LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS *SPECIAL* COMMITTEE MEETING

Tuesday, July 16, 2024
1:00pm – 4:00pm (PST)

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020
**As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.*

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

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You may provide public comment in person, or alternatively, you may provide written public comment by:

- Emailing hivcomm@lachiv.org **indicate your name and corresponding agenda item*
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

**All public comments will be made part of the official record.*

Accommodations

Requests for a translator, reasonable modification, or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act, are available free of charge with at least 72 hours' notice before the meeting date by contacting the Commission office at hivcomm@lachiv.org or 213.738.2816.

Scan QR code to download an electronic copy of the meeting packet. Hard copies of materials will not be available in alignment with the County's green initiative to recycle and reduce waste. If meeting packet is not yet available, check back prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.

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, JULY 16, 2024 | 1:00 PM – 4:00 PM

****PLEASE NOTE EXTENDED TIME*****

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/r34722b868d3c1b35c2db908f7d9c645b
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2532 469 9483

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

AGENDA POSTED: July 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 – 1:40 PM
    a. HRSA Dear Colleague Letter – Housing Security Deposit

b. Priority Setting and Resource Allocation (PSRA) Refresher

8. Co-Chair Report 1:40 PM – 1:45 PM
   a. Priority Setting and Resource Allocation Training Reminder
   b. August 27, 2024 PP&A Committee Meeting

9. Division of HIV and STD Programs (DHSP) Report 1:45 PM – 2:15 PM
   a. Ryan White Program Year 33 Expenditure Report
   b. Approval of Ryan White Program Year 34 Allocations **MOTION #3**

BREAK 2:15 PM – 2:25 PM

V. DISCUSSION ITEMS – PREPARATION FOR FY 2025 RWHAP PART A NOTICE OF FUNDING OPPORTUNITY 2:25 PM—3:50 PM

10. Review Paradigms and Operating Values
11. Review Utilization Reports
12. Rank Ryan White Program Service Categories

VI. NEXT STEPS 3:50 PM – 3:55 PM

13. Task/Assignments Recap
14. Agenda Development for the Next Meeting
    a. Brief Review of Utilization Reports
    b. Allocate Ryan White Program Funds

VII. ANNOUNCEMENTS 3:55 PM – 4:00 PM

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

VIII. ADJOURNMENT 4:00 PM

16. Adjournment for the meeting of July 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.
MOTION #3	Approve the Ryan White Program Year 34 Allocations, 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 6/26/24

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
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
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
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA*	**Rita**	Translatin@ Coalition	Vulnerable Populations (Trans)
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
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
MUHONEN	**Matthew**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts

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
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
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
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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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
June 18, 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	Matthew Muhonen	LOA
Al Ballesteros, MBA	A	Derek Murray	P
Lilieth Conolly	EA	Daryl Russell	P
Rita Garcia	A	Harold Glenn San Agustin, MD	P
Joseph Green	P	LaShonda Spencer, MD	P
Michael Green, PhD, MHSA	A	Lambert Talley	P
William King, MD, JD	P	Jonathan Weedman	A
COMMISSION STAFF AND CONSULTANTS			
Dawn McClendon, Lizette Martinez			
DHSP STAFF			
N/A			

*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, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:05pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

K. Donnelly conducted roll call vote and committee members were reminded to state their conflicts.

ROLL CALL (PRESENT): J. Green, W. King, M. Martinez, D. Murray, D. Russel, H. San Agustin, L. Spencer, L. Talley, 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.**

   J. Green noted that the Commission on HIV (COH) does not currently have a Memorandum of Understanding (MOU) with the Division of HIV and STD Programs (DHSP) and that the Executive Committee will be working towards establishing one. Additionally, he noted that the COH needs to do a better job at working as an integrated prevention and care body. The Executive Committee will be looking at efforts to effectively incorporate prevention in COH business.

   - *It was noted that the previous prevention focused committee, carried the same level of authority as the RWP Planning Council, the COH, on determining service priorities and resource allocation and providing feedback to DHSP. The COH currently does not have this authority and lack of access to prevention data are structural barriers to full prevention integration.*

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **HRSA Technical Assistance Site Visit**
      - Commission staff, L. Martinez, reminded the group that the May Planning, Priorities, and Allocations (PP&A) Committee meeting was cancelled to accommodate staff participation in the Health Resources and Services Administration (HRSA) Technical Assistance Site Visit.
      - It was noted that the site visit included presentations that outlined COH roles and responsibilities (and delineated recipient roles and responsibilities) as well as recommendations to streamline COH practices and policies. It is important to note that these recommendations were not presented as corrective action items but rather opportunities for improvement.
      - It was noted that the HRSA staff conducting the site visit were hired to provide direct technical assistance to planning councils.
      - Commission staff and COH leadership will meet to debrief and will develop action items. A

summary of preliminary, high level action items can be found in the meeting packet.

- HRSA will submit an official report to the COH within 45 business days and the report will be shared once received.

b. HRSA Dear Colleague Letter – Expungement Services

- L. Martinez reported that HRSA released a Dear Colleague Letter explaining that Ryan White Program (RWP) funds can be used for expungement services under legal services. See meeting packet for more details.

c. PSRA Consumer Survey Summary

L. Martinez provided an overview of the PSRA Consumer Survey results. The survey was conducted to help the committee understand consumer perspectives on needed services. Consumers were asked to rate their top 10 priorities (1 = highest priority, 10 = lowest priority) for RWP HIV care services as well as their top 10 HIV and STI prevention services. Additionally, survey responses also include recommendations for resource allocation to specific service categories. See meeting packet for further details.

- Survey results indicate service categories that were most voted for, and parallel top HIV care priorities raised by consumers at various Commission meetings including Housing Services, Psychosocial Support Services, and Emergency Financial Assistance.
- Some consumers noted difficulties in completing the survey due to long list format and the concept of allocating funding. Staff noted it was challenging to present the long list of service categories in a condensed format for respondents to review. Efforts will be made to simplify the survey in the future.

8. Co-Chair Report

a. New Member Introduction – Rita Garcia

- K. Donnelly welcomed new committee member Rita Garcia. He also noted that Dechelle Richardson was recently elected to the Executive Committee as an at-large member and has been moved to the Operations Committee.

b. Approval of Status Neutral Priority Setting and Resource Allocation (PSRA) Draft Framework MOTION #3

- Commission staff provided an overview of the changes. K. Donnelly report that the Status Neutral Priority Setting and Resource Allocation (PSRA) Framework was revised based on feedback received from HRSA during the technical assistance site visit.
- Previous language to include restrictions on voting rights for providers and non-RWP consumers who had a conflict of interest was removed. Any Commissioner with a conflict of interest must declare their conflicts prior to voting on services as presented as a slate. Additionally, language regarding engagement with the Consumer Caucus prior to the priority setting and resource allocation process was simplified per recommendations.
- Staff also noted the inclusion of the requirement for all Commissioners (and PP&A

Committee-only members) to complete the annual Priority Setting and Resource Allocation training to be eligible to vote on priorities and resource allocations. It was noted that the annual training typically takes place in March or April and is approximately and hour to an hour and a half. Commissioners who are unable to attend the live training must view a recording of the training (found on the Commission website under Trainings) and self-report to Commission staff, Sonja Wright, once completed. Commissioners who have not completed the training by the September full body COH meeting, when the priorities and allocations as set to be voted on by all Commissioners, will not be eligible to vote.

- **Motion #3:** Approve the Status Neutral Priority Setting and Resource Allocation (PSRA) Framework, as presented or revised and elevate to the Executive Committee. **(✓Passed; Yes=9: W. King, M. Martinez, D. Murray, D. Russell, G. San Agustin, L. Spencer, K. Donnelly, F. Gonzalez, J. Green; No = 0; Abstain = 0).**

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

a. Programmatic and Fiscal Updates

- There were no programmatic or fiscal updates. An expenditure report for program year (PY) 33 will be provided at the July PP&A Committee meeting.

V. DISCUSSION

10. Linkage and Reengagement Program Recap and Questions

- K. Donnelly opened the discussion by reminding the group that DHSP provided a presentation on the Linkage and Reengagement Program (LRP) at the last full body COH meeting on June 13th.
- K. Donnelly noted that the LRP presentation was incomplete and did not include standard utilization data. He requested DHSP report back to the Committee on the number of participants serves in the last year and the cost per service unit.
- G. San Agustin noted his agency has a lot of experience with the program and makes frequent referrals for clients who are out of care to DHSP LRP staff for follow up. He noted that there are a lot of clients who are out of care.
- L. Spencer noted that the program is very expensive but well worth the expenses as it often takes a lot of time and resources and a big commitment from DHSP staff. She noted that her clinic has staff that works to locate clients who are out of care but does not have the resources to fully fund a robust program and will refer clients to DHSP if they are unable to locate and engage clients. She noted that there are similar interventions on the Target HIV website that clinics can use to implement that their site, but they would need to write grants to secure funding for these types of interventions.
- J. Green recommended the use of buddy or peer programs to encourage clients who are out of care to return to care. L. Spencer noted that a previous study showed that patient navigators have better outcomes in certain areas and peers had better outcomes in other areas. She noted that a program that combined the two may be beneficial.

11. Timeline of Priority Setting and Allocations and HRSA Notice of Funding Award

- Commission staff shared an outline of activities and meeting times for the Committee through October 2024. It outlined key priority setting and resource allocation activities for each meeting. See meeting packet for more details.
- The time frame for activities allows the Committee, and the Commission as a whole, to complete the priority setting and resource allocation process in preparation of the next grant cycle.
- It was noted that the August 20th meeting date conflicts with the Annual RWP Conference and that the meeting would need to be rescheduled to allow interested committee members to attend the conference (whether in person or virtually). The group identified August 13th or August 27th from 1pm to 4pm as potential meeting dates. The final date will be determined on room availability at the Vermont Corridor. Staff will work with building management to secure a room and will follow up with the Committee once a date has been solidified.
- J. Green asked if DHSP has reached out to the COH about reviewing the application. Commission staff noted that they typically reach out in August or September to identify any volunteers to help with the application. DHSP staff noted that the notice of funding opportunity has not been released but will share more information and work with Commission staff to ensure all application materials are gathered in alignment with deadlines. Historically, application deadlines have been due in the month of October.

VI. NEXT STEPS

12. Task/Assignments Recap

a. Commission staff will work with building management to secure a meeting room for the rescheduled August 20th meeting of either August 13th or August 27th. Staff will follow up with Committee members with a specific date once a room is secured.

b. Commission staff will submit a data request to DHSP regarding Linkage and Re-engagement Program Utilization data.

13. Agenda Development for the Next Meeting

a. FY23 Expenditures Report and Reallocation

b. Revisit Paradigms and Operating Values

c. Priority Setting and Resource Allocation Refresher

d. Prioritize Ryan White Program Services

VII. ANNOUNCEMENTS

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

- *There were no announcements.*

VIII. ADJOURNMENT

15. Adjournment for the Meeting of June 18, 2024.

The meeting was adjourned by K. Donnelly at 2:10pm.

HRSA
Health Resources & Services Administration
HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

June 26, 2024

Dear Ryan White HIV/AIDS Program Colleagues,

Access to safe, quality, affordable housing and the support necessary to maintain it constitutes one of the most basic and powerful social determinants of health. The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) is committed to addressing barriers to housing instability that can help improve health outcomes for people with HIV.[1] The 2022-2025 National HIV/AIDS Strategy (NHAS)[2] identified social and structural determinants of health that impede access to HIV services and exacerbate HIV-related disparities, which included inadequate housing, housing instability and homelessness.

HRSA Ryan White HIV/AIDS Program (RWHAP) funds can be used for a variety of support services to help people with HIV remain in HIV care, including housing, as described in *HRSA HAB Policy Clarification Notice #16-02 (PCN 16-02) Ryan White HIV/AIDS Program Services: Eligible Individual and Allowable Uses of Funds.*[3] RWHAP recipients and subrecipients have reported that the prohibition on payment of housing security deposits continues to be a barrier to getting clients into stable and permanent housing. A cash security deposit that is returned to a client violates the RWHAP statutory prohibition on providing cash payments to clients.[4]

To address this barrier, HRSA HAB is providing clarifying guidance regarding the use of RWHAP funds to cover housing security deposits for eligible clients. **RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client.**

HRSA HAB presents this guidance as an optional opportunity for recipients to offer this support within allowable legislative and programmatic parameters. It is not HRSA's intention to compel RWHAP recipients and subrecipients to provide this service. While HRSA HAB is providing guidance regarding the use of RWHAP funds to cover housing security deposits for eligible clients, please note that RWHAP recipients and subrecipients may use a variety of funding sources to pay for a RWHAP client's security deposits.[5]

[1] See Optimizing HUD-Assisted Housing Among People in Need of HIV Care and Prevention Services 2022 Technical Expert Panel Executive Summary at https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/hrsa-housing-tep-exec-summary.pdf.
[2] https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025.
[3] https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.
[4] Allowable uses of program funds are described in HRSA HAB PCN 16-02.
[5] Examples include: Ending the HIV Epidemic (EHE) funds; program income generated through the 340B program; braided funding; and non-RWHAP grant awards.

RWHAP recipients and subrecipients interested in using RWHAP funds to pay for a RWHAP client's security deposit must maintain policies and procedures that demonstrate programmatic and legislative compliance, including that there is no violation of RWHAP's prohibition on cash payment to the RWHAP client. The procedures should also include how return of less than the full security deposit will be addressed between the recipient and the client. RWHAP recipients and subrecipients must also track returned security deposits as a refund, to be used for program purposes, and to be expended prior to grant funds.

Please contact your HRSA HAB Project Officer if you have questions about using RWHAP funds for security deposit housing services.

HRSA HAB appreciates the tireless efforts of HIV community stakeholders working to improve health outcomes for people with HIV who are at risk for or are experiencing housing instability and homelessness.

Sincerely,

/Laura W. Cheever/

Laura Cheever, MD, ScM
Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration

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COMMISSION ON HIV

Steps in the Priority Setting and Resource Allocation Process
Ryan White Program Year – March 1 to February 28

1. Review core medical and support service categories, including HRSA service definitions

2. Review data/information from DHSP & COH Caucuses

3. Agree on how decisions will be made; what values will be used to drive the decision-making process

4. Rank services by priority
   Ranking DOES NOT equal level of allocation by percentage

5. Allocate funding sources to service categories by percentage
   Ryan White Program Part A and Minority AIDS Initiative (MAI)

6. Draft Directives: Provide instructions to DHSP on how best to meet the priorities
   Informed by COH Committees, Caucuses, Task Forces, data, PLWH & provider input

7. Reallocation of funds across service categories, as needed throughout funding cycle

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Ryan White Program Service Categories

Core Medical Services

- AIDS Drug Assistance Program (ADAP) Treatments
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services (aka Home-based Case Management)
- Home Health Care
- Hospice Services
- Medical Case Management, including Treatment Adherence Services (aka Medical Care Coordination)
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care

Supportive Services

- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management Services
- Other Professional Services
  - Legal Services
  - Permanency Planning
- Outreach Services
- Permanency Planning
- Psychosocial Support
- Referral for Healthcare and Support Services
- Rehabilitation
- Respite Care
- Substance Abuse (Residential)

Click here for more information on allowable use of funds.

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Ryan White Program Parts

Program Part	Recipient	Funding Purpose
Part A and Minority AIDS Initiative Funds* **(Locally managed by DHSP)**	**Eligible Metropolitan Areas (EMAs) & Transitional Grant Areas (TGAs)**	• **Provide medical (core) and support services to cities/counties most severely affected by HIV** • **Minority AIDS Initiative – Help RWHAP recipients improve access to HIV care and health outcomes for minorities**
Part B	All 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and six U.S. territories; states distribute money to counties	• Improve the quality of and access to HIV health care and support in the U.S. • Provide medications to low-income people with HIV through AIDS Drug Assistance Program (ADAP)
Part C	Local community-based groups (e.g., FQHCs, clinics, CBOs, FBOs, etc.)	• Provide outpatient ambulatory health service s and support for people with HIV • Help for community-based groups to strengthen their capacity to deliver high-quality HIV care
Part D	Local community-based organizations	• Provide medical care for low-income women, infants, children and youth with HIV • Offer support services for people with HIV and their family members
Part F	• AETCs & SPNS • Dental Programs	• AIDS Education and Training Center (AETC) Program – Provide training and technical assistance to providers treating patients with or at risk for HIV • Special Projects of National Significance (SPNS) – Develop innovative models of HIV care and treatment to respond to RWHAP client needs • Dental Programs – Provide oral health care for people with HIV and education about HIV for dental care providers

** Indicates RWP Parts that are allocated by the Commission on HIV/Planning Council.*

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2024 Priority Setting and Resource Allocation (PSRA) Timeline (DRAFT)

Revised 6/24/24

PP&A Meeting Agenda Priorities	DHSP Solicitation Priorities
June 18, 2024 1 - 3pm • Review Consumer PSRA Feedback Survey Responses • Review and approve Status Neutral PSRA Framework **July 16, 2024 1 - 4pm** • Review FY2023 Expenditures and reallocate funds, as needed • PSRA Review/Refresher Training • Review and select/approve Paradigms and Operating Values • Brief Review of Utilization Reports • Rank Ryan White Program Service Categories **August 27, 2024 1- 4pm** • Brief Review Utilization Reports • Allocate funds among Ryan White Program Service categories ***Service ranking and allocations will go to the full body at the Sept. COH meeting to align with HRSA NOFO*** **Sept. 17, 2024 1-4pm** • Revisit and review Key Takeaways (Executive Summary) Unmet Mental Health Needs Report (2022) • Review recommendations from Caucuses/Committees • Develop directives for DHSP	**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 **Nutrition Support Services – release Oct. 2024** **Transportation Services – release Oct. 2024** **Ambulatory Outpatient Medical Services (AOM) – release Nov. 2024** Category #1 – AOM Services Category #2 – MAX Clinic Services **Medical Care Coordination Services (MCC) – release Nov. 2024**

LOS ANGELES COUNTY COMMISSION ON HIV
APPROVED ALLOCATIONS FOR
PROGRAM YEARS (PYs) 33 AND 34 (Approved by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

	FY 2022 RW Allocations (PY 32)[1]					FY 2023 RW Allocations (PY 33)[2]			FY 2024 RW Allocation (PY 34)[2]		
PY 32 Priority #	Core/ Support Services	Service Category	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI %[3]	Part A %	MAI %	Total Part A/ MAI %[3]
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
2	S	Non-MedicalCase Management - BSS/TCM/CM for new positives/RW clients	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
7	C	Mental Health Services	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
10	C	Early Intervention Services	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
11	S	Medical Transportation	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
12	S	Nutrition Support Food Bank/Home-delivered Meals	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
13	C	Oral Health Services	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
14	S	Child Care Services	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
15	S	Other Professional Services - Legal Services	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
18	C	Home Based Case Management	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
19	C	Home Health Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
20	S	Referral	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
22	S	Language	0.65%	0.00%	0.60%	0.65%	0.00%		0.65%	0.00%	
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
24	S	Rehabilitation	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
25	S	Respite Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
26	C	Local Pharmacy Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
27	C	Hospice	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
		Overall Total	**100.0%**	**100.00%**	**100%**	**100.0%**	**100.0%**	**0.00%**	**100.0%**	**100.00%**	**0.00%**

Footnotes:

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

2 - PY 33 and 34 Allocation percentages approved by PP&A on 11/16/2021 and the Executive Committee on 12/09/2021

3 - To determine total percentages, funding award amounts for Part A and MAI must be known.

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COMMISSION ON HIV

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG 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)

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.

LOS ANGELES COUNTY COMMISSION ON HIV

Planning, Priorities and Allocations (PP&A) Committee

List of Paradigms and Operating Values for Priority and Allocation Setting Process

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TASKS

Questions to Consider When Selecting Paradigms and Operating Values

- Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.
- Services must be culturally appropriate.
- Services should focus on the needs of low-income, underserved and disproportionately impacted populations.
- Equitable access to services should be provided across geographic areas and subpopulations.

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Paradigms and Operating Values

Paradigms:

- Represents the ethical perspective from which decisions are made
- A lens through which the decision-making process is approached

Operating Values:

- Represents the codes of conduct
- Values applied to the decision-making process

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Paradigms

Absolute Inclusion: No matter how meager the available resources, all community participants will receive a share.

Nuanced Inclusiveness: Guarantees complete participation but may entail differential distribution of resources.

Risk Equalization: Sharing risk across while engaging all participants in efforts to increase resources.

Equality: Equal portions to each or equal cuts

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Paradigms

Equity: Allocating levels of investments and commitment that meaningfully address the needs of populations disproportionately impacted by HIV/STIs and social determinants of health

Fairness: Similar cases treated in a similar fashion

Altruism: Volunteering to take a cut or go without

Compassion: Response to suffering of others that motivates a desire to help.

Chance: Fate decides through random choice; let the universe decide

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Paradigms

Coercion: Enforced decision by authority

Utilitarianism: Greatest good for the greatest number

Rights and Duties: Participation in the community recognizes reciprocal rights and duties

Retributive Justice: Making up for past inequities

Distributive Justice: Working toward general equality

Merit: Past or Current Contributions

Market: Ability or willingness to pay

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Paradigms

Fidelity: Recognizing and adhering to past commitments

Efficiency: Accomplishing the desired operational outcomes with the least use of resources

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Operating Values

Survival: Emphasis on maintaining the existence of the current system of care at all costs

Quality: The highest level of competence in the decision-making process

Fidelity: Primary focus on commitments that bind providers and the clients for the duration of need

Beneficence: Assurances to do the most good in the process as possible

Advocacy: Addressing the asymmetrical power relationships of stake holders in the process

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Operating Values

Representation: Ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process

Non-Maleficence: Making sure not to make the situation worse

Access: Assuring access to the process for all stakeholders and/or constituencies

Barriers: Primary focus on barriers and disparities of continuum of care

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SUMMARY OF FINDINGS

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

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

	RWP	AOM	MCC
Primary Populations Served	• Latinx and Black • Cisgender male • PLWH ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH aged 30-39 and ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH ≥ Age 50 • MSM
Utilization over time	• Decreased over time by 6% from Year 28 and 13% from Year 31 due to exit of DHS from RWP	• 35% lower number of RWP clients in Year 32 compared to Year 31 due to DHS exit from RWP	• 15% decrease in the number of MCC clients in Year 32 compared to Year 31, due to DHS exit from RWP
Telehealth	• Telehealth usage decreased to 25% compared to Year 31 (43%). The highest telehealth usage among: - Latinx - Non-binary and transgender clients - PWID - Unhoused	• 23% of AOM services provided via telehealth. The highest telehealth usage among: - Non-binary clients - Unhoused - PWID	• About 35% of MCC services were provided via telehealth in Year 32. The highest telehealth usage among: - Transgender people - Women of Color - Unhoused - PWID
HCC outcomes	• The lowest percentage of engagement in care was among unhoused people and Black MSM • The lowest percentage of RWP clients RiC was among youth aged 13-29, Black MSM and unhoused • The lowest percentage of VS was among unhoused	• AOM clients had higher engagement and RiC and VS compared to non-AOM clients	• MCC clients had lower engagement, RiC and VS compared to non-MCC clients
Service Units per Client	N/A (units vary)	3 visits per client	13 hours per client
Expenditures	$45.9 million: $42.1 million - Part A $3.8 million - MAI	Total $5,884,932 (Part A) $1,692 per client	$8,918,584 (Part A), $752,548 (MAI) $1,375 per client

Latinx MSM	• The largest populations receiving RWP services • About 25% of Latinx MSM received RWP services via telehealth • The 3rd highest percentage of engagement in HIV care • The 2nd highest percentage of VS • The highest percentage of Spanish-speakers • The highest percentage of uninsured	• Represented over a half of all AOM clients (56%) and accounted for about 60% percentage of services provided • Among priority populations average numbers of visits and expenditures were higher than respective average numbers for all AOM clients • The highest per client visits and expenditures among priority populations	• 37% MCC clients and accounted for the same percentage of services provided • Average number of visits and expenditures were slightly lower than respective average numbers for all MCC clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• 8% of all AOM clients and accounted for about 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• 18% of all MCC clients and accounted for about 16% of services provided • Average number of visits and expenditures were lower than respective average numbers for all MCC clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low MCC service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The 3rd highest percentage of uninsured among priority populations • The lowest percentage of RiC among priority populations	• 11% of all AOM clients but accounted for 9% of AOM services • Lower per client service units (visits) and expenditures than average for all AOM clients • Reasons for low AOM service utilization are unclear but may reflect	• 13% of all MCC clients and accounted for the same percentage of service hours provided • Lower per client service hours and expenditures than the average for all MCC clients

		poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• One of the lowest utilizers of MCC services as demonstrated by the percentage of total visits they received and average hours per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • The 2nd highest percentage of engagement in care among priority populations • The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • The 2nd highest percentage of uninsured, Spanish-speaking, and unhoused people	• 30% of all AOM clients and accounted for 29% of AOM services • One of the highest utilizers of AOM services as demonstrated by the percentage of total visit. • Moderately lower per client service units (visits) and expenditures than respective average for all AOM clients	• 34% of all MCC clients and accounted for 37% of services provided • One of the highest utilizers of MCC services as demonstrated by the percentage of total hours they received and average hours per client • Expenditures per client were above the average for all MCC clients
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • The 2nd highest percentage of RiC among priority populations	• 8% of all AOM clients and accounted for 9% of services provided • The second highest utilizers of AOM services as demonstrated by the number of visits per client. • The second highest per client expenditures for AOM services among priority populations	• 6% of all MCC clients and accounted for 8% of services provided • The highest utilizers of MCC services as demonstrated by the number of hours per client • The 2nd highest per client expenditures for MCC services among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • The highest percentage of unhoused people • The 2nd highest percentage of people living ≤ FPL	• 2% of all AOM clients and accounted for the same percentage of services provided • Lower per client visits and expenditures than respective averages for all AOM clients	• 4% of MCC clients and accounted for 5% of services provided • Average number of service hours and expenditures were considerably higher than respective average numbers for all MCC clients

		• Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• 7% of clients receiving AOM service and 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients	• 18% of clients receiving MCC service and accounted for 24% percentage of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • High utilization of MCC services by unhoused people may be reflective of complexity of social and behavioral issues in this subpopulation.
PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • The 2nd highest percentage of unhoused in past 12 m	• 2% of clients receiving AOM service and accounted for the same percentage of services provided • Average number of visits and expenditures were higher than respective average numbers for all AOM clients • The 2nd highest number of per client AOM visits among priority populations • The 3rd highest per client expenditures for AOM services among priority populations	• 5% of clients receiving MCC service and accounted for 7% of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • The highest number of per client hours of MCC service among priority populations • The highest per client expenditures for MCC services among priority populations

SUMMARY OF FINDINGS

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

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

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

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

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

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

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

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 8.

Table 8. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Housing Service (Permanent Supportive Housing (H4H), RCFCI, TRCF)	Emergency Financial Assistance (Food, Rental Assistance, Utilities)	Nutrition Support (Delivered Meals, Food Bank)
Main population served	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to AOM, MCC, and MH services stopping at DHS sites • However, number of clients at remaining agencies was steady	• Service still provided by DHS • Increase in total clients, largely from DHS sites	• Service still provided at DHS • Increase in total clients from Year 31 to 32 primarily from non-DHS sites	• Steady decrease in number of clients since Year 29
Service units per client	N/A (units vary)	• Days	• Dollars	• Meals • Bags of grocery
Total expenditures	$45.9 million	• $7,965,955 (Part A, B, MAI) • $33,054 per client	• 1,741,442 (part A) • $4,607 per client	• 3,740,480 (Part A) • $ 1,767 per client
HCC outcomes	• HCC outcomes were higher among RWP clients compared to PLWH in LAC	• Engagement and RiC were higher among HS clients compared to non-HS clients but no difference in VS	• HCC outcomes were higher among EFA clients compared to clients not accessing EFA	• HCC outcomes were higher among NS clients compared to clients not accessing NS

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

	RWP	Housing Services	EFA	Nutrition Support
Latinx MSM	• Largest RWP population (52%) • Largest percentage of uninsured clients	• Third largest priority population (37%) and accounted for about 35% of services provided • Expenditure per client slightly lower than the overall average	• Second largest priority population (26%) and accounted for 26% of services provided • Expenditure per client similar to the overall average	• Second largest priority population (33%) and accounted for 31% of NS provided • Expenditure and average units per client were lower than overall average for all NS clients
Black MSM	• About 4% of RWP clients • Over 2/3 living ≤ FPL	• Represented 16% of HS clients and 17% of services provided • Highest number of days per client and second highest per client expenditures	• Represented 24% of EFA clients and of services provided • Second highest number per client service units (dollars) and expenditures	• Represented 14% t of NS clients and 12% of services provided • Per client number of meals, bags and expenditures were lower than those overall averages
Youth 13-29 years old	• 12% of RWP clients • The lowest percentage of RiC among priority populations	• Smallest population by number and percent of clients (7%) • Lowest per client number of days and expenditures	• Represented 9% of EFA clients and services provided • Highest utilizers of EFA services, by service units and expenditures per client	• Smallest percent of clients (3%) & services provided (1%) • The lowest per client number of meal/bags and expenditures
Women of color	• 8% of RWP clients • The highest percentage of engagement in care and the second highest percentage of RiC among priority populations	• Represented 12% t of HS clients and 13% of services provided • Highest per client number of days and expenditures	• Represented 12% of EFA clients and 9% of services provided • Lowest per client service units (dollars) and expenditures	• Represented 12% of NS clients and 13% NS services provided • Third highest per client number of meals/bags and expenditures
PLWD ≥ age 50	• Over a third of RWP clients • The highest percentage of RiC and VS and the 2nd highest percentage of engagement among priority populations • The highest percentage of people living ≤ FPL and PWID • Second highest percentage of uninsured and unhoused	• Highest utilizers of HS, by percent of clients (47%) and services provided (50%) • Second highest per client use by service days. • Third highest overall expenditures among priority populations	• Highest utilizers of EFA services by the highest percentage of EFA clients (51%) and services provided (45%)	• Highest utilizers of NS services percentage of clients and services provided • Highest per client number of meals/bags and expenditures

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

	RWP	Housing Services	EFA	Nutrition Support
Transgender clients	• 4% of all RWP clients • Highest percentage of clients unhoused in the contract period • Second largest percentage of people living ≤ FPL	• Represented a small number and percent of HS clients and services provided (7%) • Days per client slightly higher than overall average • Per client expenditure slightly lower than overall average	• Smallest percent of EFA clients and services provided • Per client service units (dollars) expenditures were lower than the overall average however based on small numbers	• Represented small percent of NS clients (3%) and services provided (3%) • Average meals/bags provided and expenditures per client were lower than overall averages
Unhoused in the contract year	• 18% of all RWP clients • Largest percent of clients living ≤ FPL and PWID	• Second highest utilizers by HS percent of clients and services provided • Lowest per client expenditures by only third lowest per client number of days.	• Represented 6% of EFA clients and 5% of services provided • Second lowest per client units (dollars) provided and expenditures	• Represented 13% of NS clients but received only 7% of provided • Second lowest average number of meals/bags and expenditures per client
PWID	• 5% of RWP clients • Second highest percent of clients unhoused in past 12m	• Represented 10% percent of clients and 9% of services provided • Second lowest per client days and expenditures compared to overall averages	• Represented a small number and percent of EFA clients and services provided • Average amount of dollars and expenditures were considerably lower than respective averages for all EFA clients • Third lowest per client service units (dollars) and expenditures	• Represented 6% of NS clients and 7% of services provided • Second highest average number of meals/bags and expenditures per client among priority populations

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 8.

Table 8. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Main client population served	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to AOM, MCC, and MH services stopping at DHS sites • However, number of clients at remaining agencies was steady	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) Numbers of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) Number of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32.	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) • Number of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32
Service units per client	N/A (units vary)	• Procedures	• Procedures	• Procedures
Total expenditures	$45.9 million	• $7,456,098 (Part A) • $1,746 per client	• $5,439,733 (part A) • $1,360 per client	• $2,016,365 (Part A) • $ 563 per client
HCC outcomes	• HCC outcomes were higher among RWP clients compared to PLWH in LAC	HCC outcomes were higher among OH (including GOC and SOC) clients compared to clients not accessing those services		

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Latinx MSM	• The second largest priority population in RWP (38%) • Largest percent of uninsured clients	• Second largest priority population (42%) and accounted for about 45% of services provided • Highest number of OH procedures per client • Highest expenditure per client	• Second largest priority population (43%) and accounted for 46% of GOC services provided • Highest number of GOC procedures per client • Highest expenditure per client	• Second largest priority population (43%) and accounted for 46% of SOC services provided • Highest number of SOC procedures per client • Highest expenditure per client
Black MSM	• About 15% of RWP clients • Over 2/3 living ≤ FPL	• Represented 11% of HS clients and only 9% of services provided • Lowest number of procedures per client • Lowest expenditures per client	• Represented 11% of HS clients and only 9% of GOC services provided • One of lowest number of GOC procedures per client • Lowest expenditures per client	• Represented 11% of HS clients and only 9% of SOC services provided • One of lowest number of SOC procedures per client • Lowest expenditures per client
Youth 13-29 years old	• 11% of RWP clients • The lowest percent of RiC among priority populations	• The second smallest population by number and percent of clients • The second lowest percent of procedures from the total and procedures per client	• The second smallest population by number and percent of GOC clients • One of lowest numbers of GOC procedures per client • The third lowest expenditures per client	• The second smallest population by number and percent of SOC clients • One of lowest numbers of SOC procedures per client • The third lowest expenditures per client
PLWD ≥ age 50	• 43% of RWP clients • The highest percent of RiC and VS and the second highest percent of engagement among priority populations • The highest percent of PWID • Second highest percent of unhoused in the contract year	• Highest utilizers of OH services across categories by percent of clients (~ 60%) and services provided (~ 60%) • Second highest expenditures per client	• Expenditures per client slightly higher than the average for all GOC clients.	• Expenditures per client lower than the average for all SOC clients.
Women of color	• 9% of RWP clients • The highest percent of engagement in care • The second highest percent of RiC among priority populations	• Represented 11% of OH clients and same percent of services provided • The third highest per client number of days and expenditures	• Represented 11% of GOC clients and 12% of services provided • The second highest per client number of procedures and expenditures	• Represented 11% of SOC clients and 12% of services provided • The second highest per client number of SOC procedures and expenditures

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

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Transgender clients	• 3% of all RWP clients • Highest percent of clients unhoused in the contract period • Second largest percent of people living ≤ FPL	• Represented the smallest number and percent of OH clients (2%) and services provided (2%)		
		• Per client expenditure much lower than overall average and the third lowest among priority populations	• Per client expenditure slightly higher than overall average for GOC clients	• Per client procedures slightly higher than average for all SOC clients • Per client expenditures lower than overall average for SOC clients
Unhoused in the contract year	• 12% of all RWP clients • Largest percent of clients living ≤ FPL and PWID	Similar utilization of OH services across categories by clients who were unhoused in the contract year: • Represented 5% percent of clients and 4% of OH services provided		
		• Lowest per client expenditures among priority populations	• The second lowest per client expenditures among priority populations	• The second lowest per client expenditures among priority populations
PWID	• 4% of RWP clients • Second highest percent of clients unhoused in the contract year	Similar utilization of OH services across categories of clients who are PWID: • Represented 4% percent of OH clients and 4% services provided		
		• Slightly lower number of OH procedures per client than the average for all OH clients	• Slightly lower expenditures per client than the average for all GOC clients	• Per client procedures slightly higher than average for all SOC clients • Lower expenditures per client than the average for all SOC clients

Home-Based Case Management at-a-Glance

Goal	• To facilitate optimal health outcomes for functionally impaired PLWDH through home and/or community-based care, advocacy, liaison, and collaboration
Objectives	• Provide client-centered CM and social work, home health, and home care activities • Improve the health status of clients • Increase a client's sense of empowerment, self-advocacy and medical self management
Population	• Uninsured or underinsured PLWDH living ≤500% of FPL with documentation of impaired functional status
Staffing	• Registered Nurse Case Manager (licensed RN) • Social Work Case Manager (Master's degree in accredited program) • Attendant Care or Homemaker (through licensed subcontractor)

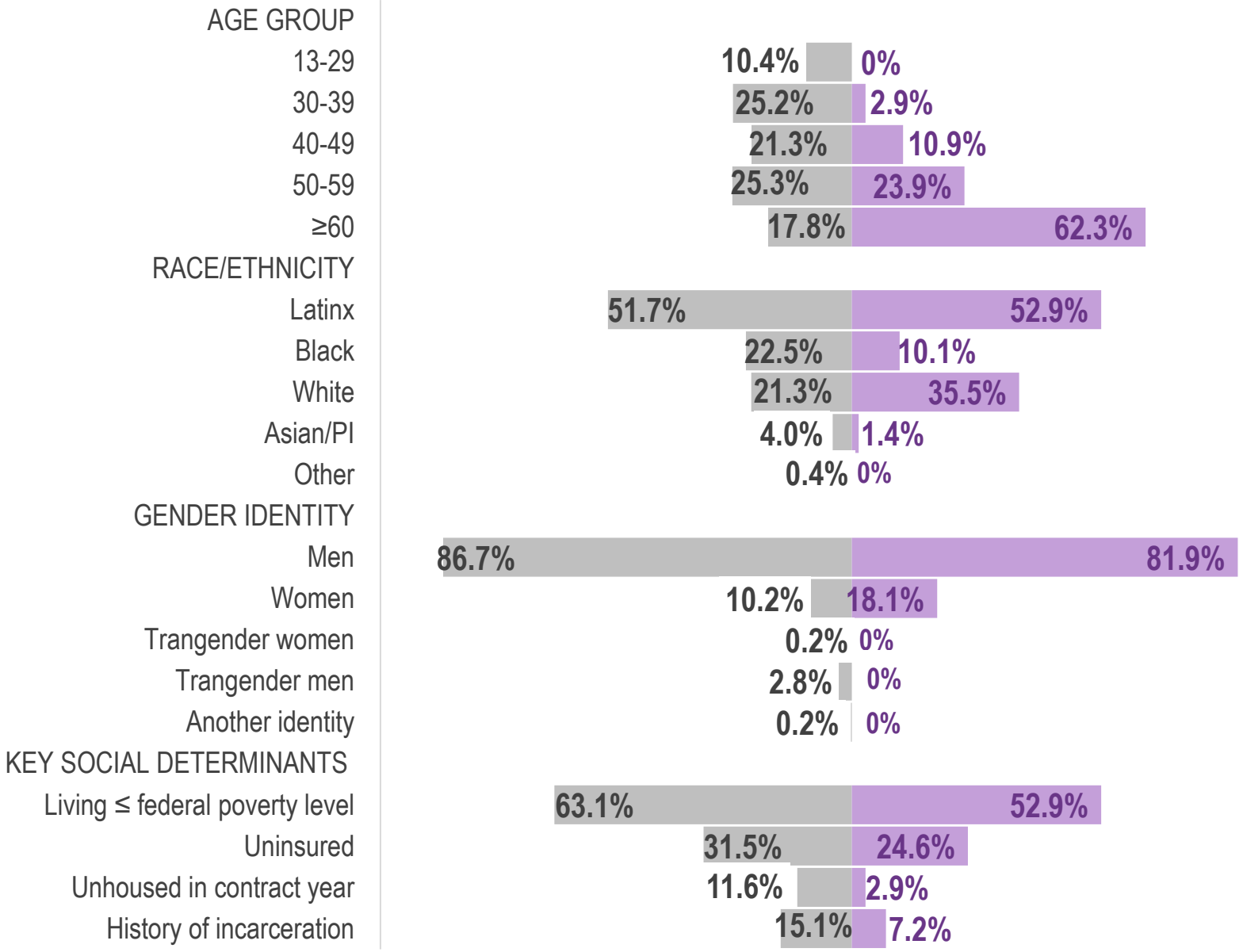
Funding Source and Annual Expenditures, Year 32

- Funding source: Part A

- Contract end: June 2024 – requires Board approval to extend

- Five agencies funded to deliver home-based services
  - Clinic average of 28 clients per year (ranging from 6 to 61 clients)

- Total estimated expenditures: $2,758,499
  - Expenditures per client: $19,989



Fewer than 1% of RWP clients accessed HBCM.

Most HBCM clients were ≥ age 60, Latinx and men in Year 32.

Compared to Ryan White clients overall, a larger percent of HBCM clients were older and women.

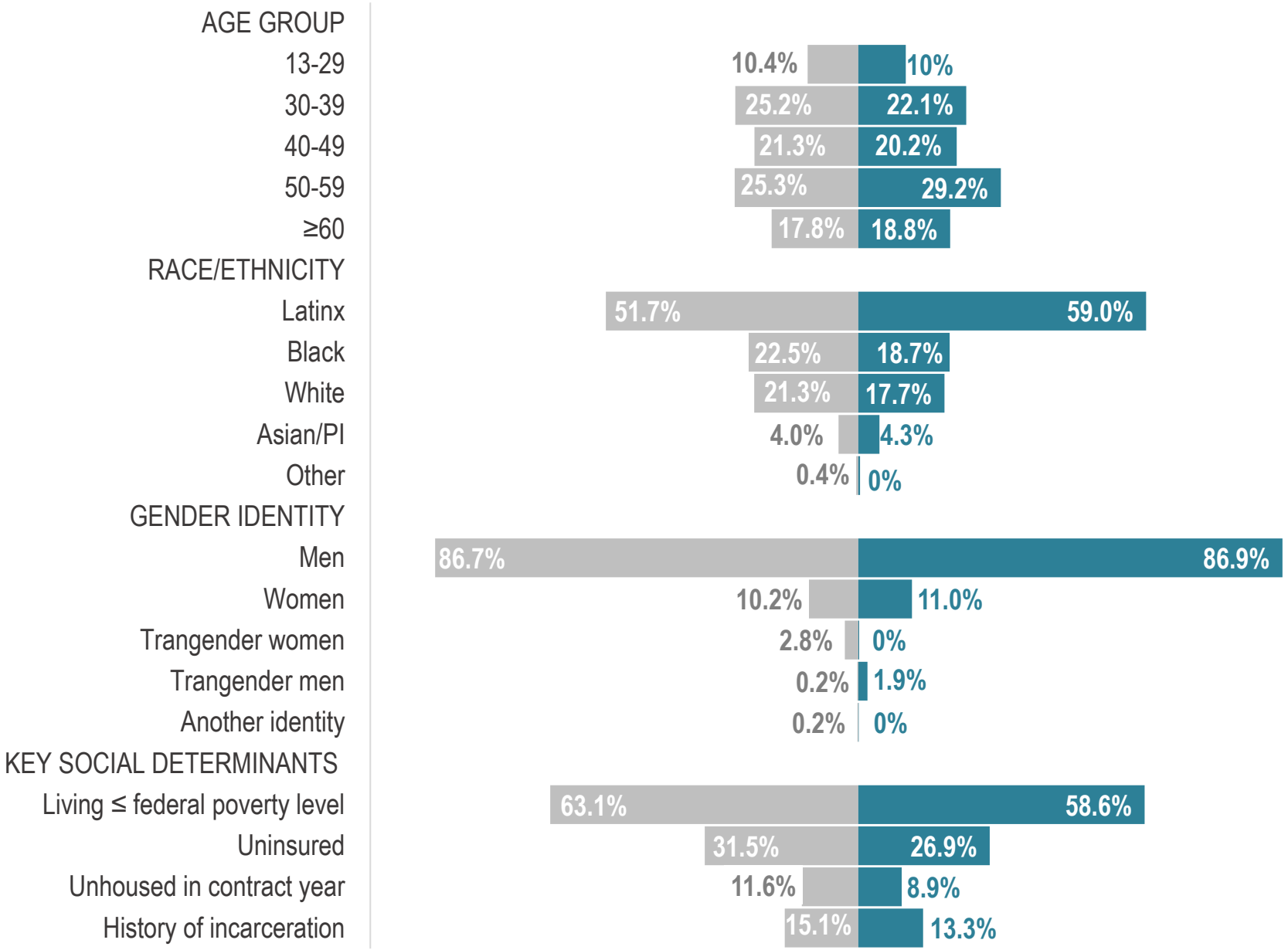
Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

Benefits Specialty Services at-a-Glance

Goal	• To address gaps in access to public benefits and programs outside of the Ryan White Program (RWP) services network among clients in LAC.
Objectives	• Assist PLWDH with entry in and movement through service systems outside RWP • Educate clients about public and private benefits • Ensure clients are receiving the benefits and entitlements for which they are eligible.
Population	• Uninsured or underinsured PWLDH with income ≤ 500% FPL
Staffing	• Certified benefits specialists (completed within 6 months of hire)

BSS Funding and Expenditures, Year 32

- Funding source: Part A
- Contract end: February 2024 with authority to extend 12 months
- Agencies funded: 11 agencies
  - Clinic average of 302 clients per year (range 40-1,702 clients)
- Total estimated expenditures: $1,413,243
  - Estimated expenditure per client: $345

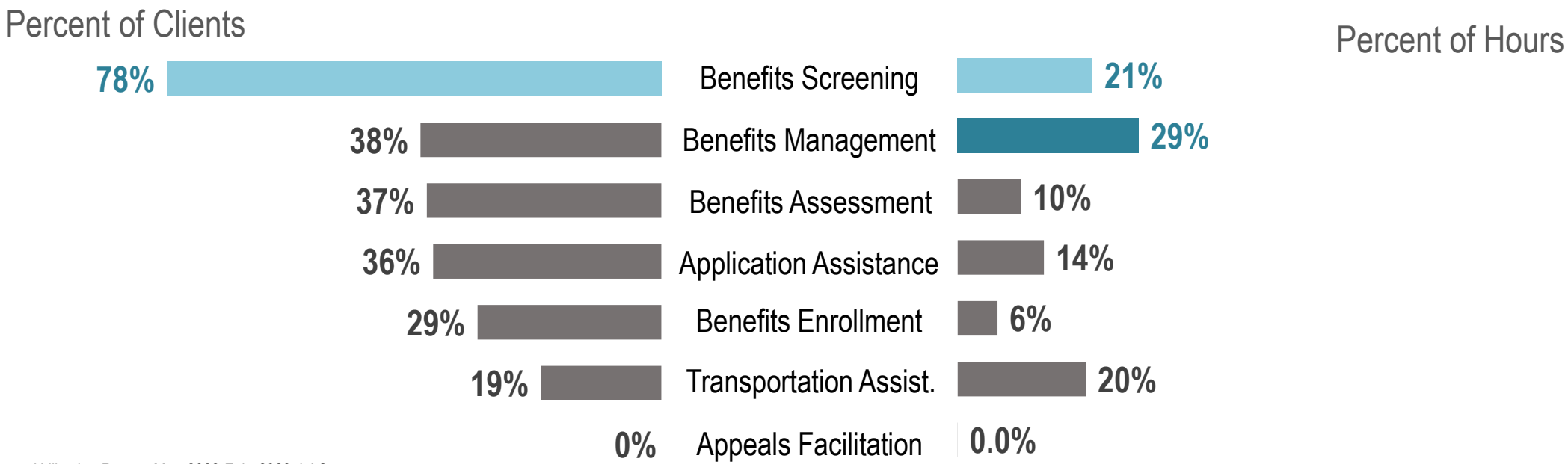


Most **BSS clients** were ≥ age 50, Latinx and men in Year 32.

Compared to Ryan White clients, a smaller percent of **BSS clients** were living ≤ FPL and uninsured.

Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

- 20,139 service hours were provided to 4,099 clients resulting in **5 hours per client** in Year 32.
- Most clients received **Benefits Screening** however it only accounted for 21% of hours.
- **Benefits Management** made up the largest percent of hours provided.
- Fewer than 5 clients received Appeals Facilitation.



Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

Transitional Case Management at-a-Glance

Goal	• To improve HIV health outcomes among justice-involved PLWH by supporting post-release linkage and engagement in HIV care
Objectives	• Identify and address barriers to care • Assist with health and social service systems navigation • Provide health education and risk reduction counseling • Refer and link to culturally competent HIV medical providers • Support reentry through community or jail-based resources
Population	• PLWDH incarcerated at Twin Towers, Men's Central Jail or the Century Regional Detention facility
Staffing	• Nurse • Case Manager
Funding	• Minority AIDS Initiative (MAI)

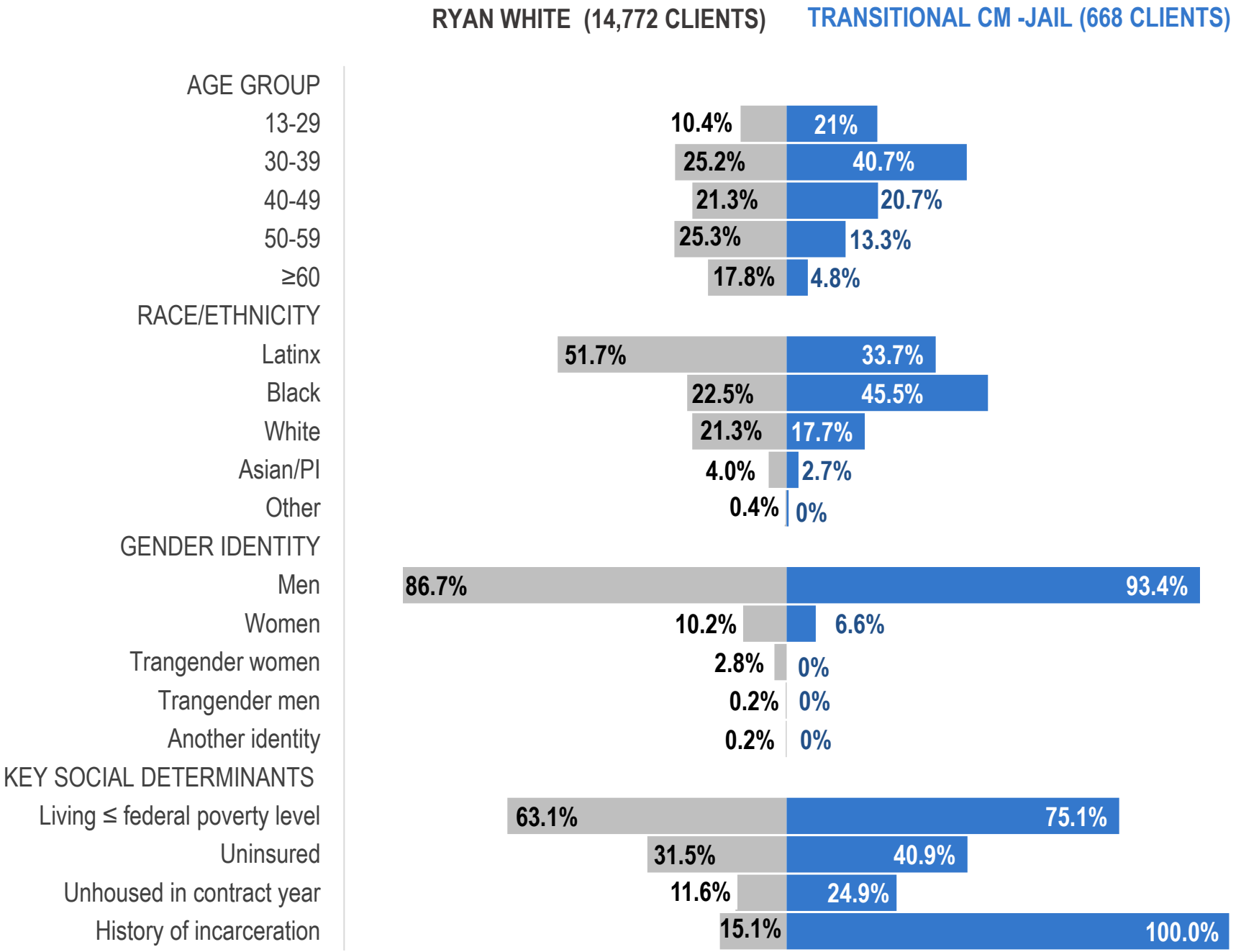
TCM -Jails Funding and Expenditures, Year 32

- Funding source: Minority AIDS Initiative (MAI)

- Contract period: Sunset September 2023
  - Services to be transferred the Office of Diversion and Re-entry at DHS

- Agencies funded: 5 agencies
  - Clinic average of 174 clients per year (range 16-260 clients)

- Total estimated expenditures: $523,926
  - Expenditure per client: $784



Most TCM clients were age 30-39, Black, and men in Year 32.

Compared to Ryan White clients overall, a larger percent of TCM clients were living ≤ FPL, uninsured and recently unhoused.

Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

Linkage and Re-engagement Program (LRP) Description

- LRP is based at DHSP within Direct Community Services

- LRP is a referral-based service and data to care program that focuses on persons who have diagnosed HIV and are not in care (NiC).

Primary Goal (2016):
LRP's overarching goal is to improve the health outcomes of HIV-positive clients by linking and re-engaging them into HIV medical care with the ultimate goal of viral suppression.

Program Enhancement (2020):
LRP prioritizes pregnant/postpartum clients to reduce the risk of perinatal transmission by ensuring a safe delivery.

Target Populations for LRP Services and Client Criteria

- LRP prioritizes persons who are highly impacted and may have multiple and complex needs, including persons not touching systems of care, and often having significant life challenges

- Criteria: Persons who have diagnosed HIV and reside in LAC
  - 2016: Any person who has been out of care for > 12 months
  - 2020: Any person who is currently pregnant or recently delivered a baby and needs additional support

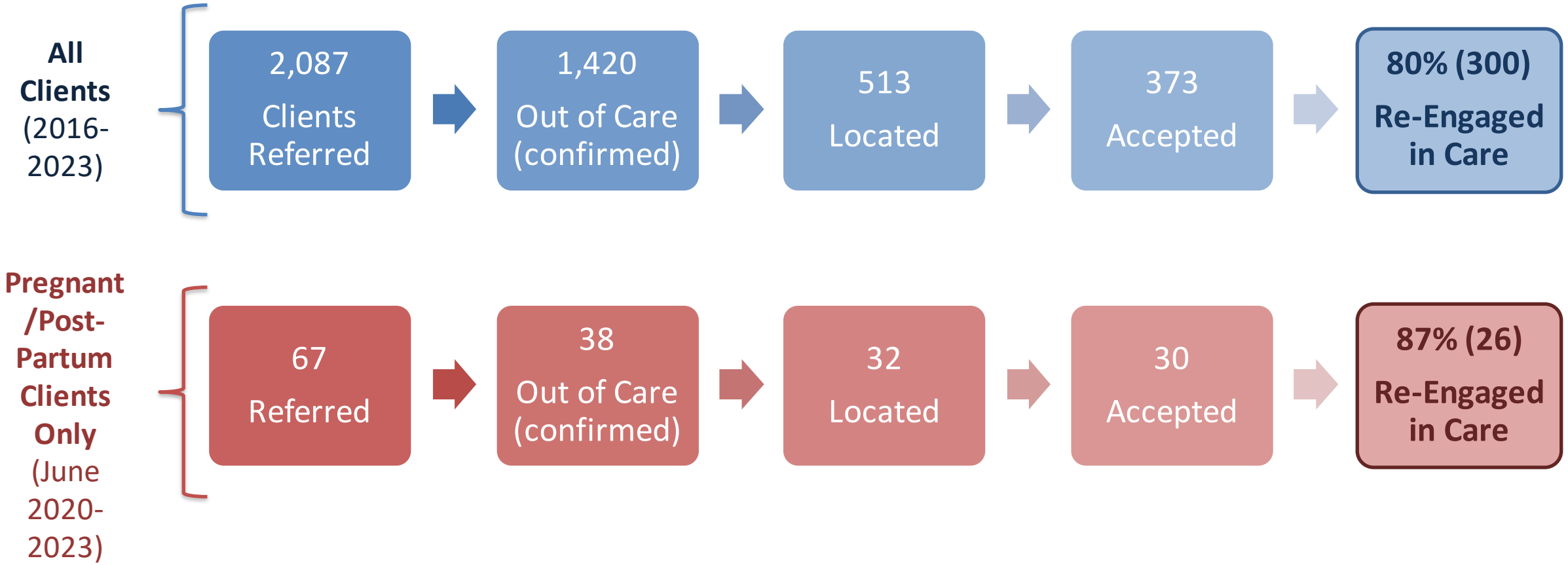
LRP Team

- Staffing model currently includes:
  - 2 clinical social workers to address immediate mental health needs and ongoing support throughout the intervention
  - 5 experienced health navigators
- DHSP-based physicians provide oversight and consultation to LRP team
- LRP team collaborates closely with the DHSP Perinatal Surveillance Coordinator

LRP's Impact on Systems and Services

- Timely communication and notification between DHSP and community partners (HIV clinics, hospitals, delivery sites, labs) to leverage client engagement
- Streamlined clinic appointments for LRP clients
  - Reduced, eliminated barriers to entering care
  - Improved processing of insurance verification
- Use of surveillance information to monitor viral load among all reported pregnant clients
- Increase HIV/Syphilis screening among hospitals of pregnant clients and knowledge of treatment protocols for patient and baby
- Improve HIV Cluster Detection and Response follow-up for LRP clients
- Coordination across DCS units to address cases of co-infection with syphilis to reduce congenital syphilis diagnosis

Overview of LRP Processes and Outcomes by Population of Focus



Los Angeles County 2022 -2026 Integrated HIV Prevention and Care Plan: Needs Assessment Data

PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE

JULY 16, 2024

LOS ANGELES COUNTY
COMMISSION ON HIV

Barriers to Services

Top 5 Barriers to Accessing HIV Testing

	Providers	Community
1	Lack of culturally appropriate services	Substance Use
2	Substance Use	Lack of accurate information about testing
3	Mental Health	They don't believe they're at risk
4	They don't believe they're at risk	Mental Health
5	Lack of accurate information about testing	Lack of culturally appropriate services

Additional identified barriers: lack of awareness of free services, lack of awareness of testing locations and hours, fear of finding out they're infected, isolation, stigma/internalized homophobia, PTSD

Barriers to Services

Top 5 Barriers to Accessing PrEP

	Providers	Community
1	Mental Health	Concern they won't be able to pay for PrEP
2	Substance Use	Substance Use
3	Lack of culturally appropriate services	Lack of accurate information about PrEP
4	Lack of stable housing	Mental Health
5	Lack of accurate information about PrEP	Trauma

Additional identified barriers: discomfort taking medication when not sick, thinking PrEP is for other people because of lack of authentic advertising, inability to store medication due to being unhoused

Barriers to Services

Top 5 Barriers to Linkage to Care

	Providers	Community
1	Substance Use	Substance Use
2	Lack of accurate information about LTC	Mental Health
3	Lack of culturally appropriate services	Concern that they won't be able to pay for HIV care
4	Lack of stable housing	Lack of accurate information about LTC
5	Trauma	Lack of stable housing

Additional identified barriers: lack of HIV+ peers to talk to, need a warm hand-off to services without having to wait, stigma, transportation, unfriendly and insensitive waiting rooms, fear of people thinking they're gay, unwilling to access care due to bad experiences with providers in the past, discomfort in clinic's physical space, concern over administrative hurdles

Barriers to Services

Top 5 Barriers to Remaining Engaged in Care

	Providers	Community
1	Substance Use	Substance Use
2	Mental Health	They don't feel sick
3	Trauma	Mental Health
4	Lack of stable housing	Lack of stable housing
5	Lack of accurate information about HIV care	Trauma

Additional identified barriers: lack of appointment time options, don't want to take medication or go to doctor's office, lack of peer support and treatment advocates, lack of respect in waiting areas/reception for drug users and homeless, stigma, transportation, medical mistrust, lack of childcare, need for peer advocates

Key Priorities Identified

- Integration and streamlining of services
- Address the mental health needs of PLWH and at-risk for HIV
- Address SUD, especially meth use disorder
- Address the needs and gaps in the HIV workforce
- Clear marketing and messaging about services and risks to reach priority populations
- Need to increase health literacy

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Recommendations for Service Category Rankings
For Program Years (PY) 33 and 34

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

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
8	8	8	Outreach Services	S	Outreach Services
			Engaged/Retained in Care		
9	9	9	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
10	10	10	Early Intervention Services	C	Early Intervention Services
11	11	11	Medical Transportation	S	Medical Transportation
12	12	12	Nutrition Support	S	Food Bank/Home Delivered Meals
13	13	13	Oral Health Services	C	Oral Health Care
14	14	14	Child Care Services	S	Child Care Services
15	15	15	Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
16	16	16	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
17	17	17	Health Education/Risk Reduction	S	Health Education/Risk Reduction
18	18	18	Home Based Case Management	C	Home and Community Based Health Services
19	19	19	Home Health Care	C	Home Health Care
20	20	20	Referral	S	Referral for Health Care and Support Services
21	21	21	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
22	22	22	Language	S	Linguistics Services

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
23	23	23	Medical Nutrition Therapy	C	Medical Nutrition Therapy
24	24	24	Rehabilitation Services	S	Rehabilitation Services
25	25	25	Respite	S	Respite Care
26	26	26	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27	27	27	Hospice	C	Hospice

Footnote:
1 – Service rankings approved 9/09/2021
2 – PY 33 & 34 Executive Committee Recommendations approved 11/16/2021 and Executive Committee Approved 12/09/2021

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under...an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals
Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care
Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

See also Psychosocial Support Services

Substance Abuse Services (residential)

Description:

Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:

Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.