LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, September 15, 2020
1:00PM-3:00PM (PST)

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, September 15, 2020|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/y4y669g6
Password: Planning
Link is for non-committee members

To Join by Phone: 1-415-655-0001
Access code: 145 252 3455

Planning, Priorities and Allocations Committee Members:			
Al Ballesteros, Acting Co-Chair	Raquel Cataldo, Co-Chair	Frankie Darling Palacios	Joseph Green
Karl T. Halfman	Diamante Johnson (Alt. Kayla Walker-Heltzel)	William King, MD, JD	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD	Maribel Ulloa
DHSP Staff			
QUORUM:	7		

Due to COVID-19, quorum requirement suspended for teleconference meetings per Governor Newsom's Executive Order N-25-20

AGENDA POSTED September 11, 2020

*Second Co-Chair seat currently vacant.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the

Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.
If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

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

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

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

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

II. PUBLIC COMMENT 1:04 P.M – 1:06 P.M.

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

III. COMMITTEE NEW BUSINESS 1:06 P.M. – 1:10 P.M.

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

IV. REPORTS 1:10 P.M. – 1:30 P.M.

5. EXECUTIVE DIRECTOR'S/STAFF REPORT
a. Consumer Caucus Update

6. CO-CHAIR REPORT 1:30 P.M. – 1:40 P.M.
a. Committee Co-Chair Nominations/Elections (Need 2nd Co-chair)

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:40 P.M. – 2:00 P.M.
a. Fiscal Update
b. Contracts and Procurement Update

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

a. Update on Housing Voucher Availability

8. **VI. DISCUSSION** 2:00 P.M. – 2:55 P.M.

a. DHSP Directives **MOTION #3**

10. **VI. NEXT STEPS** 2:55 P.M. – 2:58 P.M.

a. Task/Assignments Recap

b. Agenda Development for the Next Meeting

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

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

12. **VIII. ADJOURNMENT** 3:00 P.M.

a . Adjournment for the Meeting of September 15, 2020.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**
MOTION #3	**Approve DHSP Program Directives as presented or revised.**

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

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

August 18, 2020

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/CONSULTANTS
Al Ballesteros, MBA, *Acting Co-Chair*	Raquel Cataldo, *Co-Chair*	Alasdair Burton	Cheryl Barrit, MPIA
Frankie Darling Palacios	Diamante Johnson	Geneviéve Clavreul, RN, PhD	Carolyn Echols-Watson, MPA
Joseph Green	Kayla Walker-Heltzel	Kevin Donnelly	Jane Nachazel
Michael Green, PhD, MHSA		Jennifer Gjurashaj	
Karl Halfman, MS		Yosselin Gonzalez	**DHSP/DPH STAFF**
William King, MD, JD		Miguel Martinez, MPH, MSW	Pamela Ogata, MPH
Anthony Mills, MD		Carlos Moreno	Mario Pérez, MPH
Derek Murray		Paul Nash	
LaShonda Spencer, MD		LCDR Jose Antonio Ortiz, MPH	
Maribel Ulloa		Nataliie Sanchez, MPH	
		Julie Tolentino, MPH	

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Planning, Priorities & Allocations Committee Virtual Meeting, *8/18/2020*
2) **Agenda**: Planning, Priorities & Allocations Committee Meeting Agenda, 8*/18/2020*
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *7/21/2020*
4) **Code**: Code of Conduct, *4/11/2019*
5) **Table**: Commission Member "Conflicts-of-Interest," *Updated 7/1/2020*
6) **Summary**: Virtual Meeting - Consumer Caucus, Preparing Consumers for the Ryan White Priority Setting and Resource Allocations (PSRA) Process, Meeting Summary, *7/9/2020*
7) **Table**: Los Angeles County Commission on HIV, Multi-Year Worksheet, RW Services Allocation Descriptions, FY 2020 (PY 30), FY 2021 (PY 31), FY 2022 (PY 32), *8/18/2020*
8) **Table**: Planning, Priorities and Allocations Committee, Service Category Rankings Worksheet, *8/18/2020*

CALL TO ORDER - INTRODUCTIONS - CONFLICT OF INTEREST: Mr. Ballesteros called the meeting to order at 1:02 pm.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
MOTION 1: Approve the Agenda Order, as presented **(*Passed by Consensus*)**.

2. APPROVAL OF MEETING MINUTES
MOTION 2: Approve the 7/21/2020 Planning, Priorities and Allocations (PP&A) Committee Meeting Minutes, as presented **(*Passed by Consensus*)**.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA: There were no items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- Ms. Barrit noted that quorum is not required for virtual meetings under California regulations, but it is a best practice.
- PP&A will engage in the second part of Priority Setting and Resource Allocation (PSRA) today. The 7/9/2020 Consumer Caucus Summary was in the packet to help inform deliberations. Mr. Moreno, Consumer Caucus Co-Chair, was present.
- The Consumer Caucus considered three questions to facilitate their PSRA discussion: What services are needed to live a healthy life? Are core services helping People Living With HIV (PLWH) stay healthy? And, as part of an ongoing conversation, what are the reasons for PLWH not receiving the services that they need.

6. CO-CHAIR REPORT

a. Committee Co-Chair Nominations/Elections

- Mr. Ballesteros noted a continuing need for a second Co-Chair. Raquel Cataldo was elected at the June 2020 meeting, but he remained as Acting Co-Chair since the Committee requires two. Anyone with 12 months on PP&A is eligible.
- Ms. Barrit said the position will remain open. For those who might be hesitant to take on the duties, staff will help.
- ➲ Consider taking this opportunity to the full Commission and waiving the requirement for 12 months service on PP&A.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Fiscal Update

- *Fiscal Year (FY) 2019 (Program Year [PY] 29), 3/1/2019-2/29/2020* Ms. Ogata reviewed several years, starting with FY 2019. No action was required for FY 2019 (PY 29), but it provides a base for discussion of expenditures going forward.
- These allocations were last revised about this time last year. Revisions proved accurate in projecting expenditures and service implementation was prompt resulting in a Minority AIDS Initiative (MAI) funding carryover of only $285,908. This was a significant improvement from prior years of MAI carryover funding in the $2 to $3 million dollar range.
- A large part of funding was utilized by Ambulatory Outpatient Medical (AOM) and Oral Health (OH). She also noted an increase in Early Intervention Services (EIS) expenditures which is for HIV testing. She had originally thought this would only support staff salaries for some DHSP Community Workers who do HIV testing in the field. In FY 2019, a proportion of Partner Services salaries were added as the team also interacts with PLWH, e.g., to link them to services.
- Medical Nutritional Therapy had no expenditures as AOM and Medical Care Coordination (MCC) were re-solicited and included that option. The prior service provider did not include it in their new contract due to a perceived lack of need. MCC (Medical Case Management) expenditures were split across Part A and MAI and were consistent with allocations. Non-Medical Case Management supports Benefit Specialty Services (BSS) as well as Transitional Case Management (TCM) for both Youth and the Jails Population. BSS was billed under Part A and TCM under MAI.
- Nutrition Support (Food Bank)/Home-delivered Meals increased significantly as DHSP augmented contracts in response to Commission and overall consumer requests. That need was identified before the COVID-19 impact on services.
- The Part A/MAI grant supports three types of Housing Services: Residential Care Facilities for the Chronically Ill (RCFCI), Transitional Residential Care Facilities (TRCF), and Department of Health Services (DHS) Housing For Health (HFH) providing permanent supportive housing including case management. RCFCI, with total expenditures of slightly over $3.3 million, and TRCF, $1.4 million, are supported by Part A and, more notably, Part B state funding. HFH is wholly supported by MAI. Despite some anticipated delays in initiating the HFH program, HFH exceeded expectations by expending >$2.2 million of the $3 million allocation. In addition, Substance Use Residential totaled $785,200.
- No expenditures were reported in FY 2019 for Linguistics Services because the current contractor did not provide any services. DHSP anticipated conversations with the Commission and Ms. Barrit in addition to a mini-need assessment to determine the actual needs for this service category in light of other available resources.

- Medical Transportation expenditures were lower, most likely due to the unreliability of the three taxi companies contracted. New contractors were identified for FY 2020.
- Total FY 2019 direct services expenditures were about $35 million for Part A and a little over $5 million for MAI which includes a $2.1 million carryover from the prior year leaving, as noted, just $285,908 to carryover to FY 2020.
- *FY 2020 (PY 30), 3/1/2020-2/28/2021* Ms. Ogata continued on to review FY 2020. This table reflects revisions made last year for the annual Ryan White application submission as well as suggested revisions to Part A and MAI going forward.
- For example, Ms. Ogata was aware last year that some service categories like Mental Health (MH) and Outreach (Linkage and Retention Program, LRP) supported by DHSP could be funded by other resources so she allocated zero Part A and MAI funds. The Finance Department, however, billed some costs to Part A so allocations need to reflect that.
- On the other hand, last year's allocations included $21,000 for Medical Nutritional Therapy, but there was still no contract for that service category so no costs were accrued and the allocation needs to be zeroed out.
- As noted earlier, EIS was used in FY 2019 for DHSP staff time for testing counselors engaged in HIV testing and a percentage of Partner Services staff time. Further review of Health Resources and Services Administration (HRSA) service category definitions made it more apparent that the Partner Services portion should be under Outreach.
- There are new Medical Transportation contracts with providers that allow them to use Uber and Lyft for the first time.
- Emergency Financial Assistance (EFA) was not funded under Part A or MAI as funding up to $1.5 million will be under HRSA 078: Ending the HIV Epidemic (EtHE). Two providers will offer the service through housing contracts.
- HRSA allows EFA for rental assistance, utilities, and food/nutrition. It prohibits giving cash to clients under any service category. It allows gift cards, but not cash-like cards, e.g., Visa gift cards. DHSP was using EFA for rental assistance and utilities. EFA was not being used for food/nutrition because that was expanded under Part A and those services as well as Home-delivered Meals were also funded under HRSA's Coronavirus Aid, Relief, and Economic Security (CARES) Act.
- Mr. Martinez asked how EFA resources aligned with PP&A allocations. Ms. Barrit responded PY 30 had a 0% allocation. PY 31 and 32 were allocated 2.5%, or about $1 million, total under Part A and MAI. Ms. Ogata continued that the current proposal is for $750,000 for each of the two providers, or $1.5 million, nearly 50% of the EtHE $3 million grant.
- HFH, funded under MAI, has added a new permanent supportive development, Rampart Mint. It will provide 22 units for PLWH who also have a confirmed mental health diagnosis.
- Despite promising FY 2020 developments, it remains hard to estimate the impact of COVID-19. Preliminary review of first quarter billing does look fairly consistent with FY 2019 despite some delays with invoice submissions. As noted last month, expenditures appear lower for OH and Non-Medical Case Management (Transitional Case Management). DHSP will continue to provide expenditure updates to PP&A as available.
- Regarding a Legal Services question, Mr. Pérez said DHSP was changing providers which resulted in lower expenditures. Services address a range of legal issues, e.g., discrimination, housing, employment. The current provider decided not to continue with the contract due to loss of a staff attorney and an increased focus on housing/homeless services.
- DHSP started a new provider search late last year and recently completed a Scope of Work (SOW) negotiation with Inner City Law Center. DHSP will be requesting Board of Supervisors (Board) support for about a 30-month contract. The first phase, a needs assessment, was initially planned for February 2021 completion but may take longer due to COVID-19. It will inform a new SOW. The investment for the first full year after the assessment was expected to be several hundred thousand dollars. Expenditures were expected to grow after that as services grow.
- *FY 2021 (PY 31), 3/1/2021-2/28/2022* Ms. Ogata reported a FY 2021 HRSA award ceiling of slightly over $46 million based on guidance in its Notice of Funding Opportunity. Jurisdictions may divide their award between Part A and MAI at their discretion except that neither allocation may exceed 5% more than the prior year's award. As most services are funded under Part A, DHSP usually maxes out the Part A 5% first and then determines MAI. Based on that, the FY 2021 budget request will be: $42,600,158, Part A; and, $3,953,020, MAI. (Carryover is not included in applications).
- FY 2020 was used as a template with a Part A 5% increase. MAI HFH went up from $3 million to $3.183 due to contract augmentation to support the new Rampart Mint site. Other resources, in whole or in part, will support EFA and MCC.
- Proposed allocations are likely to change due to factors including changes in services, consumer needs, and provider needs, especially due to COVID-19 impacts, e.g., DHSP hoped to support durable medical equipment under AOM.
- FY 2021 allocations are needed for submission with the next application. They will be reviewed after award receipt.
- Some attendees asked about Child Care allocations. Ms. Ogata responded it was not included in the HRSA FY 2020 application because there was still no contracting mechanism or provider. It could be added to FY 2021, if desired.
- On Personal Protective Equipment (PPE), Ms. Ogata said it was funded for consumers under the HRSA CARES Act. DHSP contracted with a nutritional support provider to procure and distribute PPE kits at food banks. That began 8/15/2020.

- Mr. Martinez found it hard to evaluate these allocations without seeing them side-by-side with the original multi-year plan rather than simply hearing we cannot do this or that anymore. Ms. Ogata said prior allocations can be presented, if desired. She was noting major changes due to COVID-19 and highlighting the need for allocations for the application.
- Ms. Echols-Watson thought the issue pertained to the 1% Child Care originally allocated to PYs 31 and 32. Mr. Martinez said that was an example but, overall, he sought to follow through on the original work which was based on testimony from the Consumer Caucus, other consumers and, especially, women. If an allocation must be changed, we should be able to say why. Dr. Spencer added Child Care was very important to the Women's Caucus. Frankie Darling Palacios pointed out that the Standards and Best Practices (SBP) Committee was developing Child Care Standards of Care (SOC).
- Mr. Pérez appreciated the comments. He noted the Commission was deliberating allocations for PY 31 based on PY 30 spending to date which was on very shaky footing. He did not think DHSP could predict how PY 30 would end with a high level of certainty making PY 31 projections even less certain. Even so, he thought DHSP could expect less OH in the current PR 30 so an informed recommendation to fund Child Care could re-allocate $400,000-$500,000 from OH, slightly more than 1% after taking out resources for Continuous Quality Management (CQM) and Administration.
- He supported continuation of the SBP process to develop an implementable Child Care SOC. On the other hand, he felt the likelihood of funding Child Care now was negligible due to the difficulty of creating an environment with COVID-19 social distancing in either a Child Care setting or a person's home. Post-COVID-19 expenditures could reasonably be 1%. Dr. Green added that DHSP needs the SOC in order to develop a SOW with which to open solicitations. Mr. Pérez continued that DHSP will appeal for the fastest way to disburse resources, e.g., a sole source provider option.
- Regarding EFA, it again will be funded with HRSA 078: EtHE which offers more flexibility so long as recipients are PLWH.
- Mr. Pérez noted DHSP now has three new sources of supplemental funding that developed after the Commission's deliberations: HRSA 078: EtHE, a multi-year grant intended to enhance local HIV response efforts; HRSA CARES Act grant, $1 million, specifically in response to COVID-19; and a new CDC EtHE multi-year grant starting in August 2020.
- The Los Angeles County (LAC) Department of Public Health (DPH) has requested United States Department of Health and Human Services (HHS) guidance on the use of federal HHS funds to help offset COVID-19 costs. DPH leadership was briefed on receipt of the funds. Commission Co-Chairs have signaled the Board regarding Commission appetite for the funds to reach the streets quickly. There have been meetings with Board offices. Mr. Pérez advised DPH leadership some 11 days ago of the need to know whether DHSP can move forward to expend the funds, but has not yet heard.
- Dr. Green noted DHSP received slightly over $3 million for the HRSA 078: EtHE grant. That was only 30%-35% of funding requested. Consequently, DHSP was in the process of revising its budget for the grant.

b. Contracts and Procurement Update: There was no additional discussion.

8. RYAN WHITE PART D DATA (Services for Women, Infants, Children, and Youth)

- Dr. Spencer said limitations of this data are that it is from women participating in LAC Part D programs so may not reflect other populations. The women's demographics were: 66% Latina, 28.6% African American, 2% Asian, 2.2% Caucasian, 1.2% other. Overall Ryan White HIV/AIDS Program (RWHAP) demographics were: 49% Latinx, 33% Black, 22% White.
- PY 29 Continuum of Care (CoC) data reflects total Part D women of 534 with 527 (98.7%) engaged compared to RWHAP's 96% engaged. Other CoC aspects were also similar as noted on the table presented.
- Utilization tables were broken down by race/ethnicity and those virally suppressed versus those who were not. The top five categories for the suppressed were: AOM, Psychosocial Support, Non-Medical Case Management, Medical Nutritional Therapy, and Medical Case Management. Categories for those unsuppressed were the same with the last two reversed. The same categories led in various orders for race/ethnicity. Medical Transportation and Navigation also scored high.
- Dr. Spencer noted 0% expended in PY 29 for Child Care. The Maternal Child and Adolescent/Adult (MCA) Center normally offers Child Watch, but the provider was on medical leave throughout PY 29 which occupied the item without anyone to provide services. The lack of those services presented a major hindrance for the MCA Center.

V. DISCUSSION

9. CONFLICTS OF INTEREST

- Attendees stated their Conflicts of Interest.
- ➲ Addition to Conflicts of Interest table for Dr. Mills: Promoting healthcare engagement among Vulnerable Populations.

10. PY 30, PY 31, AND PY 32 SERVICE CATEGORY PRIORITIZATION

- Mr. Ballesteros reviewed the table which reflects the three PYs service category priorities with the current PY 30, and the more future looking PYs 31 and 32 with additional revisions. PYs 31 and 32 priorities were the same.

- Mr. Martinez noted we do not yet know what next year will look like, but these priorities were based on need and can be revised later, if desired. He recommended approval.

MOTION 3: Approve PY 30, PY 31, and PY 32 Service Category Prioritization, as determined **(*Passed: Yes* -** Darling-Palacios, Joseph Green, King, Mills, Murray, Spencer, Ballesteros***; No* -** none***; Abstentions* -** Michael Green, Halfman**)**.

11. PY 30, PY 31, AND PY 32 ALLOCATIONS PERCENTAGES

- Frankie Darling-Palacios asked for updates on Housing Opportunities for Persons With AIDS (HOPWA) vouchers, HFH, EFA.
- Ms. Ulloa reported no more vouchers were available now. HOPWA was working with Housing Authorities on an estimate by the end of 2020 on how many might be available in future. This impacts the ability of clients to transition to Section 8.
- Ms. Ogata reported the HFH program was doing quite well. It has spent more than $2.2 million of the $3 million allocated despite common start-up issues. The FY 2020 contract should be more than maximized since the new Rampart Mint site was expected to open by October 2020. Consequently, DHSP has augmented the HFH contract to $3.1 million.
- Ms. Ogata reported the two EFA contractors were going through different processes to modify their contracts. The HFH contract will be modified via a Memorandum Of Understanding (MOU) which was in process. Mr. Pérez continued that the other will be a Delegated Authority memorandum to the Board. Before proceeding, DHSP needed to secure County Counsel endorsement that services proposed for purchase are consistent or congruent with originally funded services. Once endorsement is provided, the memorandum can be pursued quite quickly.
- Joseph Green asked how aging and HIV was being addressed under various service categories. Ms. Ogata reported she wanted to continue the needs assessment for Home- and Community-Based Health Services which is used by many in that population. Mr. Pérez added many categories serve those over 50, the current definition of "aging." SOCs and services can be refined to be more responsive and better reflect feedback.

➲ Ms. Ulloa will update the Commission and/or PP&A on housing voucher availability as information is received.
➲ Refer aging topic to the Aging Task Force.
➲ Agreed to move 1% from OH to Child Care.

MOTION 4: Approve PY 30, PY 31, and PY 32 Allocations Percentages, as determined **(*Passed: Yes* -** Darling-Palacios, Joseph Green, King, Mills, Murray, Spencer, Ballesteros***; No* -** none***; Abstentions* -** Michael Green, Halfman**)**.

VI. NEXT STEPS

12. TASK/ASSIGNMENTS RECAP

- Ms. Barrit thanked everyone for their work. PSRA is hard in person and meeting virtually adds another layer of challenge.

➲ Recommendations will be forwarded to the 8/27/2020 Executive Committee Meeting for approval. They will then be forward to the 9/10/2020 Commission Meeting for its approval. Once approved, they will be submitted to DHSP for inclusion in the RWHAP PY 31 grant application.

13. AGENDA DEVELOPMENT FOR NEXT MEETING

➲ The next meeting will focus on Program Directives.

VII. ANNOUNCEMENTS

14. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: There were no announcements.

VIII. ADJOURNMENT

15. ADJOURNMENT: The meeting adjourned at 3:13 pm.

CENTERS FOR DISEASE AND CONTROL (CDC) GRANTS- COMMUNITY ENGAGEMENT/PLANNING COUNCIL

PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments, National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

Grant Term: FY 2018-FY 2022 (5 years)

"8. Develop partnerships to conduct integrated HIV prevention and care planning

- Develop partnerships to conduct HIV prevention and care planning. Jurisdictions should establish and maintain an HIV planning group (HPG) and a process that entails engaging partners and stakeholders in prevention and care planning, improving the scientific basis of program decisions, and targeting resources to those communities at highest risk for HIV transmission and acquisition. For additional information on HIV planning processes, refer to the CDC HIV Planning Guidance at https:// www.cdc.gov/ hiv/ ;pdf/ funding/ announcements/ ps12-1201/ cdc-hiv-hiv_planning_guidance.pdf." (Page 20, PS18-1802 RFA)

PS20-2010 Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States CDC-RFA-PS20-2010

"Health department funding recipients are required to establish a new or expand an existing EHE advisory group or committee, as a standing or ad hoc committee, as allowed by planning group policies, procedures, and/or bylaws, to: 1) advise the health department funding recipient on EHE-related priorities and activities; and 2) ensure ongoing representation from the community throughout the 5-year project period. Additionally, health department funding recipients must adhere to guidance provided in the EHE Planning Program Guidance when establishing criteria for recruiting advisory group or committee members. At a minimum, the composition of the advisory group or committee must be inclusive of representatives from the Phase 1 counties (e.g., health department staff, community members) and members of local communities affected by or living with HIV who may not have been fully heard or may not have felt fully engaged in the past. The proposed structure and role and responsibilities of the group must be described in the EHE plan as well as the PS20-2010 application for funding." (Page 11, PS20-2010)

Notice of Funding Opportunity (NOFO) PS18-1802: Integrated HIV Prevention Programs for Health Departments

Component A Funding

Division of HIV/AIDS Prevention

Centers for Disease Control and Prevention

Recipient	Annual Funding (Includes Surveillance and Prevention funding)
Alabama	$4,807,660
Alaska	$1,033,858
Arizona	$5,667,606
Arkansas	$2,084,560
Baltimore*	$4,237,790
California	$22,176,700
Chicago	$8,307,882
Colorado	$4,346,535
Connecticut	$3,974,203
Delaware	$1,353,326
District of Columbia	$5,835,118
Florida	$38,904,419
Georgia	$17,697,095
Hawaii	$1,176,488
Houston	$8,671,633
Idaho	$1,054,017
Illinois	$5,037,849
Indiana	$4,006,660
Iowa	$1,121,113
Kansas	$1,233,568
Kentucky	$2,591,200
Los Angeles	$17,950,094
Louisiana	$7,244,981
Maine	$1,075,537
Maryland	$7,887,181
Massachusetts	$7,360,636
Michigan	$5,754,160
Minnesota	$2,985,918
Mississippi	$3,508,228
Missouri	$4,477,486
Montana	$1,029,058
Nebraska	$1,103,682
Nevada	$3,266,705
New Hampshire	$1,064,374
New Jersey	$13,492,553
New Mexico	$1,306,348
New York City	$35,204,236
New York State	$13,964,488
North Carolina	$10,962,335
North Dakota	$1,000,000

Recipient	Annual Funding (Includes Surveillance and Prevention funding)
Ohio	$7,602,764
Oklahoma	$2,254,311
Oregon	$2,500,169
Pennsylvania	$6,539,490
Philadelphia	$6,336,535
Puerto Rico	$6,525,313
Rhode Island	$1,116,566
San Francisco	$5,008,376
South Carolina	$6,116,419
South Dakota	$1,026,481
Tennessee	$6,210,435
Texas	$20,772,433
Utah	$1,151,669
Vermont	$999,999
Virgin Islands	$1,029,967
Virginia	$8,281,766
Washington State	$4,656,563
West Virginia	$1,097,367
Wisconsin	$2,384,515
Wyoming	$1,015,467

*Annual funding is representative of prevention funds only.
Important Note: Funding is subject to the availability of funds.

Integrated HIV Surveillance and Prevention Funding for Health Departments

A Cornerstone for National HIV Prevention

The Centers for Disease Control and Prevention (CDC) has renewed and strengthened its flagship funding program to support HIV surveillance and prevention efforts led by state, territorial, and local health departments. These funding awards – which integrate CDC's HIV surveillance and prevention programs for the first time – represent the agency's largest single investment in HIV surveillance and prevention and will be the cornerstone of national prevention efforts for the next 5 years.

The awards are designed to take full advantage of recent advances in surveillance data collection and HIV prevention and maximize the impact of every federal dollar. The nation is already making significant progress in HIV prevention: the number of annual infections has declined significantly in recent years, and more people than ever know their HIV status.

These new awards will accelerate the nation's progress toward a goal of no new infections through two central priorities:

- ***Ensure that all people living with HIV are aware of their infection and successfully linked to medical care and treatment to achieve viral suppression.*** People who take antiretroviral therapy daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner, making this one of the most powerful HIV prevention strategies available. CDC and its health department partners use available surveillance data to expand HIV testing and diagnosis, promptly link people to medical care when they receive a diagnosis, and re-connect them to care if they have fallen out. CDC research indicates that, by doing so, roughly 9 in 10 new infections can be prevented.

- ***Expand access to pre-exposure prophylaxis (PrEP), condoms, and other proven HIV prevention strategies for people at high risk of becoming infected.*** PrEP, in particular, could have a major impact in further reducing new infections but must be more readily available in the communities most affected by HIV.

Quick Facts

Awardees:

- Health departments in all 50 states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands
- Local health departments serving Baltimore City, Chicago, Houston, Los Angeles County, Philadelphia, New York City, and San Francisco

Number of awards: 60
Minimum award amount: $1 million

First-year awards under this funding cycle began on January 1, 2018, totaling about $400 million. This is approximately level with prior funding. The program was informed by input from many partners and stakeholders, including the National Alliance of State and Territorial AIDS Directors (NASTAD), the Council of State and Territorial Epidemiologists (CSTE), Urban Coalition for HIV/AIDS Prevention Services (UCHAPS), and individual state and local health departments.

Integrating HIV Surveillance and Prevention

Integrating HIV surveillance and prevention programs will help health departments plan and execute more efficient, coordinated, and data-driven prevention efforts, and was strongly supported by stakeholders.

HIV surveillance and prevention activities are already increasingly linked at the state and local levels. For example, a growing number of health departments are implementing Data-to-Care, a CDC-supported public health strategy that uses routinely collected HIV surveillance and other data to identify and follow up with people who have received HIV diagnoses, but who are not in care or who have persistently elevated HIV viral loads. Ensuring that everyone with HIV is aware of their infection and receiving the treatment they need to remain virally suppressed is a core focus of CDC's High-Impact Prevention approach.

Directing Resources Where They're Needed Most

To maximize impact, the awards fully align CDC's HIV surveillance and prevention funding with the current geographic distribution of HIV. Funding is apportioned to each eligible state, territory, or directly funded city based on the number of people living with diagnosed HIV in that jurisdiction as of 2014, the most recent year for which complete data are available.

Building on Success in HIV Prevention

CDC's HIV surveillance and prevention funding to communities has helped drive down new infections nationally. In 2015 alone, this funding enabled state, territorial, and local health departments to:

- Provide nearly 3 million HIV tests
- Diagnose 11,500 HIV infections
- Connect, or re-connect, thousands of people living with HIV to appropriate medical care
- Provide risk-reduction interventions to nearly 50,000 people at high risk for or living with HIV
- Further strengthen data collection and reporting so that 37 states and the District of Columbia now report critical information on the care outcomes of people living with HIV

In addition, allocations are now based on the most recent known address for each person living with HIV rather than their residence at the time their infection was first diagnosed, to account for geographic mobility. Recent improvements in data collection and reporting have made this change possible.

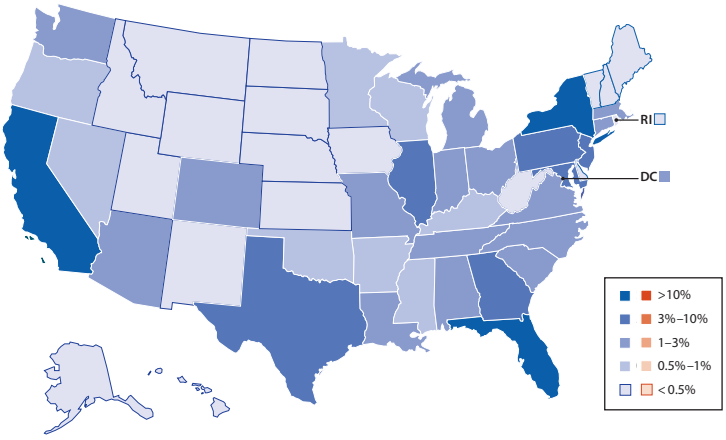
Through these awards, CDC is also taking steps to sustain core HIV surveillance and prevention capacity even in areas where the impact of HIV infections is relatively low. Every eligible jurisdiction has been allocated a minimum of $1 million, which is an increase that better reflects the needs of jurisdictions and was revised in consultation with health departments and the national organizations that represent them.

With a fixed amount of overall funding, CDC continues to allocate funds according to the burden of HIV, which has shifted over time. As a result of these changes, most health departments are receiving increases in funding – including many located in the South, which is now the most heavily affected region in the United States. Some health departments in areas with decreases in HIV infections are receiving less, and CDC will provide technical assistance to support ongoing high-quality surveillance and prevention activities.

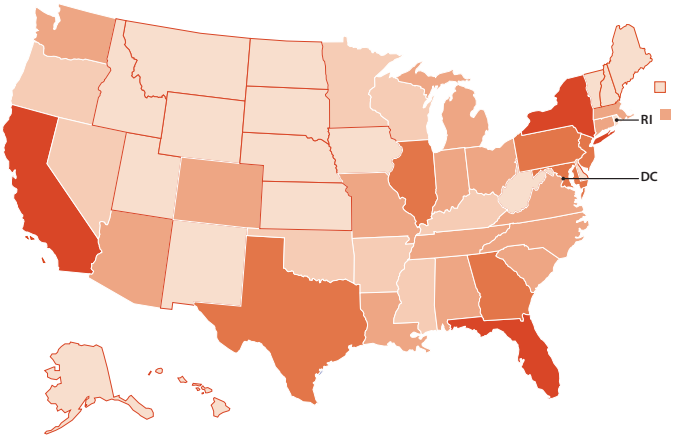
Matching Surveillance and Prevention Funds to HIV Prevalence[1]

CDC's HIV surveillance and prevention funding for health departments is fully aligned with the current geographic distribution of HIV.

Proportion of Americans Living with an HIV Diagnosis (2014)[2]



Proportion of CDC HIV Surveillance and Prevention Funding (2018)



[1]Maps do not include U.S. territories receiving CDC HIV surveillance and prevention funding.
[2]Prevalence is based on most recent known address for each person living with HIV rather than residence at the time their infection was first diagnosed, to account for geographic mobility.

Prioritizing High-Impact Prevention Strategies

In keeping with CDC's High-Impact Prevention approach, these awards prioritize proven, cost-effective prevention strategies with the greatest potential to reduce new HIV infections. Examples include:

- **HIV testing and diagnosis efforts**, informed by lessons from intensive testing efforts supported over the last several years by CDC's health department funding
- **Expanded use of innovative approaches such as Data-to-Care** to ensure people with HIV are engaged in medical care over the long-term and are achieving and maintaining viral suppression
- **Increasing prevention efforts for people most likely to acquire HIV, including PrEP awareness and availability** for communities most likely to benefit, such as gay and bisexual men of color and transgender people of color
- **Maintaining state-of-the-art surveillance and monitoring of infections**, trends, and care outcomes
- **Supporting community-level prevention activities,** including condom distribution, syringe services programs, and social marketing campaigns
- **Identifying and responding to HIV transmission clusters and outbreaks** through standard surveillance combined with cutting-edge transmission network analyses

Health departments will continue to have significant flexibility to allocate funds according to local needs.

More Information

For detailed information on the awards, including available technical assistance for health departments, visit https://www.cdc.gov/hiv/funding/announcements/ps18-1802

Notice of Funding Opportunity PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States

Component A Funding

Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Recipient with Corresponding Eligible Phase I Jurisdictions	Annual Funding
Alabama Department of Health	**$2,552,996 ***
Arizona Department of Health • Maricopa County	**$2,236,643**
Arkansas Department of Health	**$2,117,968 ***
California (CA) **CA Department of Public Health** • Alameda County • Orange County • Riverside County • Sacramento County • San Bernardino County • San Diego County **Los Angeles County Department of Public Health** • Los Angeles County **San Francisco Department of Public Health** • San Francisco County	**$8,421,484** **$3,360,658** **$2,290,288**
Florida Department of Health • Broward County • Duval County • Hillsborough County • Miami-Dade County • Orange County • Palm Beach County • Pinellas County	**$10,610,419**
Georgia Department of Public Health • Cobb County • DeKalb County • Fulton County • Gwinnett County	**$5,884,364**

Illinois **Chicago Department of Health** • Cook County	**$2,683,773**
Indiana State Department of Health • Marion County	**$2,048,962**
Kentucky State Cabinet for Health	**$1,988,268 ***
Louisiana Department of Health • East Baton Rouge Parish • Orleans Parish	**$3,232,231**
Maryland (MD) **Baltimore City Health Department** **MD Department of Health** • Montgomery County • Prince George's County	 **$2,250,648** **$3,281,428**
Massachusetts Department of Public Health • Suffolk County	**$2,087,400**
Michigan Dept. of Health and Human Services • Wayne County	**$2,111,141**
Mississippi State Department of Health	**$2,083,699 ***
Missouri Department of Health	**$2,519,930 ***
Nevada Department of Health **Southern Nevada Health District** • Clark County	**$2,144,080**
New Jersey Department of Health • Essex County • Hudson County	**$3,404,766**
New York City Dept. of Health & Mental Hygiene • Bronx County • Kings County • NY County • Queens County	**$7,988,289**

North Carolina Department of Health • Mecklenburg County	**$2,080,728**
Ohio Department of Health • Cuyahoga County • Franklin County • Hamilton County	**$4,392,029**
Oklahoma State Department of Health	**$2,146,293 ***
Pennsylvania **Philadelphia Department of Health** • Philadelphia County	**$2,442,477**
South Carolina Department of Health and Environmental Control	**$2,785,979 ***
Tennessee Department of Health • Shelby County	**$2,094,733**
Texas **Houston Dept of Health and Human Services** • Harris County **Texas Department of State Health Services** • Bexar County • Dallas County • Tarrant County • Travis County	**$2,642,329** **$6,069,792**
Washington State Department of Health • King County	**$2,118,114**
Washington, D.C. **District of Columbia Department of Health**	**$2,349,853**
Puerto Rico Department of Health • San Juan Municipio	**$2,011,005**

* Infectious Disease Consequences of the Opioid Epidemic (IDO) funding is included in the total funding amount for the seven rural states. IDO funding in the amount of $1,588,000 (approximately $226,857 for each rural state) must be allocated to support the opioid epidemic in their respective jurisdictions.

Important Note: Funding is subject to the availability of funds.

PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the U.S.
Logic Model

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Component A: Ending the HIV Epidemic Initiative (EHE) - Core			
Diagnose • Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities • Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings • Increase at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings	• **Increased routine opt-out HIV screenings in healthcare and other institutional settings** • **Increased local availability of and accessibility to HIV testing services** • **Increased HIV screening and re-screening among persons at elevated risk for HIV**	• **Increased knowledge of HIV status** • **Reduced new HIV diagnoses**	**Reduced new HIV infections**
Treat • Ensure rapid linkage to HIV medical care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV • Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs	• **Increased rapid linkage to HIV medical care** • **Increased early initiation of ART** • **Increased immediate re-engagement to HIV prevention and treatment services for PWH who have disengaged from care** • **Increased support to providers for linking, retaining, and re-engaging persons with HIV (PWH) to care and treatment**	• **Increased receipt of HIV medical care among persons with HIV** • **Increase viral suppression among persons living with diagnosed HIV**	
Prevent • Accelerate efforts to increase pre-exposure prophylaxis (PrEP) use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP • Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs)	• **Increased screening for PrEP indications among HIV-negative clients** • **Increased referral and rapid linkage of persons with indications for PrEP** • **Increased access to SSPs**	• **Increased PrEP prescriptions among persons with indications PrEP** • **Increased knowledge about the services and evidence-base of SSPs in communities** • **Increased quality of evidence-based SSP service delivery**	
Respond • Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response • Investigate and intervene in networks with active transmission • Identify and address gaps in programs and services revealed by cluster detection and response	• **Increased health department and community engagement for cluster detection and response** • **Improved surveillance data for real-time cluster detection and response** • **Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks**	• **Improved response to HIV transmission clusters and outbreaks**	
Component B: HIV Incidence Surveillance			
• Work with stakeholders (e.g., community, laboratories, and providers) to identify best practices for implementing a recency-based incidence surveillance • Conduct recency-based HIV incidence surveillance in selected jurisdictions • Review incidence results from a CD4 depletion model and a recency-based assay model	• Improved coordination with stakeholders including community, laboratory, and clinical providers to develop recency-based incidence surveillance • Increased capacity to collect recency-based assays from all persons aged 13 years and older with a new HIV diagnosis	• **Estimate HIV incidence in selected jurisdictions using a recency-based assay** • Review HIV incidence using a CD4 depletion model and a recency-based assay model.	

PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the U.S.
Logic Model

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Component C: Scaling up HIV prevention services in STD clinics			
• Conduct assessment of clinic infrastructure to document current HIV/STD prevention services, identify gaps, and assess service quality • Implement evidence-based approaches to scale up capacity for sexual risk assessments, self-collected STD testing, timely treatment, and HIV-related tests • Expand capacity of STD clinics to offer PrEP/nPEP and strengthen clinic and laboratory capacity for recommended follow-up visits • Optimize linkage to, retention in, and re-engagement in HIV medical care • Facilitate partnerships with community HIV clinical providers, health departments and community-based organizations for implementation of the EHE	• **Increased identification of new HIV and STD infections in STD specialty clinics** • **Increased rapid linkage to care for individuals newly diagnosed with HIV at STD specialty clinic** • **Increased identification of virally unsuppressed people in STD specialty clinics** • **Increased re-engagement to care for persons living with HIV who are not virally suppressed** • **Increased screening for PrEP/nPEP indication in STD specialty clinics** • **Increased PrEP-eligible individuals in STD specialty clinics who are offered and initiate PrEP, if indicated**	• Increased knowledge of HIV status • Increase viral suppression among persons living with diagnosed HIV • Increase persons receiving PrEP/nPEP.	Reduced new HIV infections

	Service Category	YR 29 (2019) Allocations		YR 29 (2019) Final Expenditures				2020 Allocations		
		Part A	MAI	Part A	MAI	Part B	HIV NCC	CDC EHE	HRSA CARES	HRSA 078
CORE SERVICES	Outpatient/Ambulatory Outpatient (AOM)	$ 9,810,822	$ -	$ 9,633,451	$ -	$ -	$ -	$ -	$ -	$ -
	Oral Health	$ 6,300,000	$ -	$ 5,821,872	$ -	$ -	$ 1,719	$ -	$ 15,000	$ 120,000
	Early Intervention Services (EIS)	$ 500,000	$ -	$ 1,088,738	$ -	$ -	$ -	$ -	$ -	$ -
	Mental Health	$ 300,000	$ -	$ 297,720	$ -	$ -	$ -	$ -	$ -	$ -
	Home and Community Based Health Services	$ 2,390,352	$ -	$ 2,581,793	$ -	$ -	$ -	$ -	$ -	$ -
	Medical Nutritional Therapy	$ 21,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Medical Case Management/ Medical Care Coordination (MCC)	$ 10,569,206	$ -	$ 8,888,809	$ 2,042,205	$ -	$ 230,131	$ -	$ -	$ -
SUPPORT SERVICES	Non-medical Case Management	$ 1,753,458	$ 752,024	$ 1,564,020	$ 830,408	$ -	$ 4,819	$ -	$ -	$ -
	Nutritional Support and Home Delivered Meals	$ 1,299,557	$ -	$ 2,117,073	$ -	$ -	$ -	$ -	$ 130,000	$ -
	Housing	$ 500,000	$ 1,455,000	$ 1,042,161	$ 2,238,934	$ 3,714,800	$ -	$ -	$ -	$ -
	Legal Services	$ 137,436	$ -	$ 115,567	$ -		$ -	$ -	$ -	$ -
	Linguistic Services	$ 17,976	$ -	$ -	$ -		$ -	$ -	$ -	$ -
	Medical Transportation	$ 1,148,938	$ -	$ 643,950	$ -		$ -	$ -	$ -	$ -
	Emergency Financial Assistance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,500,000
	Substance Use Residential Transitional	$ -	$ -	$ -	$ -	$ 785,200	$ -	$ -	$ -	$ -
	Outreach	$ -	$ 1,000,000	$ 1,193,902	$ -	$ -	$ -	$ -	$ -	$ -
OTHER SERVICES	Electronic Panel Management Tool						$ -	$ 200,000	$ -	$ -
	Community Mobilization						$ -	$ 1,000,000	$ -	$ -
	Community Engagement (COH)						$ -	$ 250,000	$ -	$ -
	Social Marketing/Media						$ -	$ 274,592	$ -	$ -
	DHSP Staff to implement Pillar 1 and 3 EHE Activities						$ -	$ 700,000	$ -	$ -
	Home Test Kits						$ -	$ 600,000	$ -	$ -
	PPE (for consumers)						$ -	$ -	$ 735,000	$ -
	DHSP Staff to implement Pillar 2 EHE Activities						$ -	$ -	$ -	$ 200,000
	Street Medicine Program						$ -	$ -	$ -	$ 825,427
	Re-engagement Incentives ($50 Gift Cards)						$ -	$ -	$ -	$ 250,000
	Vulnerable Populations						$ 1,982,735	$ -	$ -	$ -
	Heath Education/Risk Reduction						$ 721,690	$ -	$ -	$ -
	Biomedical HIV Prevention						$ 1,000,620	$ -	$ -	$ -
	HIV Testing Services						$ 1,311,523	$ -	$ -	$ -
	STD Services						$ 11,775	$ -	$ -	$ -
	NCC 2nd District/UUT						$ 532,555	$ -	$ -	$ -
	Other						$ 6,070	$ -	$ -	$ -
	Direct Services Total	$ 34,748,745	$ 3,207,024	$ 34,989,056	$ 5,111,547	$ 4,500,000	$ 5,803,637	$ 3,024,592	$ 880,000	$ 2,775,427
	DHSP Direct Services, CQM, Planning, Evaluation and Administration			$ 5,416,463	$ 356,336	$ 500,000	$ 12,398,621	$ 336,066	$ 120,000	$ 308,381
	Total			$ 40,405,519	$ 5,467,883	$ 5,000,000	$ 18,202,258	$ 3,360,658	$ 1,000,000	$ 3,083,808

Notes: Final MAI includes $2.1 in Carryover

LOS ANGELES COUNTY
COMMISSION ON HIV

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PROPOSED/FOR PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE APPROVAL (Revised 1.27.20; Includes changes from 12/17/19; 2/18/20 PP&A Meetings)

September XX, 2020

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

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

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

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

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

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities,

and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)

This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

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

The 2019 HIV Surveillance Report notes following areas of disparities:

Commented [BC1]: New information. Recent data from the 2019 HIV Surveillance Report

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

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

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

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

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug

use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWHA. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

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

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

1. Beginning in 2020: Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

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

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

Commented [BC2]: Committee asked to define "action". Revised to reflect suggestions from the Committee.

Commented [BC3]: Moved to the end of list per Committee discussion.

- Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
- It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (MSM), African American men and women, Latinx communities, and transgender individuals.

4. Continue to enhance Foodbank and Home Delivered Meals services to include better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins) and increase the amount food available for clients based on their individual needs or at least by 25%; cover essential non-food items such as personal hygiene products and household cleaning supplies. Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in the Housing for Health (HFH) program; increase target number of clients served under HFH from 125 to 250. Funds should also be used to support additional family housing for women and men with children and a housing specialist trained on the needs of women and families.

6. Continue to investigate the feasibility of expanding Medical Transportation to include ride-sharing services such as Uber and Lyft to support clients in accessing Ryan White services; expand the availability of vans to services with documented need and demand.

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

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

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

Commented [BC4]: Added per Committee discussion.

Commented [BC5]: Move line up as part of #9

domestic and intimate partner, or community violence.

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

10. Funds psychosocial services and support groups for women. Psychosocial support services must include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

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

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

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

Commented [BC6]: Updated dates and status information.

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

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

ATTACHMENT: Black/African American Task Force Recommendations (Click to open)