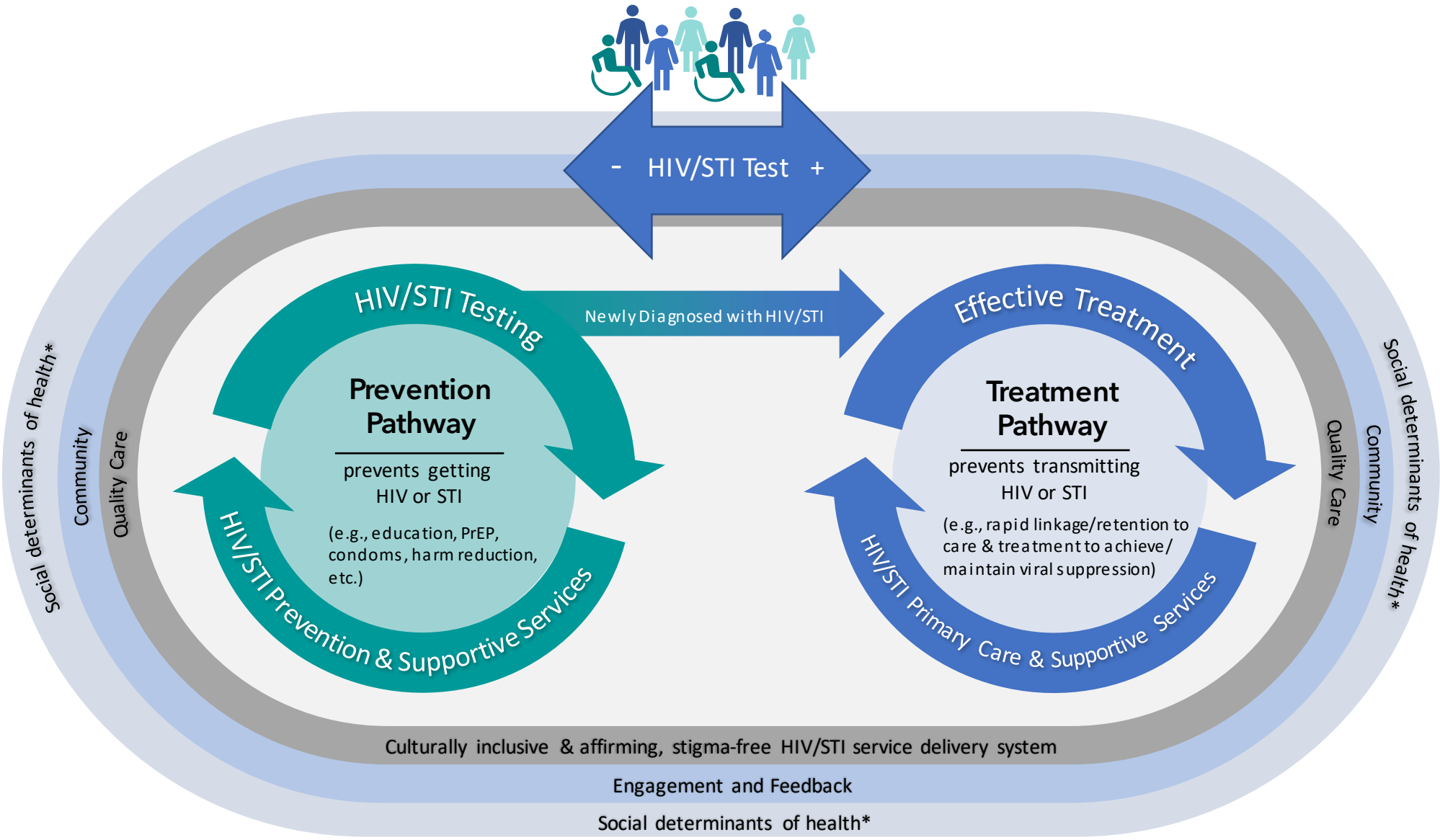
1 Based on the World Health Organization's (WHO) definition of equity.

2 Compassion moved to second position per April 20, 2021 committee meeting decision.

3 Wording change per April 20, 2021 committee meeting decision.

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 10/18/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

See Healthy People 2030 for more details on the social determinants of health.

LOS ANGELES COUNTY
COMMISSION ON HIV

List of Prevention Services from Prevention Services Standards (Draft/Proposed Updates as of 12/5/23)

1. HIV Testing
2. Testing and Treatment of STIs
3. Treatment as Prevention for PLWH
4. PrEP and PEP
5. Doxy PEP
6. Partner Services
7. Harm Reduction (drugs, alcohol use, and sexual activity)
    a. Narcan/Naloxone
    b. Fentanyl test strips and other substance testing kits
    c. Syringe Services Programs
    d. Peer Support
    e. Contingency management
    f. Mobile/Street Medicine
    g. Medication Assisted Treatment
8. Education/Counseling
9. Supportive Services
    a. syringe exchange
    b. housing services
    c. mental health services
    d. substance abuse services
    e. food and nutrition support
    f. employment services
    g. unemployment financial assistance
    h. drug assistance programs
    i. health insurance navigation
    j. childcare
    k. legal assistance
    l. other services, as identified and needed
    m. health literacy education
    n. peer support
10. Social Marketing and Outreach

11. Navigation Services

LOS ANGELES COUNTY
COMMISSION ON HIV

2024 TRAINING SCHEDULE

SUBJECT TO CHANGE

- "*" Asterisk denotes mandatory training for all commissioners.
- All trainings are open to the public.
- Click on the training topic to register.
- Certifications of Completion will be provided.
- All trainings are virtual.

Co-Chair Roles and Responsibilities	February 13, 2024 4:00-5:00PM
General Orientation and Commission on HIV Overview *	March 26, 2024 3:00-4:30PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 23, 2024 3:00-4:30PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 17, 2024 3:00-4:30PM
Policy Priorities and Legislative Docket Development Process	October 2, 2024 3:00-4:30PM

LOS ANGELES COUNTY
COMMISSION ON HIV

WOMEN'S CAUCUS

Join us for our quarterly virtual meetings where we dive deep into topics that impact, empower, and uplift women living with HIV in Los Angeles County!

MEETING DATES & TIME

- January 22, 2024 @ 2pm-4pm
- April 15, 2024 @ 2pm-4pm
- July 15, 2024 @ 2pm-4pm
- October 21, 2024 @ 2pm-4pm

All meetings are held virtually via Webex.

For more information visit: https://hiv.lacounty.gov/meetings

DHSP Solicitations Priorities 2024

I. Active solicitations:

1. **Case Management - Home-Based Services WOS**

2. **Community Engagement – Clinical Provider Trainings & Health Fairs Services WOS**

II. Upcoming Solicitations (List by Priority, estimated release dates)

1. **Administrative Auditing Services** – release Feb. 24

2. **Prevention Services** – release Aug/Sep. 2024
   Category #1 - HIV Testing Services
   Category #2 – Biomedical Services
      a. PrEP Services
      b. PEP Services
      c. Navigation Services
   Category #3 - Vulnerable Populations Services
   Category #4 - STD Screening, Diagnosis and Treatment Services

3. **Nutrition Support Services** – release Oct. 2024

4. **Transportation Services** – release Oct. 2024

5. **Ambulatory Outpatient Medical Services (AOM)** – release Nov. 2024
   Category #1 – AOM Services
   Category #2 – MAX Clinic Services

6. **Medical Care Coordination Services (MCC)** – release Nov. 2024

7. **Residential Care Services** – release Nov. 2024
   Category #1 - Residential Care Facilities for Chronically Ill

   Category #2 - Transitional Residential Care Facilities

   Category #3 - SUD Transitional Housing

8. **Non-Medical Case Management – Benefits Specialty Services** – Nov. 2024

9. **Psychosocial Support/Peer Support Services** – release TBD

10. **Clinical Quality Management Services** – release TBD

Prevention Focused Planning:

Priority Populations

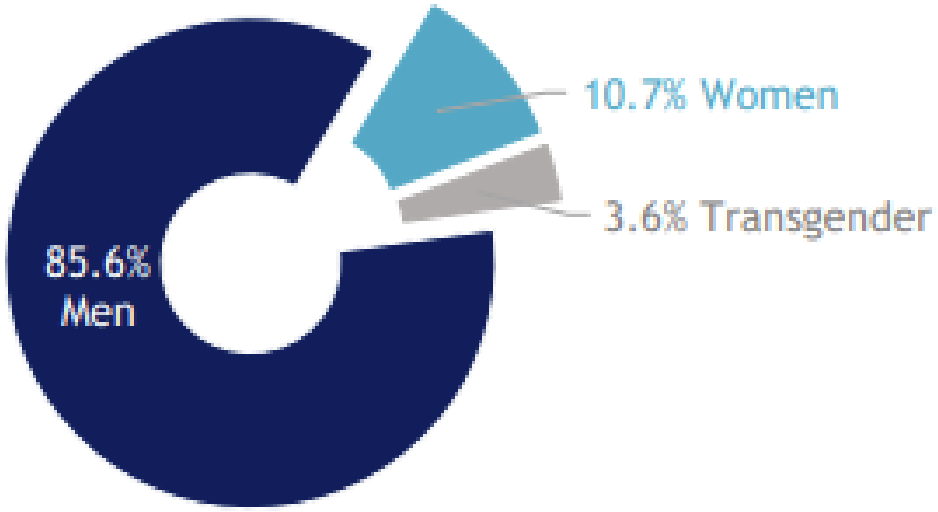
Planning, Priorities, and Allocations Committee
April 16, 2024

LOS ANGELES COUNTY
COMMISSION ON HIV

Purpose:

- Review examples of prevention data as related to priority populations, as requested
  - Black/African American & Latinx MSM
  - Transgender persons
  - Cisgender women of color
  - People who inject drugs
  - People under the age of 30
  - PLWH 50 years of age or older
- Identify needed prevention strategies – What does high-impact HIV/STD prevention look like?

New HIV diagnoses by gender among persons aged ≥ 13 years, Los Angeles County 2021

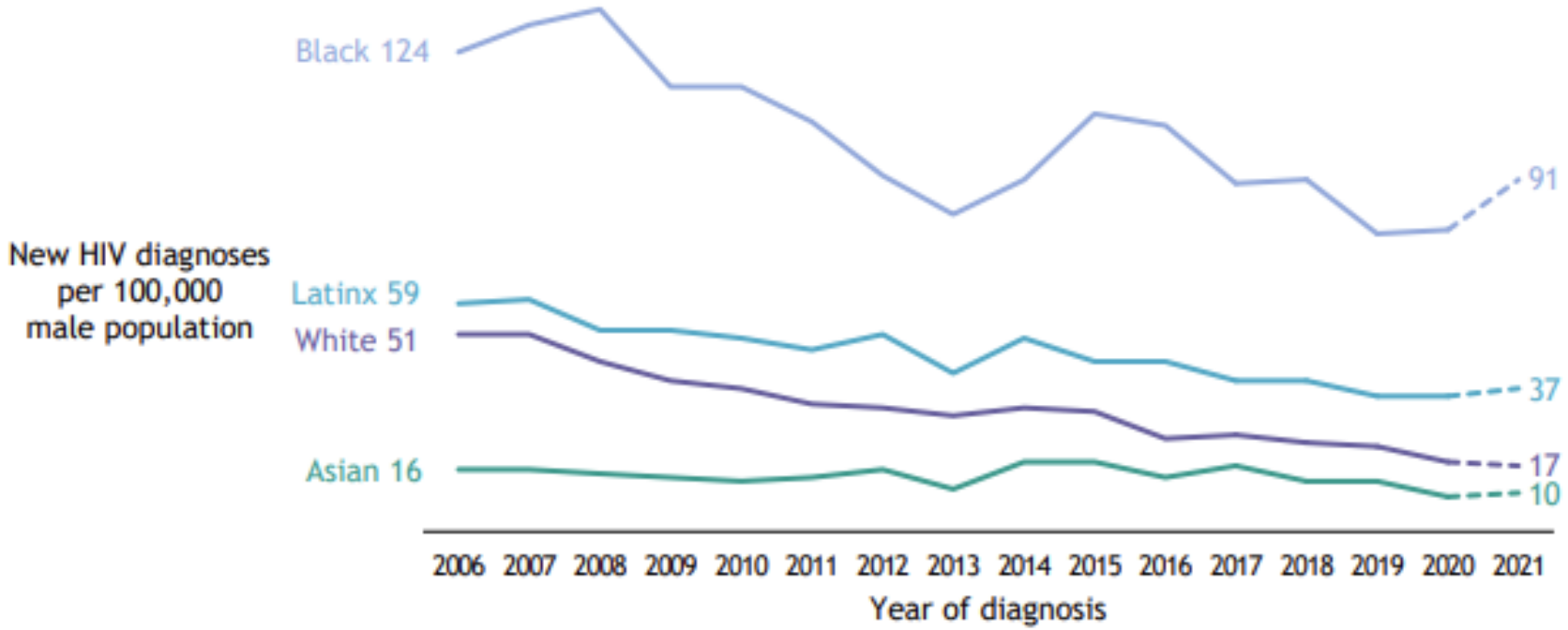


Note: Among the 56 transgender persons newly diagnosed with HIV in 2021, most identified as transgender women. Since transgender reporting relies on accurate gender classification from laboratories and health care providers it is likely to be underreported.

Men made up most of the new HIV diagnoses in 2021 (N=1,300, 85.6%). Women (N=162, 10.7%) and transgender persons (N=56, 3.6%) represented a much lower number and percentage of new HIV diagnoses in 2021.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

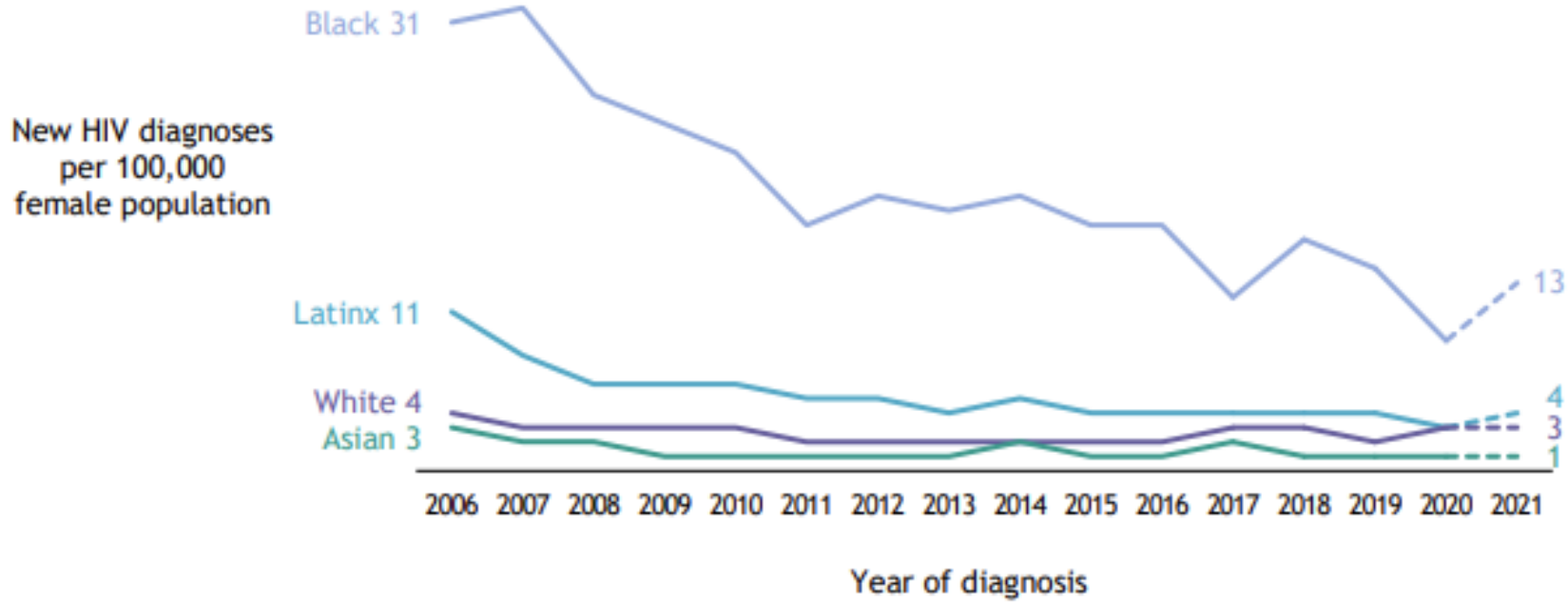
HIV diagnoses rates among males aged ≥ 13 years by race/ethnicity, Los Angeles County 2006-2021



Between 2006 to 2013, HIV diagnoses rates declined for males across all race/ethnicity groups. After 2013, HIV diagnoses rates increased among Black, Latinx, and Asian males, and after 2015, rates declined in these groups. Black persons have higher HIV diagnoses rates compared with other race/ethnicity groups, though the difference has been narrowing.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

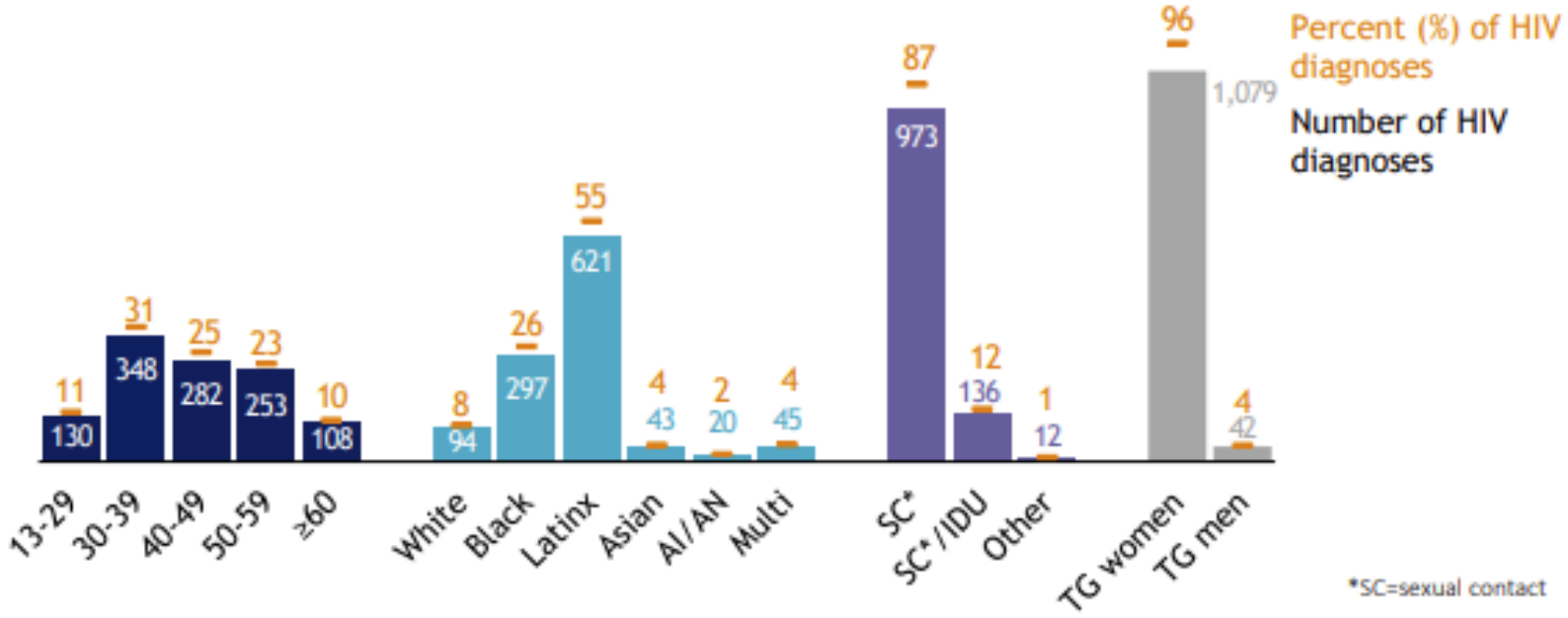
HIV diagnoses rates among females aged ≥ 13 years by race/ethnicity, Los Angeles County 2006-2021



Between 2006 to 2021, HIV diagnoses rates declined in all racial/ethnic groups. Although rates have declined by 58% among Black females their rates remain the highest compared with other racial/ethnic groups.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Transgender people living with diagnosed HIV infection aged ≥ 13 years by age group, race/ethnicity and transmission category, Los Angeles County 2022

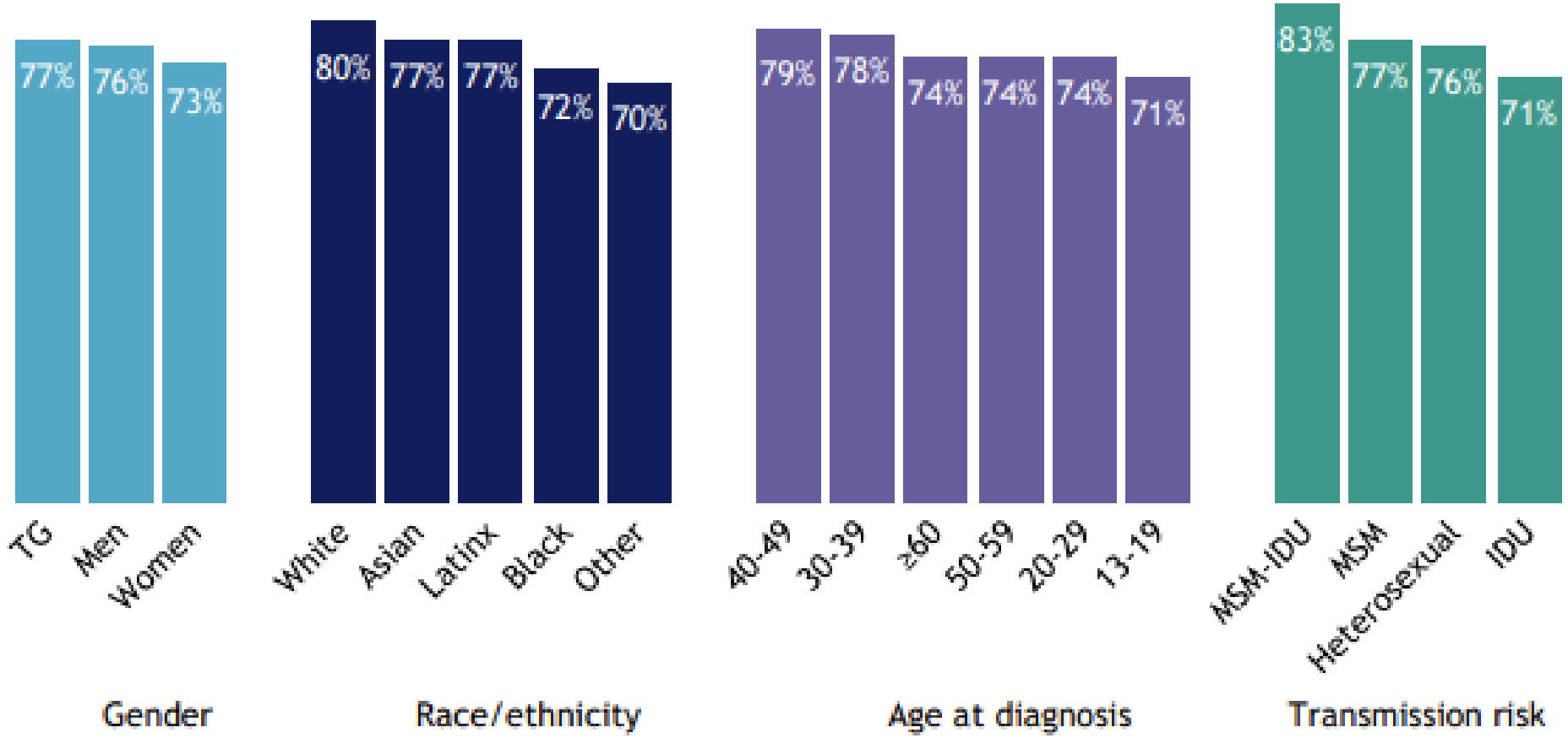


Among PLWDH in LAC at year-end 2022 who identified as transgender at the time of diagnosis, most identify as trans women (96%, n=1,079), Latinx (55%, n=621), were aged 30-49 years (56%, n=630), and had a likely transmission of sexual contact (87%, n=973).

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

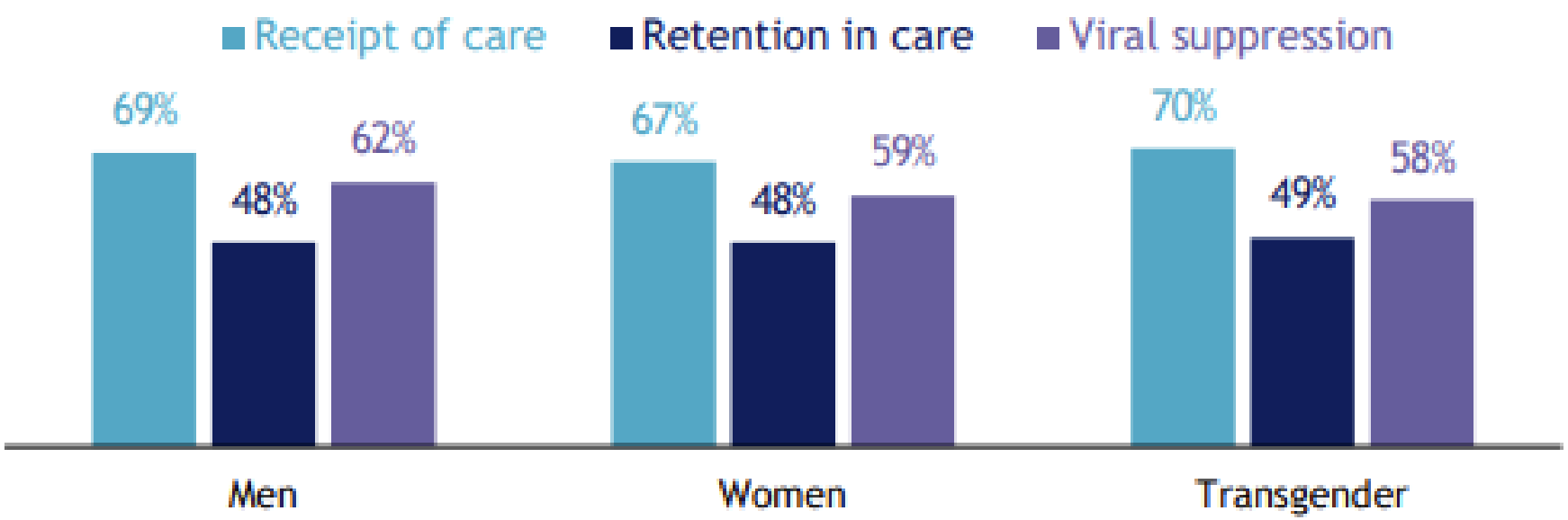
Treatment As Prevention

Persons aged ≥ 13 years newly diagnosed with HIV and linked to care within 1 month of diagnosis by select demographic and risk characteristics, Los Angeles County 2021



Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

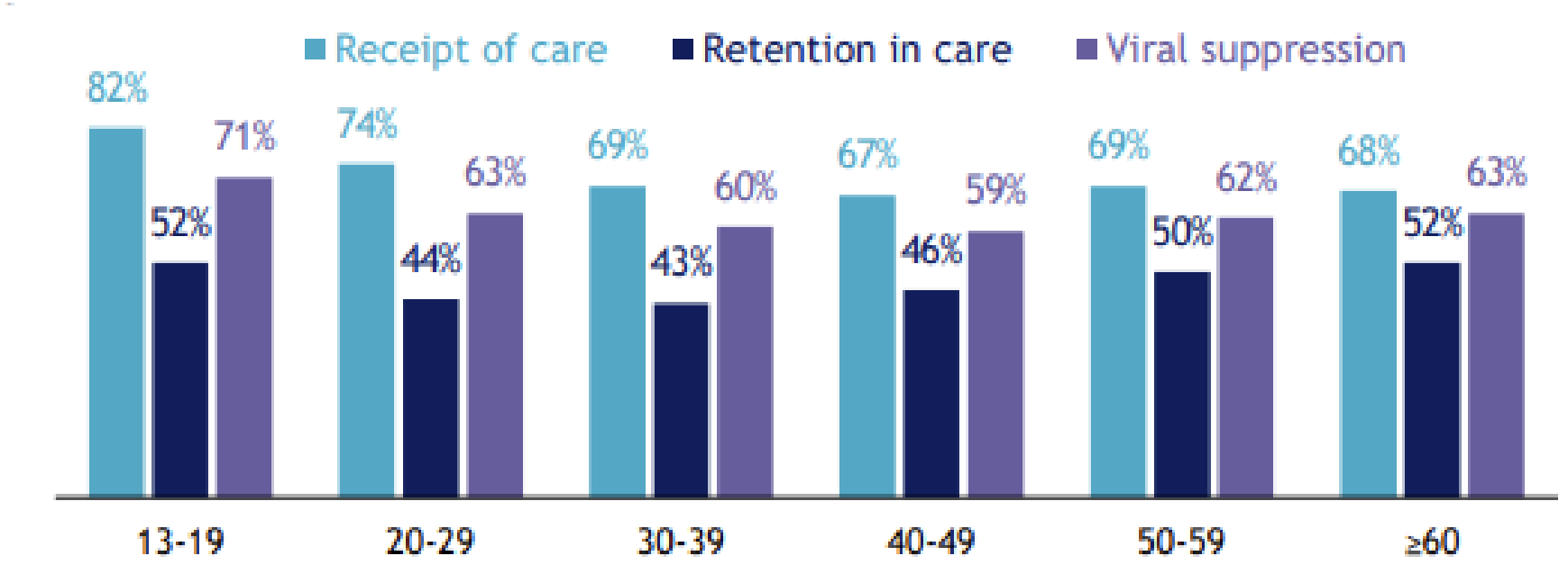
Receipt of care, retention in care, and viral suppression by gender among PLWDH aged ≥ 13 years diagnosed through 2021 and living in LAC at year end 2022, Los Angeles County 2022



Change since last surveillance report: Receipt of care and viral suppression increased among men and transgender persons, while retention in care declined among women.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

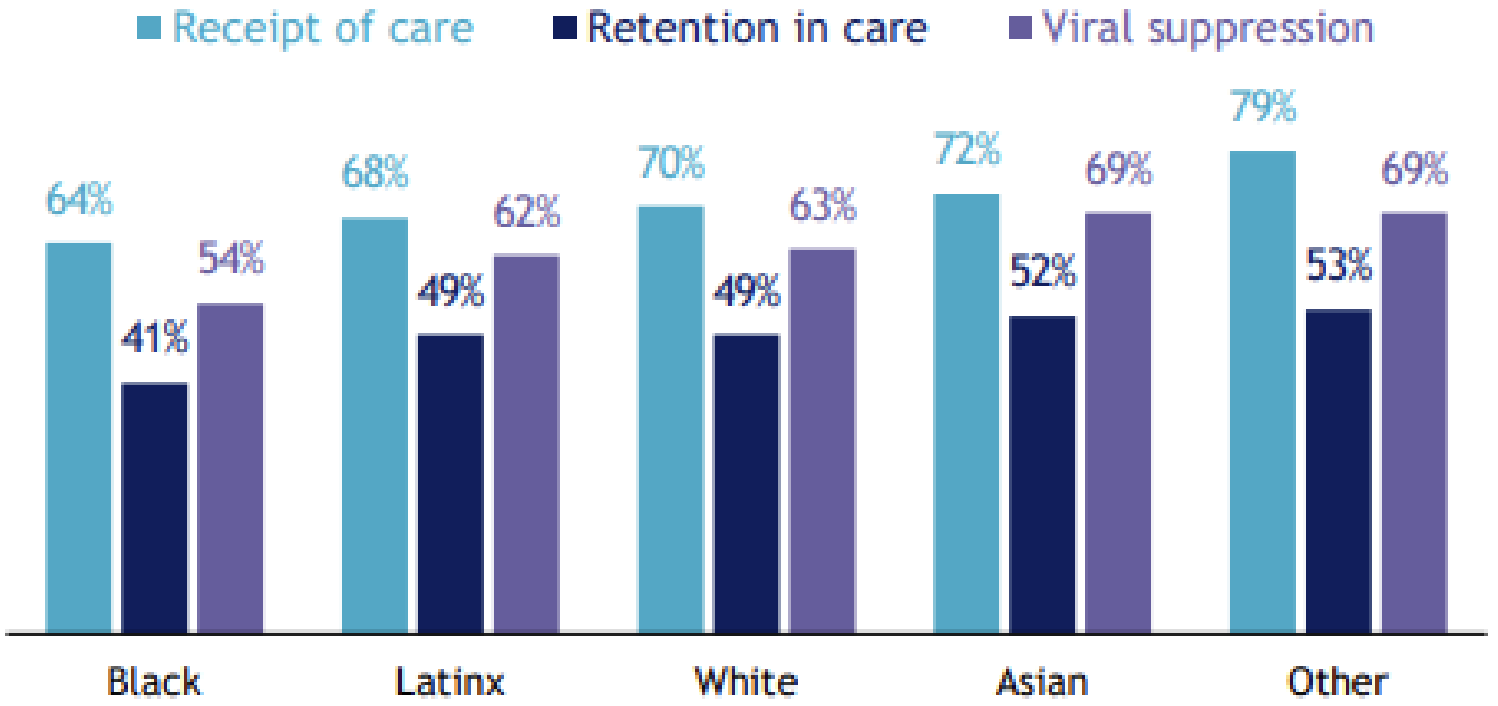
Receipt of care, retention in care, and viral suppression by age group among PLWDH aged ≥ 13 years diagnosed through 2021 and living in LAC at year end 2022, Los Angeles County 2022



Change since last surveillance report: Receipt of care, retention in care, and viral suppression decreased among adolescents, increased among seniors, and remained relatively stable for the rest.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Receipt of care, retention in care, and viral suppression by race/ethnicity among PLWDH aged ≥ 13 years diagnosed through 2021 and living in LAC at year end 2022, Los Angeles County 2022



Changes since last surveillance report: Receipt of care, retention in care, and viral suppression remained stable or increased slightly across race/ethnicity groups.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

HIV Bio-behavioral Surveillance

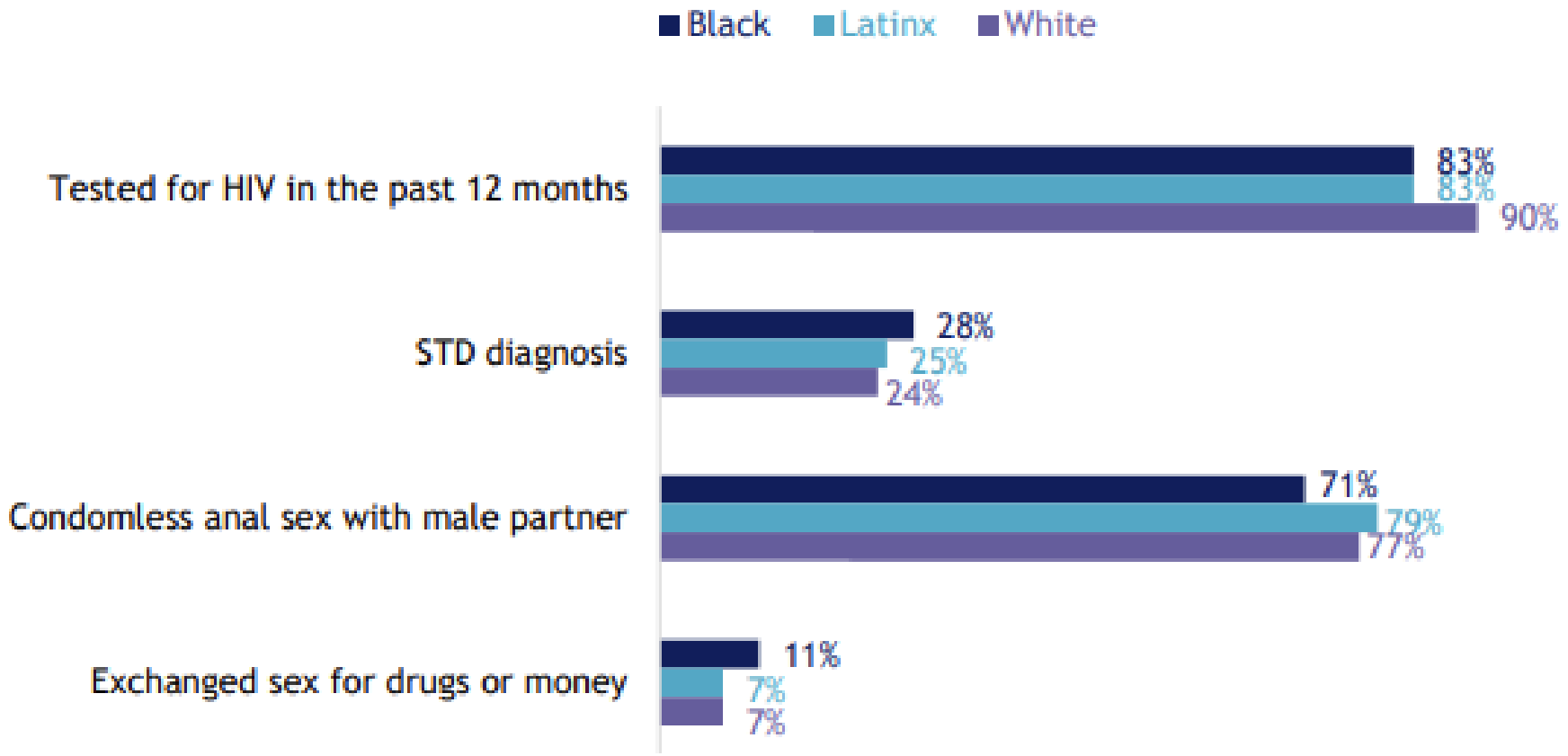
Bio-behavioral surveys help us understand factors that may be associated with behavioral and clinical outcomes in vulnerable populations at increased risk for HIV or living with HIV.

- National HIV Biobehavioral Surveillance (NHBS)
- Medical Monitoring Project (MMP)

Data in this section provide the best estimates available for the populations presented.

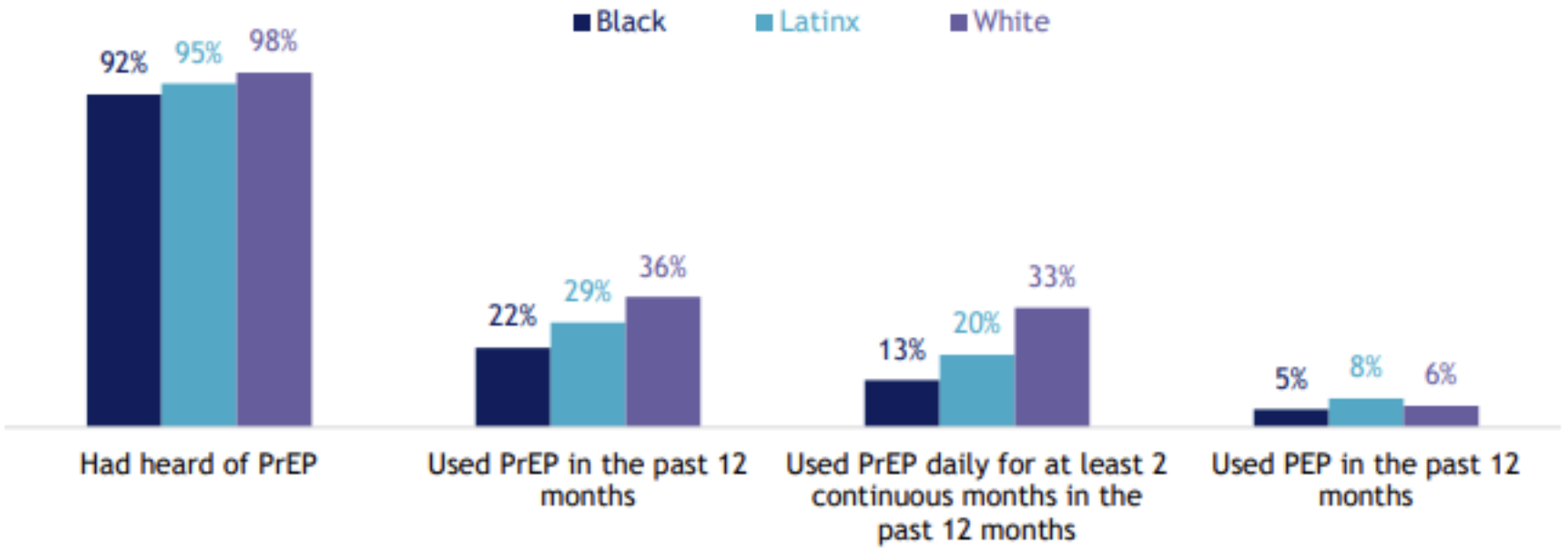
- Estimates (not true values)
- Generalizations should be made with caution

HIV testing behavior, STD diagnosis, and sexual behavior among NHBS-MSM participants by race/ethnicity, Los Angeles County 2017



Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

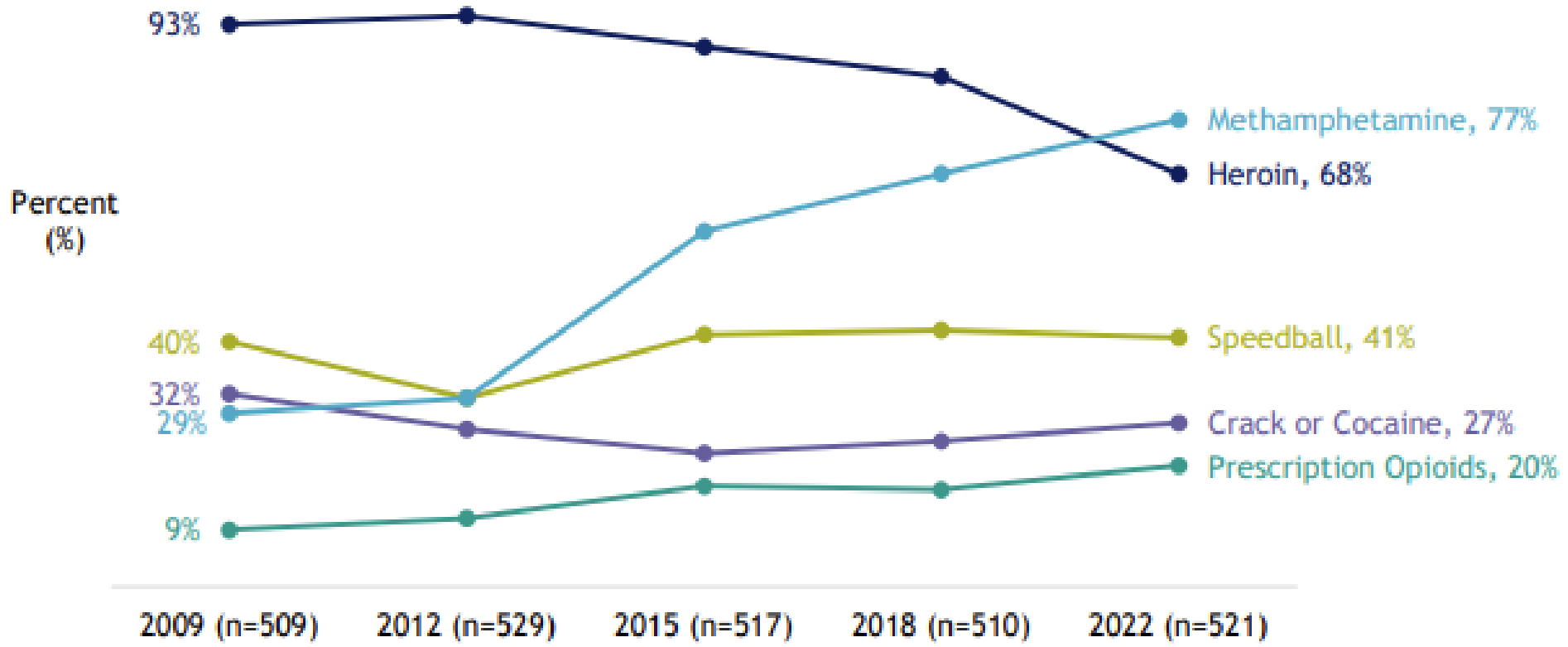
PrEP and PEP among NHBS-MSM participants by race/ethnicity , Los Angeles County 2017



In 2017, knowledge of PrEP was high (≥92%) among MSM irrespective of race/ethnicity. Among participants who reported HIV-negative or unknown HIV status, 36% of White MSM had used PrEP within the past 12 months compared with 22% of Black MSM and 29% of Latinx MSM. Within the past 12 months, compared with Black and Latinx MSM, White MSM were more likely to have used PrEP consistently for 2 or more continuous months. More recent LAC data suggests appreciable increases in PrEP use since this 2017 survey was conducted.

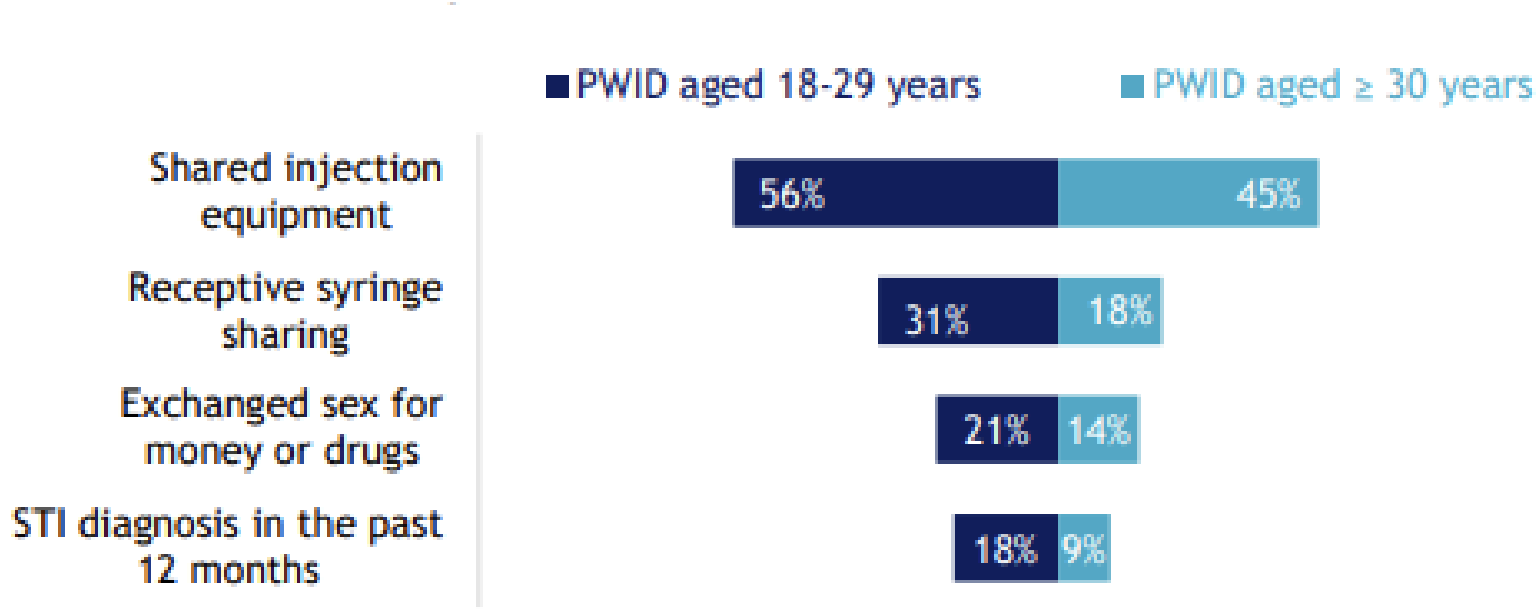
Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Drugs injected in the past 12 months among NHBS-PWID participants, Los Angeles County 2009-2022



Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

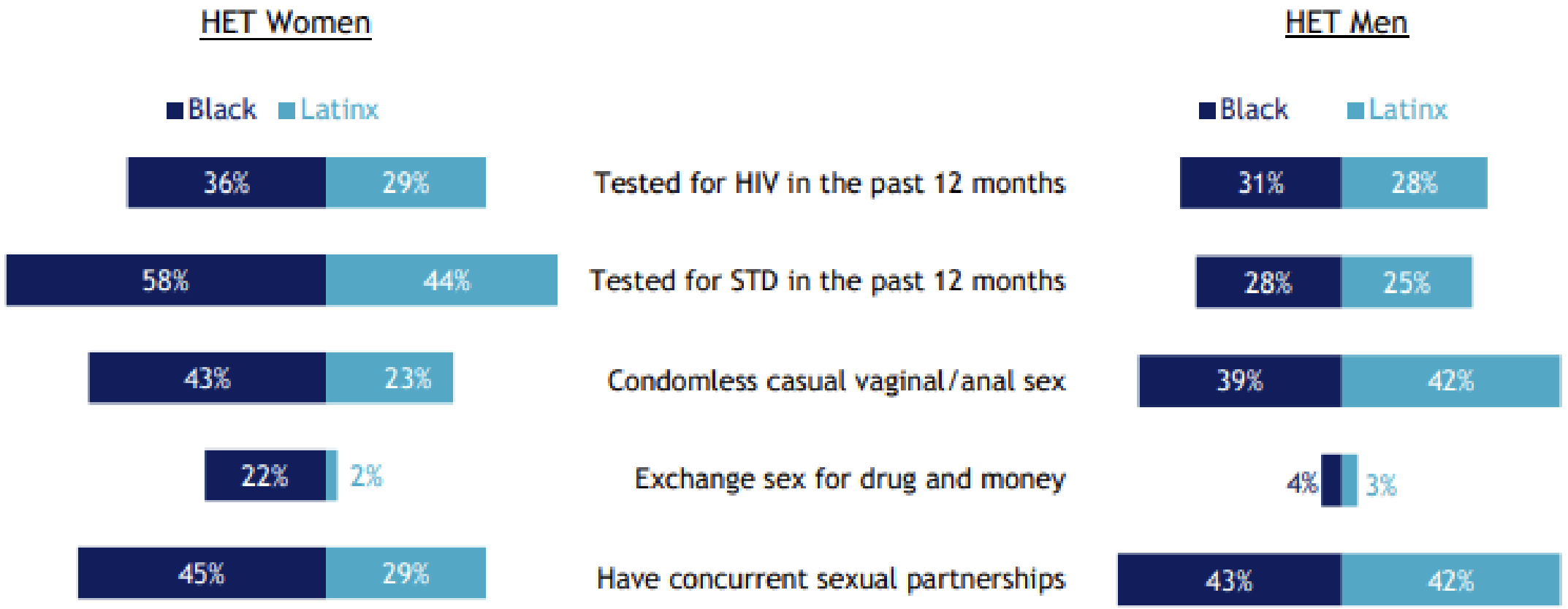
Injection drug use behavior and recent sexual behavior among NHBS-PWID participants by age group, Los Angeles County 2022



Note: In total, 19% of participants reported using a syringe that had been previously used by someone else. Syringe sharing was more common among Young PWID. Sharing syringes puts PWID at high risk for HIV and other infections.

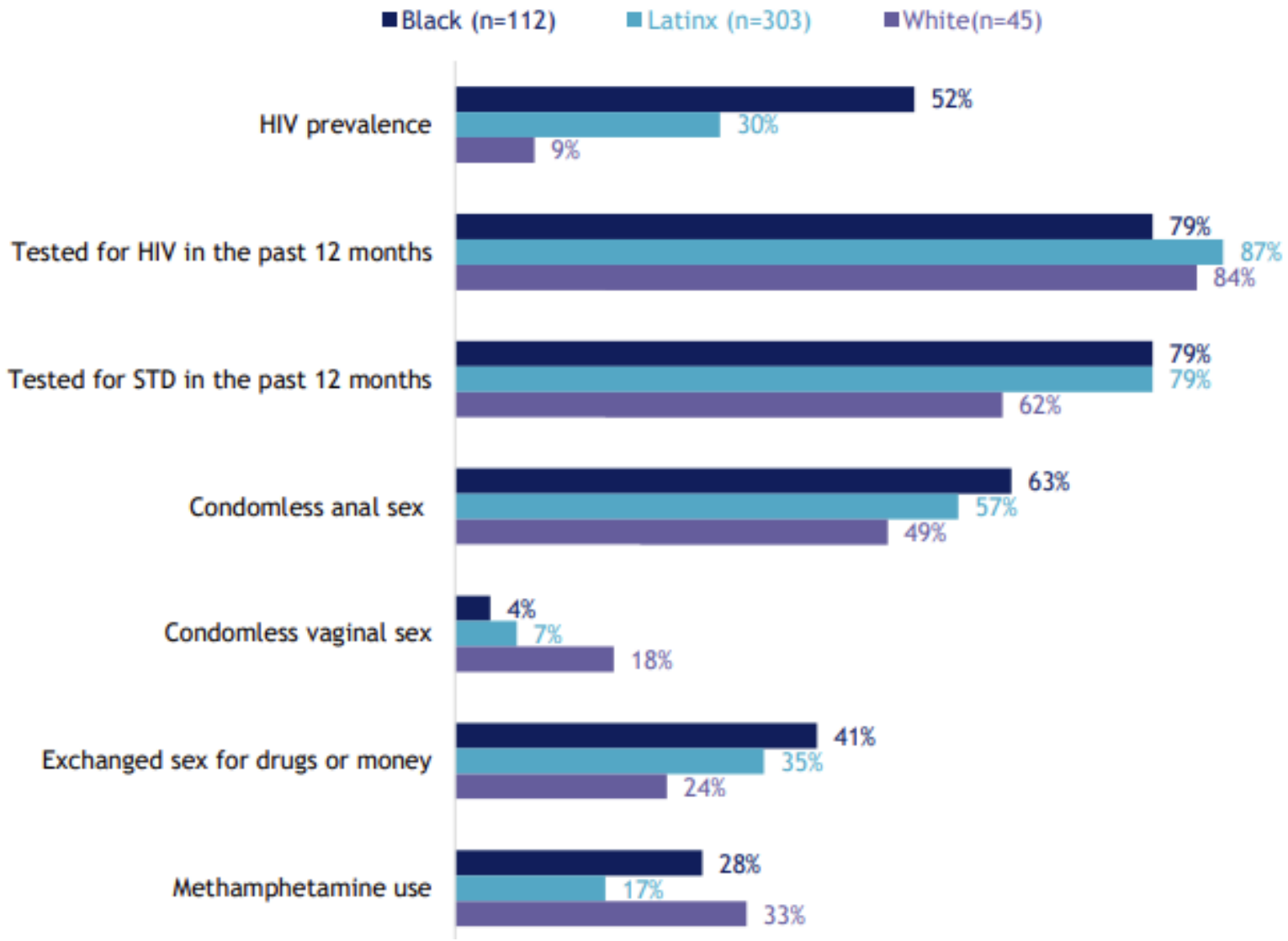
Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Testing and sexual behavior among NHBS heterosexuals at increased risk of HIV (HET) by sex and race/ethnicity, Los Angeles County 2019



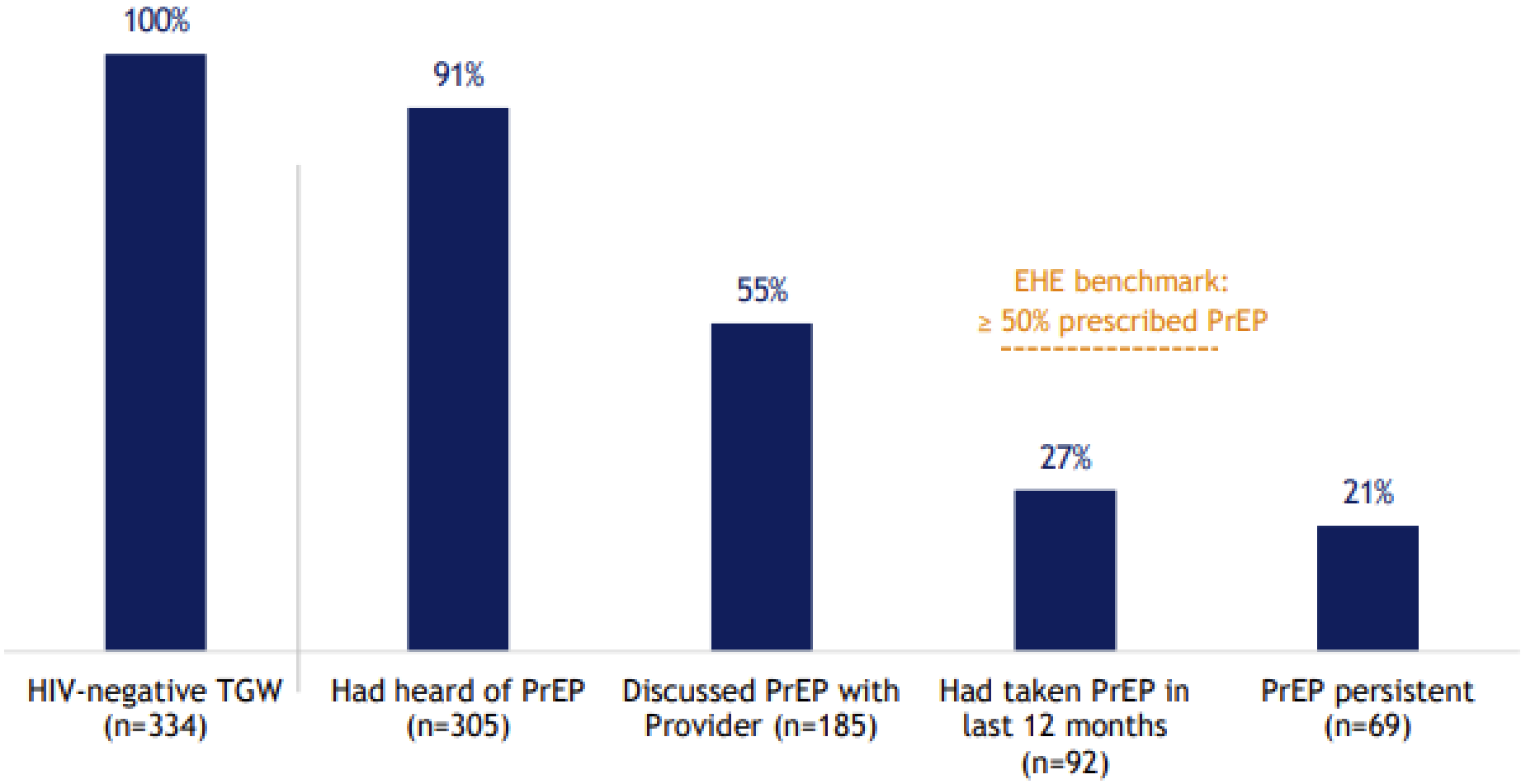
Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

HIV prevalence, HIV/STD testing behavior, sexual behavior, and drug use among NHBS-Transgender Women (TGW) by race/ethnicity, Los Angeles County 2019



Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

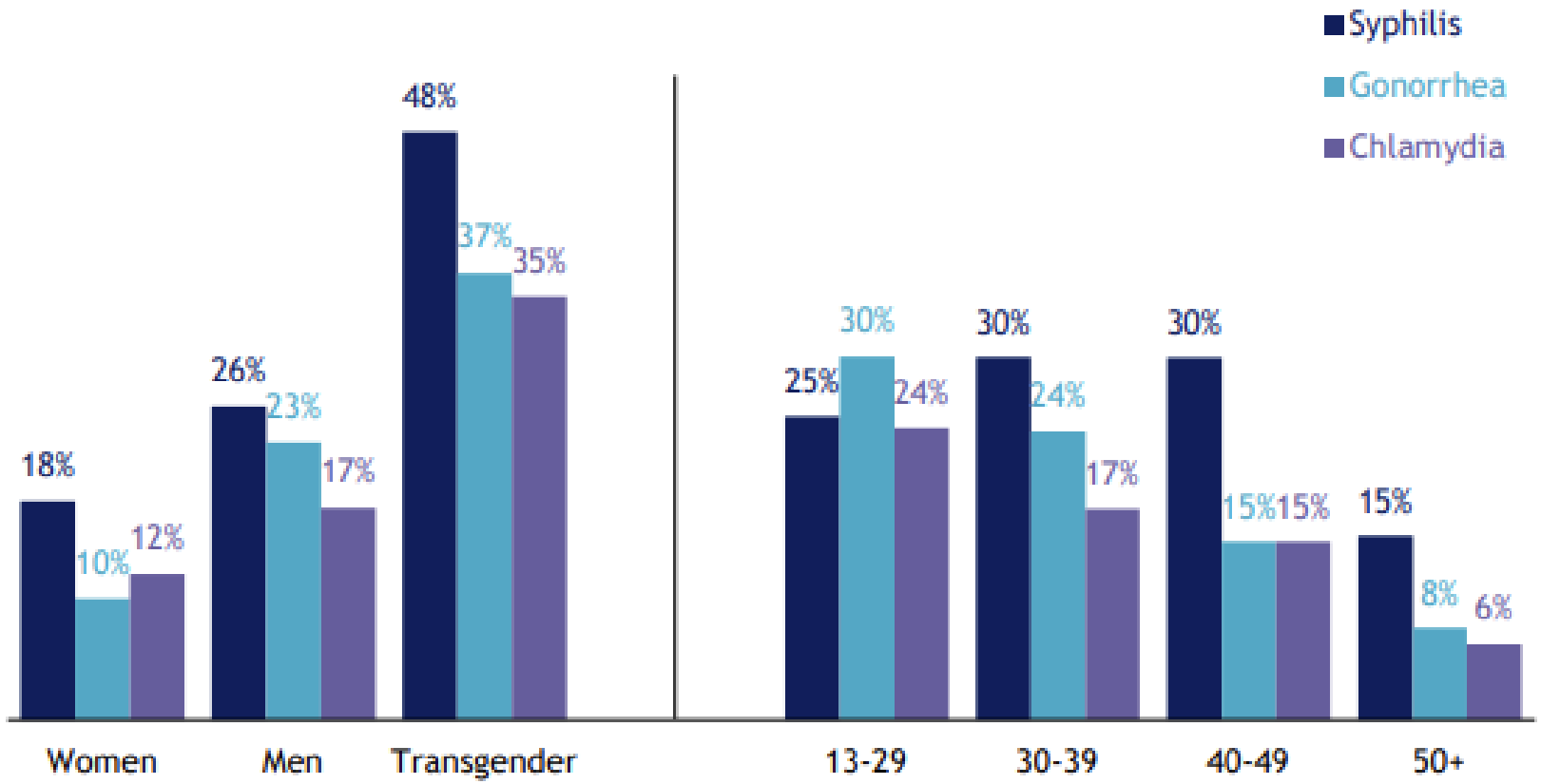
PrEP cascade among NHBS-Transgender Women (TGW), Los Angeles County 2019



Source: : Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

HIV & STD Diagnoses

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, and/or chlamydia in the same calendar year as HIV diagnosis, Los Angeles County (excluding Long Beach and Pasadena) 2012-2021



Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Discussion

What does high-impact HIV/STD prevention look like?

Prevention Standards

- HIV Testing
- Testing and Treatment of STIs
- Treatment as Prevention for PLWH
- PrEP and PEP
- Doxy PEP
- Partner Services
- Harm Reduction (drugs, alcohol use, and sexual activity)
- Education/Counseling
- Supportive Services
- Social Marketing and Outreach
- Navigation Services

Thank you