LOS ANGELES COUNTY
COMMISSION ON HIV

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Planning, Priorities, and Allocations Committee Meeting

Tuesday, October 17, 2023
1:00pm-4:00pm (PST)
Please note extended time

510 S. Vermont Ave,
Terrace Conference Room
Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

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

Members of the Public May Join in Person* or Virtually.
For Members of the Public Who Wish to Join Virtually, Register Here:

https://tinyurl.com/2a5hdjf5

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2537 099 0527

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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, OCTOBER 17, 2023 | 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://tinyurl.com/2a5hdjf5
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2537 099 0527

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros MBA, Co-Chair	Lilieth Conolly	Felipe Gonzalez
Michael Green, PhD	Ish Herrera	William King, MD, JD	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray, MSW	Jesus "Chuy" Orozco	Dechélle Richardson (Alternate)
Redeem Robinson (LOA)	Harold Glenn San Agustin, MD	LaShonda Spencer, MD	Lambert Talley (Alternate)
Jonathan Weedman			
QUORUM: 9			

AGENDA POSTED: October 12, 2023.

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

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.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, 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		1:00 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 1:18 PM – 1:30 PM
    a. Commission on HIV Annual Conference
    b. Bylaws Review Taskforce Updates
    c. CDC/HRSA Integrated HIV Plan Feedback Meeting
8. Co-Chair Report 1:30 PM – 1:45 PM
    a. Debrief Prevention Planning Workgroup September 27 Meeting
    b. November and December Meeting Schedule
    c. 2024 Co-chair Nominations
    d. 2024 Committee Priorities and Workplan Planning
9. Division of HIV and STD Programs (DHSP) Report 1:45 PM – 2:00 PM
    a. Fiscal Year 2022 Utilization Report - Housing, Emergency Financial Assistance and Nutrition Services
    b. Programmatic and Fiscal Updates

B R E A K 2:50 PM – 3:00 PM

V. DISCUSSION ITEMS 3:00 PM—3:50 PM

10. Prevention Integration and Status Neutral Planning

VI. NEXT STEPS 3:50 PM – 3:55 PM

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

VII. ANNOUNCEMENTS 3:55 PM – 4:00 PM

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

VIII. ADJOURNMENT 4:00 PM

14. Adjournment for the meeting of October 17, 2023

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.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/27/23

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL *	**Danielle**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	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
DANIELS	**Shonte**	Unaffiliated consumer	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	No Affiliation	No Ryan White or prevention contracts
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	**Ish**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
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
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (No Affiliation)	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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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

DRAFT

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

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
September 19, 2023

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	Derek Murray	P
Al Ballesteros, MBA, Co-Chair	P	Jesus "Chuy" Orozco	P
Lilieth Conolly	P	Dechelle Richardson	P
Felipe Gonzalez	P	Reverend Redeem Robinson	LOA
Michael Green, PhD, MHSA	EA	Harold Glenn San Agustin, MD	P
Ismael "Ish" Herrera	EA	LaShonda Spencer, MD	P
William King, MD, JD	P	Lambert Talley	P
Miguel Martinez, MPH, MSW	P	Jonathan Weedman	P
Anthony M. Mills, MD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon			
DHSP STAFF			
Sona Oksuzyan, MD, MPH			

*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. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, Dr. Mills, K. Donnelly, J. Weedman, M. Martinez, Dr. King, L. Conolly, F. Gonzalez, D. Murray, C. Orozco, D. Richardson, Dr. San Agustin, Dr. Spencer, L. Talley

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 were no public comments.

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. Weedman shared that the 5th Supervisorial District will be hosting a World AIDS Day breakfast event and invited the committee members to attend. More information to follow as the event approaches.

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **Bylaws Review Taskforce Updates**
      - C. Barrit, Commission on HIV (COH) Executive Director, reported that the Bylaws Review Taskforce (BRT) continues to make progress on review and update of the bylaws document. The BRT will meet Sept. 21st and plan to review the remaining portion of the document. Commission staff continue to work with County Counsel (CoCo) to ensure any suggested changes are within County guidelines and federal requirements.

   b. **Los Angeles Homeless Services Authority (LAHSA) Data Request Update**
      - C. Barrit noted that the first data request that was received in August was incomplete and Commission staff requested additional filters be added to the data. The updated data was received two weeks ago, and Commission staff are working on preliminary analysis. Initial analyses will be shared with the committee at a future Planning, Priorities, and Allocations (PP&A) Committee meeting.

   c. **RWP FY 2024 Non-Competing Progress Report Deadline**
      - C. Barrit reminded the committee that approximately two and a half years ago the Ryan White Program (RWP) changed from an annual application to a three-year funding cycle and noted this cycle aligns with the committees planning process. She noted the next Non-Competing Progress Report for the upcoming 2024 fiscal year is due on October 2nd to the

Health Resources and Services Administration (HRSA) and explained that the portion of the report that the Planning Council (PC) was responsible for was the Letter of Assurance that outlines responses to five questions from HRSA as related to planning processes, priority setting and resource allocation, training for members and the assessment of the administrative mechanism. The Letter of Assurance has been signed by Commission co-chairs and was submitted to the Division of HIV and STD Programs (DHSP). See meeting packet for more details.

8. Co-Chair Report

a. New Member Welcome

- K. Donnelly welcomed new PP&A committee members, Dr. Harold Glen San Agustin, and Lambert Talley. He noted new member Ismael "Ish" Herrera was absent due to illness.

b. Sexual Health and Older Adults September 22 Event

- K. Donnelly reminded Commissioners of the upcoming Sexual Health and Wellness for Older Adults event organized by the Aging Caucus. The event is geared toward providers to better serve their older patients, but all are welcome to attend. The event will be held on Friday, September 22 from 10am to 2pm at the Vermont Corridor. Approximately 90 have RSVPed for the event. See meeting packet for event flyer.

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

a. Fiscal Year 2022 Expenditures and Utilization Report

- DHSP staff, Sona Oksuzyan, provided a report on Mental Health and Substance Abuse Residential Services utilization for fiscal year 2022. See meeting packet for more details.
- It was noted that there has been a decline in Mental Health services within the RWP in program year 32 despite recent data showing the need for more mental health services for people living with HIV. It was noted that more data was needed to better understand the trend downward, but some possible explanations include lack of providers, Medi-Cal expansion, coverage by RWP Parts C & D over RWP Part A, and the Department of Health Services and/or other programs covering costs.
- Wendy Garland, DHSP staff, reminded the committee that the numbers only reflect RWP clients and that most services are covered by Medi-Cal, noting that the numbers indicate utilizing the RWP as the payor of last resort. She noted that currently, the RWP covers the same mental health services that are also covered by Medi-Cal and if the committee wants to see different populations served, then the Commission on HIV (COH) will need to identify and cover mental health services that are not covered by Medi-Cal. For example, W. Garland noted psychotherapy is not covered by Medi-Cal. W. Garland also noted that DHSP is currently working to identify other ways that mental health services can be provided acknowledging the need for services and noted that there was also a shortage of providers.
- A. Ballesteros commented that a key challenge faced providers with Ryan White funded mental health services is the fee for service model. A fee for service model hampers the

ability of providers to hire a full-time mental health professional. DHSP needs to allow for a line-item budget for mental health services and staff similar to Part C grants. He explained most agencies cannot afford to hire a mental health provider under the fee for service structure noting that billing is not enough to cover salary and benefits and would result in the agency running in a deficit. He suggested that this may be another reason why mental health services utilization is low under RWP Part A and asked that DHSP consider switching to a line-item budget. He noted mental health providers were previously structured as line-items and it would help increase capacity and access.

- Dr. San Agustin recommended getting feedback from clients as to why people are no longer seeking mental health services to help identify both positive factors that keep patients engaged in care and negative factors that contribute to stopping care.
- F. Gonzalez noted that more needs to be done to support the mental health needs of women of color.
- C. Orozco commented that the ability to fund permanent supportive housing for HOPWA clients is due to the increased need for mental health services.
- D. Murray recommended identifying what is covered under Medi-Cal and what is not to increase services within the RWP. C. Barrit noted that the committee can identify new services to support that are not supported by Medi-Cal and coordinate with the Standards and Best Practices Committee to then develop service standards for service delivery.
- L. Talley commented that, based on his experience, a lot of clients are unaware of the mental health services that are available to them and that more needs to be done to increase awareness.
- L. Conolly noted that more providers need to be trained in offering compassionate care, particularly for women who are often needing mental health support beyond HIV, such as dealing with raising children as a single provider.
- M. Martinez noted many communities of color utilize a paraprofessional model to provide needed support and escalate to licensed professionals based on acuity and asked if the service standards allow for this type of model. It was noted that RWP regulations specifically state licensed mental health professionals.
- Carlos Vega-Matos reported that though telehealth is offered many young individuals cannot access this service due to incompatibility with software and lack of privacy within their living situations to engage in services. He recommended access to technology be tracked in the future.
- A. Ballesteros recommended the committee request that DHSP pilot the transition of mental health services as a line-item budget vs a fee for service model, explore ancillary services, such as the use of paraprofessionals, that can help support/round out mental health services, and identifying factors that contribute to drop off in mental healthcare.
- M. Martinez recommended requesting a presentation from the Department of Mental Health (DMH) on mental health services for people living with HIV and other priority populations.
- D. Murray requested information on what services are being provided in residential

substance use facilities as well as what specific substances clients being treated for. A. Ballesteros added that, based on the report, the average daily rate for services is approximately $70/day and requested a report back from DHSP on what services are provided. He noted this rate is much lower than the average daily rate for services under the Substance Abuse Prevention and Control (SAPC) program. W. Garland indicated that she will check the SAPC rate and specific services provided under residential substance use.

- Dr. Spencer suggested comparing mental health services utilization data with under Part C and D providers.

b. Programmatic and Fiscal Updates

- No report was provided.

V. DISCUSSION

10. Prevention Planning Workgroup (PPW) August 23 Meeting Recap & Status Neutral Recommendations

- Dr. King and M. Martinez, Prevention Planning Workgroup (PPW) co-chairs, reported that the PPW continue to make progress on Prevention Standards recommendations and provided a presentation on proposed status neutral recommendations and integration of prevention within the PP&A Committee. See meeting packet for details.
- Recommendations included adding medical home within Quality Care and community engagement and outreach into the graphic. It was noted that many patients seek HIV and STI services outside of their primary care providers but that securing a medical home is important for clients that do not have one.
- D. Murray asked if integrating prevention into the committee and commission would require revisions to the bylaws or any other formal process. C. Barrit noted current bylaws already articulate the charge of the PP&A Committee and the COH as an integrated planning body. However, she recommended developing a written status neutral priority setting and resource allocation process to ensure a strong prevention component to the Committee's deliberations and decision making.
- A recommendation was made to continue the PPW as a committee to ensure prevention discussions and priorities continue. M. Martinez commented that continuing as a committee will continue to have prevention separated from care and would undermine the goal of the status neutral framework.

11. Review Community Listening Sessions Questionnaire Feedback

- L. Martinez, Commission staff, reported that minor changes to the Community Listening Sessions Questionnaires were made based on feedback received. She noted the review was another opportunity for committee members to provide any additional feedback before the questionnaires are finalized.
- A recommendation was made to add an option to decline to respond to sexual orientation and gender identity questions in addition to adding a column in the client/consumer questionnaire

table regarding being unaware but needing services. See meeting packet for more details.

12. Recap Department of Health Services (DHS) HIV Cascade Data Presentation

- K. Donnelly postponed the discussion to the next PP&A Committee meeting due to time constraints.

13. Recap Cities/Health Districts Harm Reduction Report

- K. Donnelly postponed the discussion to the next PP&A Committee meeting due to time constraints.

VI. NEXT STEPS

- **Task/Assignments Recap**
  - **a.** Review FY 33 RWP Expenditures
  - **b.** Review and Analyze LAHSA Data
  - **c.** Recap HIV & STDs Surveillance and Data Challenges for LA County Native American Communities

- **Agenda Development for the Next Meeting**
  - **a.** Continue RWP Utilization Reports
  - **b.** Review FY33 RWP Expenditures
  - **c.** LAHSA Data Review

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

- **Adjournment for the Meeting of September 19, 2023.**
  The meeting was adjourned by K. Donnelly at 3:58pm.

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COMMISSION ON HIV

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The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

On the web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles Public Health
Division of HIV and STD Programs

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Comparta sus inquietudes con nosotros.

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¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

¿Puedo llamar de forma anónima?

Si.

¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

En el sitio web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles
Public Health
Division of HIV and STD Programs

CDC DHP and HRSA HAB, HIV Integrated Prevention and Care Plan, CY2022-2026
Summary Statement

CENTERS FOR DISEASE CONTROL AND PREVENTION

Health Resources & Services Administration

SECTION I: Integrated Plan Submission and Review Summary	
Jurisdiction	**Los Angeles County Department of Public Health**
Submission Type	☐ Integrated state/city prevention and care plan ☐ Integrated state-only prevention and care plan ☒ Integrated city-only prevention and care plan ☐ Other:_____
RWHAP Part A Jurisdictions (EMA/TGA) or MSAs included in the plan	**Los Angeles EMA**
Did the jurisdiction use portions of other plans to satisfy requirements (e.g., EHE plan)?	☒ Yes ☐ No or Not Applicable **Name of Plan(s) Used:** EHE Plan **If available, URL to other Plan(s):** https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf
Executive Summary Included	☒ Yes ☐ No
CDC and HRSA Reviewer's Name(s)	
CDC Reviewer's Name:	Kevin Ramos
CDC Reviewer's Name:	Benjamin T. Laffoon
HRSA Reviewer's Name:	Babak Yaghmaei
HRSA Reviewer's Name:	Tonia Schaffer

SECTION II: Community Engagement and Planning Process	
Please select all planning bodies that participated in developing the Integrated Plan.	☒ Integrated HIV Prevention and Care Planning Body ☒ RWHAP Part A Planning Council/Planning Body ☐ RWHAP Part B Advisory Group ☐ HIV Prevention Group (HPG) ☒ EHE Planning Body

	☐ Other, please specify:
1. Jurisdiction Planning Process: Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals, and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans, such as the EHE plan. Please be sure to address the items below in your description.	**CDC-HRSA Response** Yes
a. **Entities Involved in Process:** List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities, such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. See *Appendix 3* for a list of required and suggested stakeholders.	**CDC-HRSA Response** Yes
b. **Role of RWHAP Part A Planning Council/Planning Body (not required for state-only plans):** Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.	**CDC-HRSA Response** Yes
1. **Role of Planning Bodies and Other Entities:** Describe the role of the CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement that occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.	**CDC-HRSA Response** Yes

2. **Collaboration with RWHAP Parts:** Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system.	**CDC-HRSA Response** Yes
3. **Engagement of People with HIV:** Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan.	**CDC-HRSA Response** Yes
4. **Priorities:** List key priorities that arose out of the planning and community engagement process.	**CDC-HRSA Response** Yes
5. **Updated to Other Strategic Plans Used To Meet Requirements (Only for those jurisdictions that used sections of other plans):** If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe the following: 1. How the jurisdiction uses annual needs assessment data to adjust priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders. 3. Any changes to the plan because of updated assessments and community input. Any changes made to the planning process because of evaluating the planning process.	**CDC-HRSA Response** Yes

General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing):

- The Los Angeles Department of Public Health submitted a detailed Integrated HIV Prevention and Care Plan that meets the Integrated Plan Guidance submission requirements for the jurisdictional planning process. The Ending the HIV Epidemic in the U.S. (EHE) Plan was used to inform the Integrated HIV Prevention and Care Plan for setting goals and objectives. It was a collaborative effort between the HIV Planning Council, the Los Angeles County Division of HIV and STD Programs (LAC DHSP), as well as community stakeholders, including people with HIV. The jurisdiction provided a detailed list of community entities involved in the planning process. Additionally, the jurisdiction collaborates with Ryan White HIV/AIDS Program (RWHAP) planning bodies, specifically the RWHAP Part A Planning Council, where the Los Angeles Commission on HIV/AIDS serves as a member. It is important to note that RWHAP Part B, Part C, Part D, and Part F were also engaged in the planning process. As a result, of these collaborative efforts, the jurisdiction successfully identified, using current surveillance data and ongoing feedback from

stakeholders, 10 key priorities further addressed and discussed in the Integrated HIV Prevention and Care Plan.

SECTION III: Contributing Data Sets and Assessments	
1. **Data Sharing and Use:** Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data-sharing agreements and for what purpose.	**CDC-HRSA Response** Partial
2. **Epidemiologic Snapshot:** Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction that uses the most current available data (trends for the most recent five years). The snapshot should highlight key descriptors of people diagnosed with HIV and at risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at risk for exposure to HIV. This snapshot should also describe any HIV clusters identified and outline key characteristics of clusters and cases linked to these clusters. Priority populations for prevention and care should be highlighted and aligned with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction, showing the impact of HIV in the jurisdiction.	**CDC-HRSA Response** Yes
3. **HIV Prevention, Care, and Treatment Resource Inventory:** Create an HIV Prevention, Care, and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive: • Organizations and agencies providing HIV care and prevention services in the jurisdiction. • HRSA (must include all RWHAP parts) and CDC funding sources. • Leveraged public and private funding sources, such as those through HRSA's Community Health Center Program, HUD's HOPWA Program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding. • Describe the jurisdiction's strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services.	**CDC-HRSA Response** Yes

• Services and activities provided by these organizations in the jurisdiction and, if applicable, which priority population the agency serves. • Describe how services will maximize the quality of health and support services available to people at risk for or with HIV.	
a. Strengths and Gaps: Please describe strengths and gaps in the HIV prevention, care, and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools, such as injectable antiretrovirals, and other environmental impacts.	**CDC-HRSA Response** Yes
b. Approaches and Partnerships: Please describe the approaches the jurisdiction used to complete the HIV prevention, care, and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.	**CDC-HRSA Response** Yes

4. **Needs Assessment** Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data, including: 1. Services people need to access HIV testing, as well as the following status-neutral services needed after testing: a. Services people at risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs 2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression –Needs 3. Barriers to accessing existing HIV testing, including state laws and regulations, HIV prevention services, and HIV care and treatment services – Accessibility	**CDC-HRSA Response** Yes
a. Priorities: List the key priorities arising from the needs assessment process.	**CDC-HRSA Response** Yes
b. Actions Taken: List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.	**CDC-HRSA Response** Yes
c. Approach Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in *Appendix 3.*	**CDC-HRSA Response** Yes

General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing):

- The jurisdiction met the submission requirements for Section II: Contributing Data Sets and Assessments. The jurisdiction uses multiple data sources to monitor HIV/STD epidemics, as well as track service utilization. The jurisdiction provided an epidemiological snapshot, highlighting the impact that HIV is having on the 26 health districts, especially those in the Service Planning Areas (SPAs) that have the highest rates of HIV.
- The jurisdiction submitted a detailed resources inventory list and funding amounts of each entity; however, the list, per the jurisdiction, is incomplete, as it did not include the funding amounts from private donors.
- The jurisdiction met the requirements for the Needs Assessment section of the Integrated HIV Prevention and Care Plan. The jurisdiction discussed their use of multiple assessment activities

and methods to assess people with HIV and people affected by HIV in Los Angeles County. The jurisdiction also used numerous secondary data sources and reports to complete the Statewide Coordinated Statement of Need (SCSN). A detailed list of all sources and reports are denoted in the plan.

- HRSA: Data sharing is partially met. The submission includes lots of data sets but does not include language on how the jurisdiction will share the data.

SECTION IV: Situational Analysis	
1. Situational Analysis: Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues affecting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas: a. Diagnose all people with HIV as early as possible. b. Treat people with HIV rapidly and effectively to reach sustained viral suppression. c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs). d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. *Please note jurisdictions may submit other plans to satisfy this requirement if applicable to the entire HIV prevention and care service system across the jurisdiction.*	**CDC-HRSA Response** Yes
a. **Priority Populations:** Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.	**CDC-HRSA Response** Yes
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for the Situational Analysis section of the Integrated HIV Prevention and Care Plan. Specifically, the Situational Analysis highlights the disparities experienced by the seven identified key priority populations. These disparities are driven by structural and systemic issues, including housing status, poverty, recent incarceration, and comorbid conditions, i.e., substance use and mental health disorders.	

SECTION V: 2022-2026 Goals and Objectives	
Did the plan list and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent, and respond to HIV? Be sure the goals address any barriers or needs identified during the planning process. There should be at least three goals and objectives for each of these four areas. See Appendix 2 for the suggested format for Goals and Objectives.	
Diagnose	**CDC-HRSA Response** Yes
Treat	**CDC-HRSA Response** Yes
Prevent	**CDC-HRSA Response** Yes
Respond	**CDC-HRSA Response** Yes
a. Updates to Other Strategic Plans Used to Meet Requirements (applicable only if the recipient used other plans to satisfy this requirement): If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made because of the analysis of data.	**CDC-HRSA Response** Yes
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for the Goals and Objectives section (Section IV) of the Integrated HIV Prevention and Care Plan. As previously discussed, the Ending the HIV Epidemic in the U.S. Plan was used to inform the goals and objectives of the Integrated HIV Prevention and Care Plan. The plan includes specific, measurable, achievable, realistic, time-bound (SMART) goals and objectives that are aligned with the four pillars: Diagnose, Treat, Prevent, and Respond. Further, the jurisdiction also included key foundational and cross-pillar elements, which support each pillar's strategies and activities.	

SECTION VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up	
1. 2022-2026 Integrated Planning Implementation Approach: Describe the infrastructure, procedures, systems, or tools that will support the five key phases of integrated planning to ensure goals and objectives are met.	**CDC-HRSA Response** Yes

a. **Implementation** Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdiction's Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams, including but not limited to HAB and CDC funding.	**CDC-HRSA Response** Yes
b. Monitoring Describe the process for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. *<u>Note</u>: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.*	**CDC-HRSA Response** Yes
c. Evaluation: Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts an analysis of the performance measures and presents data to the planning group/s.	**CDC-HRSA Response** Yes
d. Improvement: Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.	**CDC-HRSA Response** Yes
e. Reporting and Dissemination: Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation, and improvements made to the plan.	**CDC-HRSA Response** Yes

2. Updates to Other Strategic Plans Used to Meet Requirements (applicable only if the recipient used other plans to satisfy this requirement): If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe the following: 1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities. 2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes. 3. Revisions are made based on work completed.	**CDC-HRSA Response** Yes
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for Section VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up. The Integrated HIV Prevention and Care Plan includes an implementation plan that also includes performance measures, responsible parties, and timelines related to each activity. The Commission on HIV, in collaboration with the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), is responsible for monitoring progress toward meeting plan goals and objectives, which were discussed in detail.	

SECTION VII: Letters of Concurrence	
1. CDC Prevention Program Planning Body Chair(s) or Representative(s) 2. Community Co-Chair	**CDC-HRSA Response** Concurrence
3. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	**CDC-HRSA Response** Concurrence
4. RWHAP Part B Planning Body Chair or Representative	**CDC-HRSA Response** Concurrence
5. Integrated Planning Body	**CDC-HRSA Response** Concurrence
6. EHE Planning Body	**CDC-HRSA Response** N/A
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for Section VII: Letters of Concurrence. A letter of concurrence from the Los Angeles Commission on HIV, including Ryan White HIV/AIDS Program Part A, is addressed to the Director of the Division of HIV and STD Programs and has been signed by the County Commission on HIV (COH) co-chairs.	

Integrated Plan Submission Review Summary

I. Highlights and Observations of Plan:

- Overall, the jurisdiction submitted an Integrated HIV Prevention and Care Plan that met all Integrated Plan Guidance submission requirements. As previously stated, the jurisdiction used the EHE Plan as the foundation for development and implementation. The jurisdiction engaged a wide breadth of internal and external partners, as well as diverse community stakeholders, especially people with HIV. Also, the jurisdiction used current epidemiological data from a variety of data resources. As a result, the jurisdiction identified six priority populations, as well as three priority jurisdictions (Hollywood, Wilshire, and Long Beach) that have the highest rates of HIV.

II. Plan Strengths:

- The Integrated HIV Prevention and Care Plan met all the Integrated Plan Guidance submission requirements.
- The Integrated HIV Prevention and Care Plan utilized current epidemiological data, which was abstracted from a variety of data resources listed in the plan.
- The status-neutral approach to HIV care and prevention is embraced by the jurisdiction. It was identified as one of the key priority areas of focus that arose out of the community engagement process.
- The Goals and Objectives (Section V) was comprehensive, with clearly laid out objectives and strategies to ensure that implementation has a positive impact on the communities. Additional goals were listed beyond the necessary requirements.

III. Programmatic/Legislative Compliance Issues:

None noted.

Action Items to Resolve Programmatic/Legislative Compliance Issues:

None noted.

IV. Recommendations for Plan Improvement:

- Improve how data sharing occurs within the entities involved. The submission includes data systems, along with data presentation, but it is unclear "how" data was shared and what agreements are in place.
- Additional information is needed as to how the community is being engaged and playing a key role within the components of the Integrated HIV Prevention and Care

Plan. Submission indicates that the community members will be engaged but does not go further to define how this engagement will occur in the long term.

V. Capacity Building/Technical Assistance Suggestions:

None noted.

VI. Items for Future Monitoring Discussions:

Discuss plan components and/or activities in the monthly call.

LOS ANGELES COUNTY COMMISSION ON HIV

2023 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly & Alvaro Ballesteros
Committee Adoption Date:	Revision Dates:

GOAL: To focus and prioritize key activities for COH 2023
Objective: Reduce the number of new HIV and STD infections while increasing HIV care outcomes for PLWH in LA County.

#	TASK	ACTIVITIES/DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
	Achieve consensus and a common vision of how to conduct planning, priority, setting and resource allocations (PSRA) using a status neutral approach.	1. Education and training on status neutral approach and how to implement in planning process. 2. Develop status neutral PSRA process document by building upon paradigms, values, priority populations, and identifying ways to complement/enhance funded RW services categories to create stronger, more integrated prevention services.	March, April, May PP&A meetings	• Education would focus on establishing a baseline and common understanding of status neutral approach. • Weave in service needs discussions around priority areas such as housing, mental health, substance use, and STDs. **Resources:** Target HIV slides/webinar recording, NYC speakers, COH Comprehensive HIV Prevention and Care Framework, Prevention Planning Workgroup
	Use agreed upon status neutral PRSA process to prepare for FY 25, 26, 27 Ryan White funding cycle and grant application.	1. Utilize agreed upon status neutral PSRA process to plan for the RWP and CDC grant applications. 2. Review unmet need estimates report from DHSP. 3. Identify additional data needed to inform planning process.	June, July, August, Sept PP&A meetings	Target months may change depending on when Notices of Funding Opportunity are released. **Resources:** NOFO, unmet need estimates, service utilization report for prevention and care programs/services,

LOS ANGELES COUNTY COMMISSION ON HIV

2023 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

	Use agreed upon status neutral PRSA process to prepare CDC grand application.	4. Develop status neutral programmatic elements to include in grant applications. 5. Harness input from Caucuses, workgroups, and Committees. 6. Develop status neutral program directives.		
	Review CHP Performance Indicators	1. Monitor the implementation of the CHP The Committee will work with DHSP and various partners to implement and monitor progress toward meeting the goals and objectives of the CHP. 2. Develop progress report.	November-December PP&A meetings	**Resources:** CHP and EHE plans, DHSP updates, County departments
ONGOING ACTIVITIES				
	1. Continue to track expenditures and service needs as reallocation RW and CDC funding as needed. 2. Continue to monitor status of program directives, service utilization, Part A, MAI, and other funding sources. 3. Continue to collaborate with PPW to strengthen integrated prevention and care planning. 4. Monitor and discuss systems of care changes and impact on care and prevention planning.			

Ryan White Program Year 32

Care Utilization Data Summary

Part 3 – Housing, Emergency Financial Assistance, Nutrition Support

Oct 17, 2023
COH Planning, Priorities, and Allocations Committee

Sona Oksuzyan, PhD, MD, MPH
Division of HIV and STD Programs

HOUSING, EMERGENCY FINANCIAL ASSISTANCE AND NUTRITION SERVICES

BACKGROUND

As a Ryan White Program (RWP) Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives grant funds from the Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB) to increase access to core medical and related support services for people living with HIV (PLWH)[1]. The amount of the award is based on the number of PLWH residing in LAC. DHSP receives additional funding from HRSA-HAB to reduce disparities in health outcomes among persons of color living with HIV through the Minority AIDS Initiative (MAI) and discretionary funds from the LAC Department of Public Health (net county costs [NCC]). DHSP received a total of $45.9 million from HRSA-HAB in fiscal year 2022 that included $42.1 million for Part A and $3.8 million for MAI.

HRSA-HAB and the Centers for Disease Control and Prevention (CDC) require that local HIV planning bodies develop integrated HIV prevention plans in collaboration with the health department to guide prevention and care efforts within the jurisdiction[2]. HIV surveillance and supplemental surveillance along with program service data and unmet need estimates are used to identify priority populations of focus. In LAC, the populations of focus overlap with priority populations identified in the local "Ending the HIV Epidemic" strategic plan and shown in bold[3]. These include:

1. **Latino Cisgender Men Who Have Sex with Men (MSM)**
2. **Black Cisgender MSM**
3. **Cisgender Women of Color**
4. **Transgender Persons**
5. **Youth Aged 13-29**
6. PLWH ≥ Age 50
7. **Persons Who Inject Drugs (PWID)**
8. RWP Clients Who Were Unhoused

Though not identified as priority populations in the integrated or Ending the HIV Epidemic (EHE) plans, we include RWP clients 50 years of age and older and those experiencing homelessness as an important subpopulation living with HIV with need for RWP services in LAC.

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[1] Ryan White HIV/AIDS Programs Parts & Initiatives. (2022). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/about/parts-and-initiatives
[2] Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026.(2021). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf
[3] Ending the HIV Epidemic Plan for Los Angeles. (2021). In lacounty.hiv. Retrieved July 19, 2023, from https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

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

This report series summarizes utilization of medical and support services by RWP clients in Contract Year 32 (March 1, 2022-February 28, 2023) to inform the planning and allocation activities of the LAC Commission on HIV (COH). To inform focused discussion, we will present services in the following service clusters:

1. Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services
2. Mental Health and Substance Abuse (Residential) services
3. **Housing, Emergency Financial Assistance (EFA), and Nutrition Support (NS) services**
4. General and Specialty Oral Health services
5. Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

The data presented is intended to provide priority highlights of who is accessing RWP services in LAC (demographic and socio-economic characteristics, priority populations), the types of services accessed, funding sources, and how these services are delivered (in-person or telehealth). The detailed source tables are included in the appendix for reference.

Outcomes and Indicators

The following information will be used to describe service utilization and estimate expenditures. Each of the five service clusters will include:

- HIV Care Continuum Outcomes (engagement in care, retention in care (RiC) and viral suppression (VS) among priority populations:
  - Engagement in HIV care =≤1 viral load or CD4 test in the contract year
  - Retention in HIV care =≤2 viral load or CD4 tests at least 90 days apart in the contract year
  - Viral suppression =Most recent viral load test <200 copies/mL in the contract year
- RWP service utilization and expenditure indicators by service category:
  - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
  - Service units per client=Total service units/Number of clients
  - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
  - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

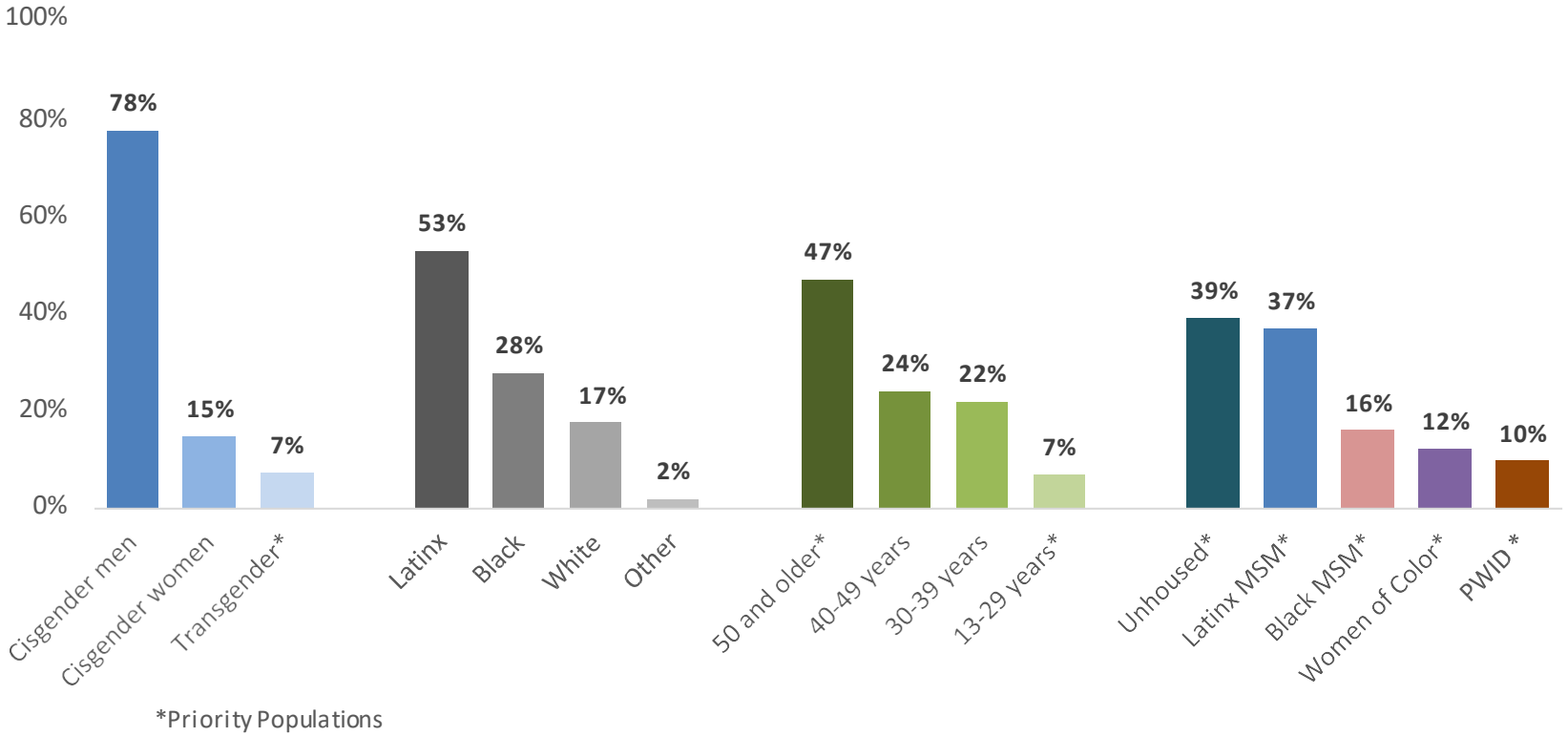
- HIV Casewatch (local RWP data reporting system)
  - Client characteristics and service utilization data reported by RWP contracted service agencies
  - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

HOUSING SERVICES

Population Served:

- In Year 32, a total of 241 clients received Housing Services in Year 32. In LAC this category includes:
  - Permanent Supportive Housing, also known as Housing for Health [H4H], that served 157 clients
  - Residential Care Facilities for Chronically Ill (RCFCI) that served 54 clients
  - Transitional Residential Care Facilities (TRCF) that served 31 clients
- Most Housing Services clients were cisgender men, Latinx, and aged 50 and older (Figure 1)
- Among the priority populations, the largest percent served were PLWH ≥ age 50, followed by unhoused people and Latinx MSM
- Unhoused status includes those clients who reported experiencing homelessness at their most recent intake during the contract year but may not necessarily reflect their housing status at the time they received the service).

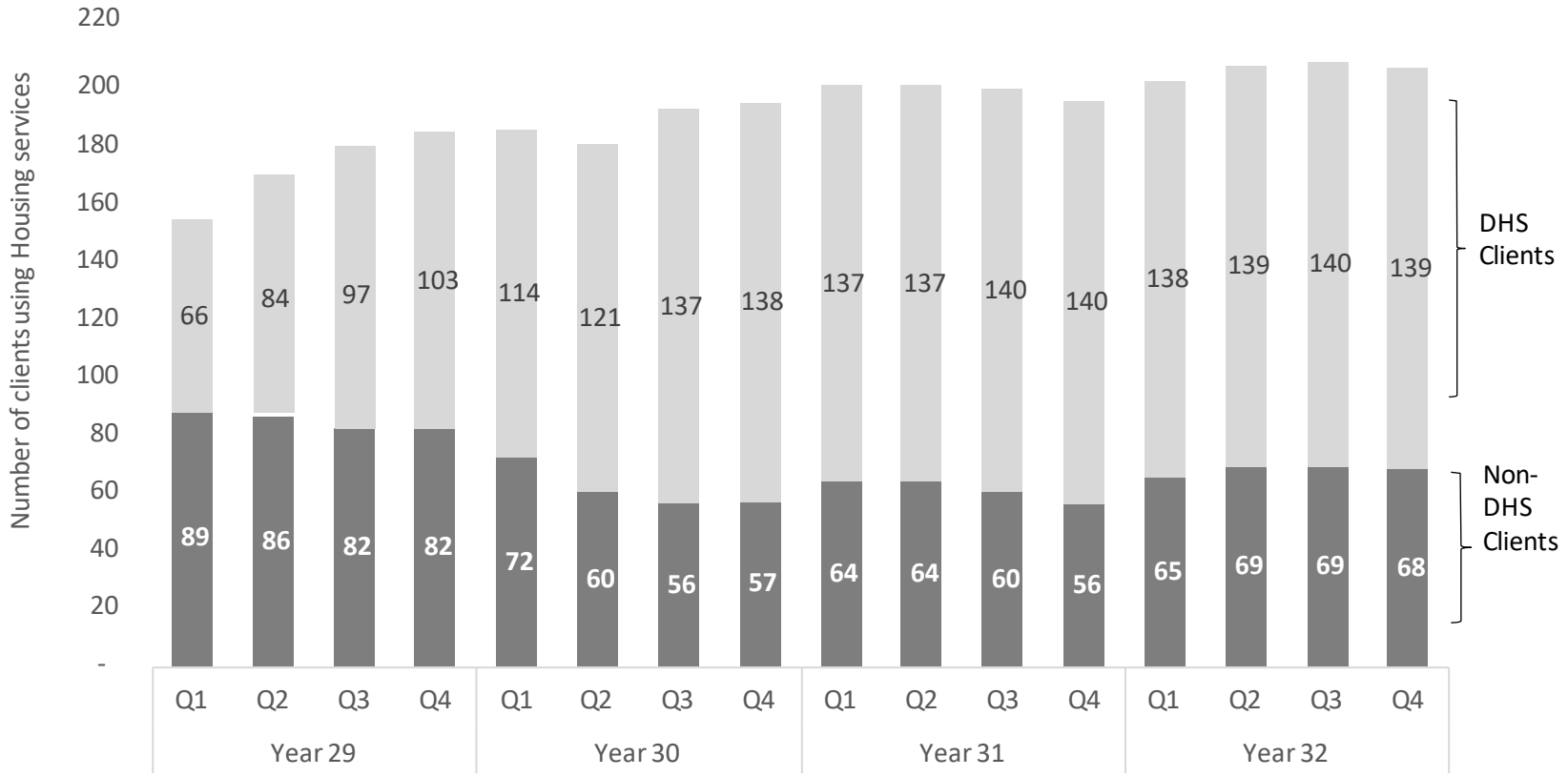
Figure 1. Key Characteristics of RWP Clients in Housing Services in LAC, Year 32



Service Utilization

Figure 2 below shows the number of RWP clients accessing Housing services from Year 29 through Year 32 by quarter. While DHS discontinued providing Ambulatory Outpatient Medical, Medical Care Coordination and Mental Health Service in Year 31, they continue to provide Housing and EFA services. The light grey part of the bar shows the number of DHS clients. The darker grey part of the bar shows the number of all other (non-DHS) clients. The total number of Housing clients increased over time including during the COVID-19 pandemic in Year 30. During this time, the number of Housing clients at DHS sites increased while the number clients served at non-DHS sites gradually decreased. All Housing services were provided in-person.

Figure 2. Department of Health Services (DHS) and Non-DHS Housing Clients by Quarter in LAC, RWP Years 29-32



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

Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (5%), Part B (54%), MAI (41%)**
- Percentage of RWP Clients Accessing Housing services in Year 32: **1.6%**
- Unit of Service: **Days**

Table 1. Housing Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total days	% of days	Days per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total Housing clients	***241***	***100%***	***70,157***	***100%***	***291***	***$33,054***	***$7,965,955***
H4H	*157*	*65%*	*48,577*	*69%*	*309*	*$13,625*	*$3,283,615 (MAI)*
RCFCI	*54*	*22%*	*15,354*	*22%*	*284*	*$55,086*	*$418,179 (Part A) + $4,264,161 (Part B)*
TRCF	*31*	*13%*	*6,226*	*9%*	*201*		*Total $4,682,340*
PLWH ≥ age 50	114	**47%**	**34,895**	**50%**	**306**	**$34,938**	**$3,982,978**
Unhoused in the contract year	94	**39%**	**24,889**	**35%**	265	$29,660	**$2,788,084**
Latinx MSM	89	**37%**	**24,697**	**35%**	277	$31,327	**$2,788,084**
Black MSM	38	16%	11,926	17%	**314**	**$35,637**	$1,354,212
Women of Color	29	12%	9,095	13%	**314**	**$35,709**	$1,035,574
Persons who inject drugs (PWID)	23	10%	5,990	9%	260	$31,171	$716,936
Transgender Persons	17	7%	5,181	7%	305	$32,801	$557,617
Youth aged 13-29	16	7%	**4,054**	6%	**253**	$29,872	$477,957

Table 1 Highlights

- *Population Served:* The largest number and percent of HS clients were PLWH ≥ age 50 (47%), followed by clients who were unhoused in the contract year (39%) and Latinx MSM (37%).
- *Service Utilization:*
  - PLWH ≥ age 50 had received half of HS days.
  - Utilization of days per client was the highest among Black MSM and women of color (314 days/client each), followed by clients ≥ age 50 (306 days/client) compared to all clients overall and other subpopulations.
  - While days per client were the lowest among youth aged 13-29 clients (253 days/client), they also represented the smallest numbers of HS clients.

- The percent of HS in days was slightly higher relative to their population size among clients ≥ age 50 (47% vs 50%).
- The percent of HS in days was slightly lower relative to their population size among Latinx MSM (37% vs 35%).

- *Expenditures:*
  - Expenditure per client were highest among Black MSM and women of color, although those subpopulations did not represent the highest percentage of HS clients.
  - Expenditures per client were the lowest among clients who were unhoused in the contract year despite being the second largest subpopulation served by HS (39%).

HIV Care Continuum (HCC) Outcomes

Table 2 below shows HCC outcomes for RWP clients receiving HS in Year 32. Housing clients had slightly higher engagement in care and retention in care compared to RWP clients who did not accessing HS. There was no difference in viral suppression between HS and non-HS clients.

Table 2. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use Housing services (HS) in LAC, Year 32

HCC Measures	HS clients		Non-HS clients	
	N=241	%	N=14,531	%
Engaged in HIV Care [a]	230	95%	13,616	94%
Retained in HIV Care[b]	187	78%	10,194	70%
Suppressed Viral Load at Recent Test[c]	199	83%	12,078	83%

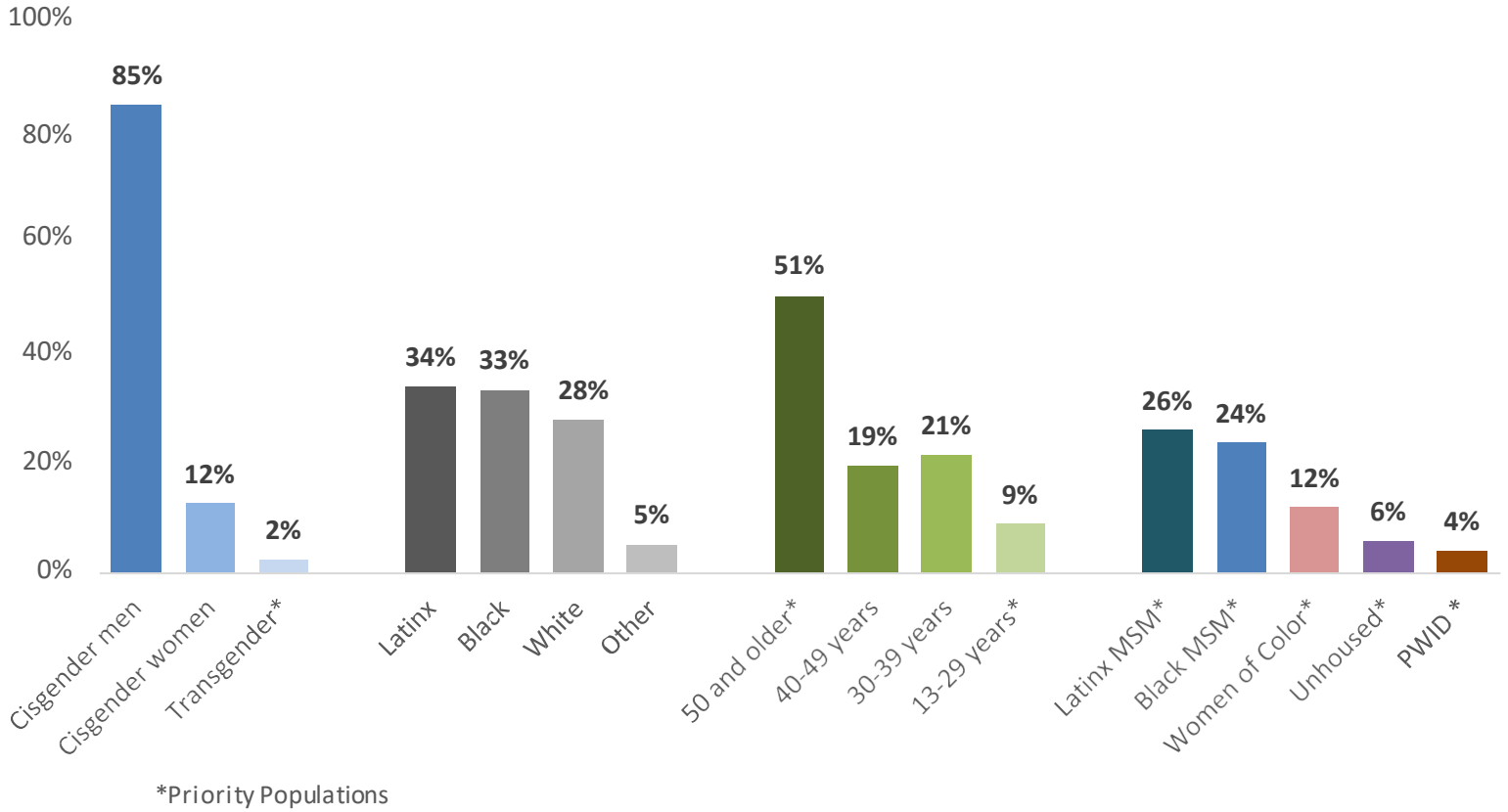
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

EMERGENCY FINANCIAL ASSISTANCE (EFA) SERVICES

Population Served:

- In Year 32, a total of 378 clients received EFA that includes three types of service:
  - Food Assistance provided to 30 clients
  - Rental Assistance provided to 283 clients
  - Utility Assistance provided to 162 clients
- Most EFA clients were cisgender men, Latinx and Black, and aged 50 and older (Figure 3)
- PLWH ≥ age 50 represented the largest percent among priority populations (51%), followed by Latinx MSM (26%) and Black MSM (24%).

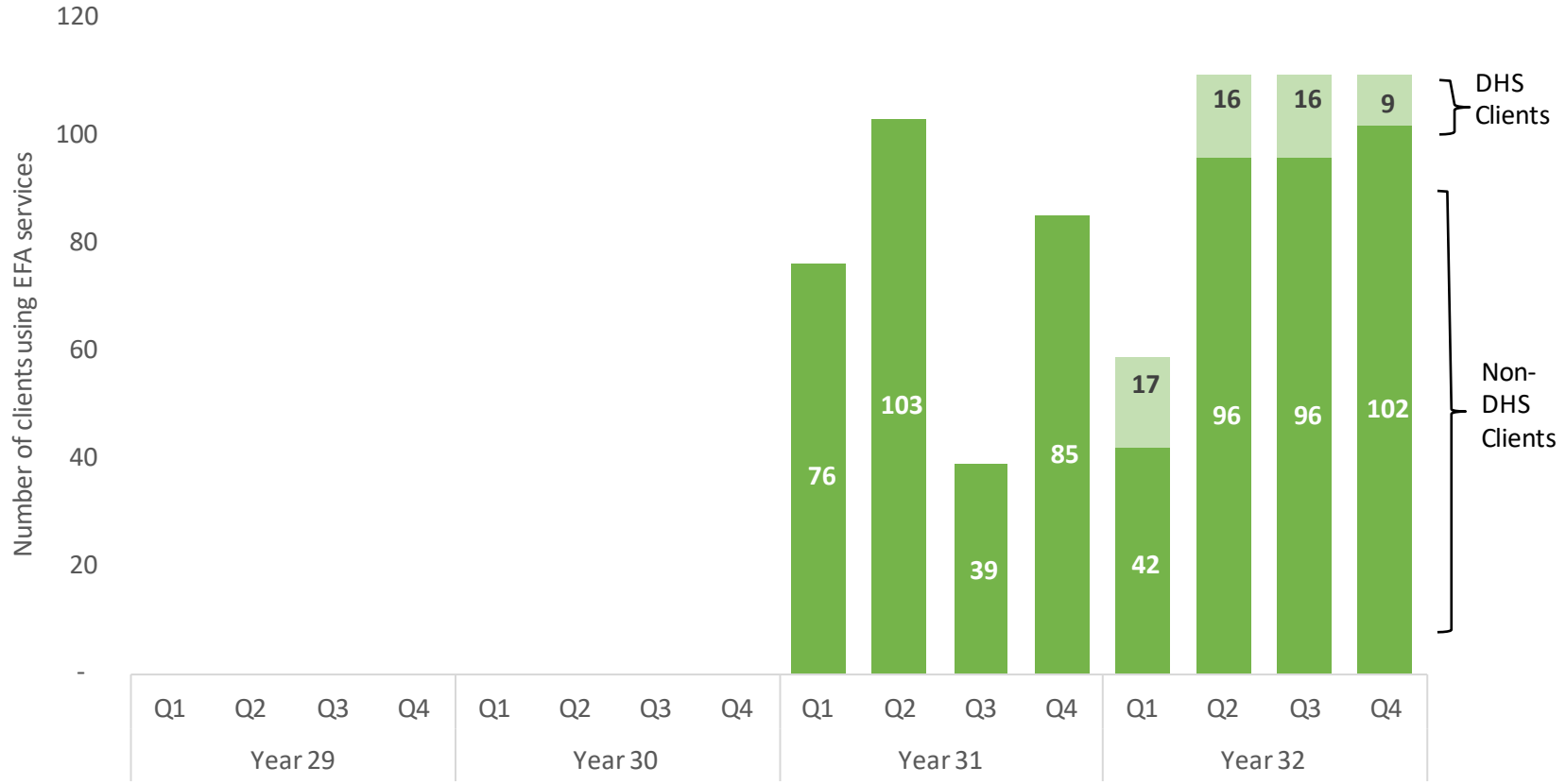
Figure 3. Demographic Characteristics and Priority Populations among EFA Clients in LAC, Year 32



Service Utilization

The figure below presents the number of clients using EFA since it launched in Year 31 at both DHS and non-DHS sites. All EFA services were delivered in-person. The light green part of the bar shows the number of DHS clients. The darker green part of the bar shows the number of all other (non-DHS) clients. The number of clients accessing EFA services increased from Year 31 to Year 32, particularly among clients accessing services at non-DHS sites.

Figure 4. Department of Health Services (DHS) and Non-DHS EFA Clients by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
- Percentage of RWP Clients Accessing EFA in Year 32: **3%**
- Unit of Service: **Dollars**

Table 3. EFA Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total dollars	% of dollars	Dollars per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total EFA clients	***378***	***100%***	***1,210,558***	***100%***	***$3,203***	***$4,607***	***$1,741,442 (Part A)***
Food	*30*	*8%*	*8,035*	*1%*	*$268*	*$385*	*$11,559*
Rental Assistance	*283*	*75%*	*1,049,839*	*87%*	*$3,710*	*$5,337*	*$1,510,241*
Utilities	*162*	*43%*	*152,684*	*13%*	*$942*	*$1,356*	*$219,643*
PLWH ≥ age 50	191	**51%**	548,067	**45%**	$2,869	$4,128	*$788,418*
Latinx MSM	98	26%	313,970	26%	$3,204	$4,609	*$451,660*
Black MSM	89	24%	293,026	24%	**$3,292**	**$4,736**	*$421,531*
Women of Color	44	**12%**	112,680	**9%**	**$2,561**	**$3,684**	*$162,095*
Youth aged 13-29	33	9%	113,597	9%	**$3,442**	**$4,952**	*$163,415*
Unhoused in the contract year	21	6%	55,570	5%	$2,646	$3,807	*$79,941*
Persons who inject drugs (PWID)	14	4%	38,819	3%	$2,773	$3,989	*$55,843*
Transgender Persons	8	2%	22,370	2%	$2,796	$4,023	*$32,180*

Table 3 Highlights

- *Population Served:* PLWH ≥ age 50 (51%) made up half of all EFA clients, followed by Latinx MSM (26%) and Black MSM (24%) in Year 32
- *Service Utilization:*
  - Service units (dollars) per client were the highest among youth aged 13-29 and Black MSM compared to total EFA clients and other subpopulations. Per client utilization was lowest among women of color and clients who were unhoused in the contract year.
  - The percent of EFA units (dollars) was lower relative to the population size of PLWH ≥ age 50, women of color, clients who were unhoused in the contract year, and PWID.
- *Expenditures:*
  - Per client expenditures were highest for youth aged 13-29 ($4,952), followed by Black MSM ($4,736).
  - Women of color had the lowest expenditures per client ($3,684).

HIV Care Continuum (HCC) Outcomes

Table 4 below compares HCC outcomes for RWP clients who did and did not access EFA in Year 32. A larger percent of clients in EFA were engaged in care, retained in care, and achieved viral suppression compared to those clients not using EFA.

Table 4. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use EFA Services in LAC, Year 32

HCC Measures	EFA clients		Non-EFA clients	
	N=378	Percent	N=14,394	Percent
Engaged in HIV Care[a]	368	97%	13,478	94%
Retained in HIV Care[b]	297	79%	10,084	70%
Suppressed Viral Load at Recent Test [c]	333	88%	11,944	83%

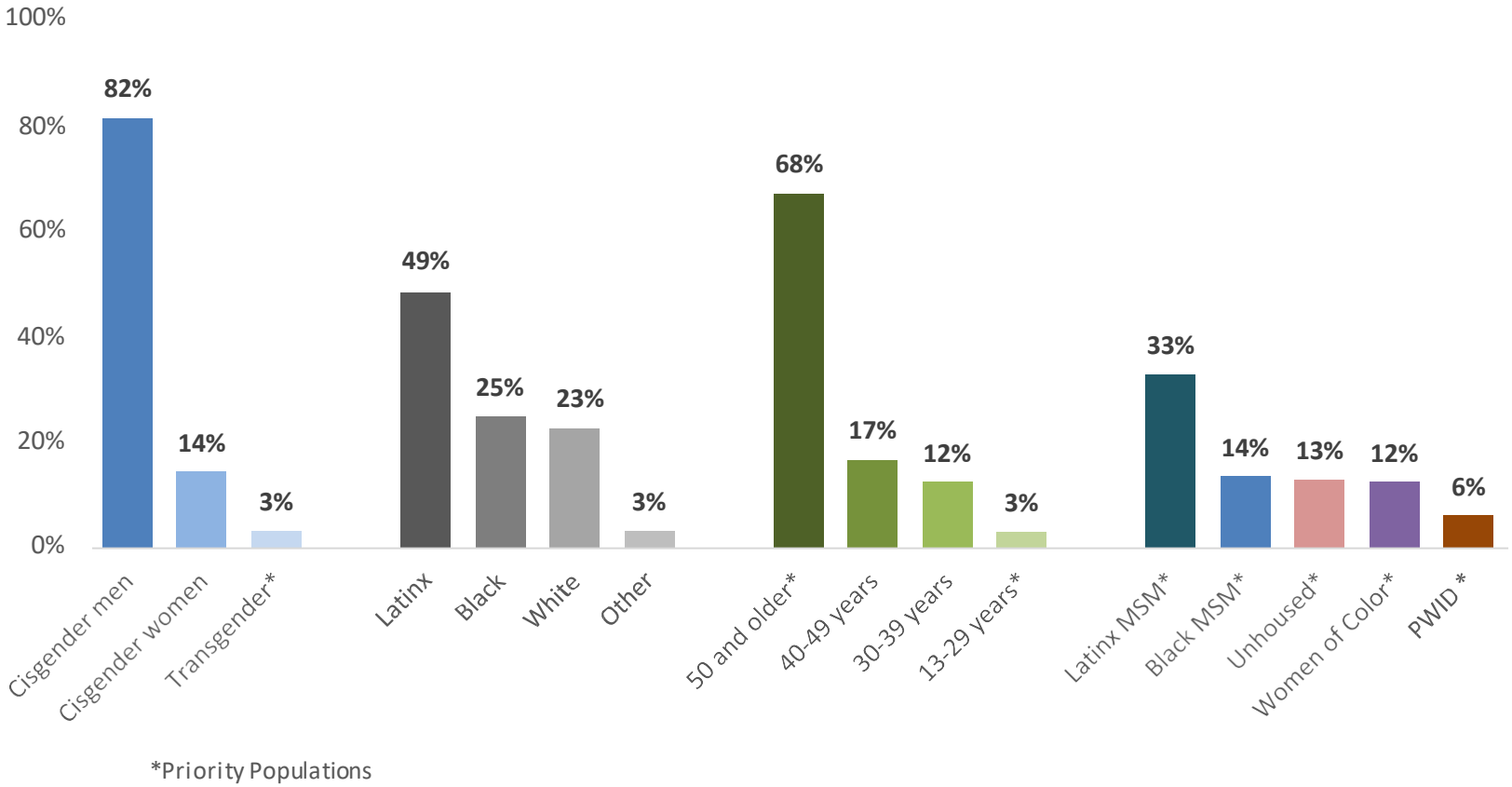
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

NUTRITION SUPPORT SERVICES

Population Served:

- In Year 32, a total of 2,117 clients received Nutrition Support (NS) services that include:
  - A total of 541 who received Delivered Meals
  - A total of 1,724 who accessed the Food Bank
- Most NS clients were cisgender men, Latinx and Black, and PLWH ≥ age 50 (Figure 5).
- PLWH ≥ age 50 represented the largest percent among priority populations (68%), followed by Latinx MSM (33%).

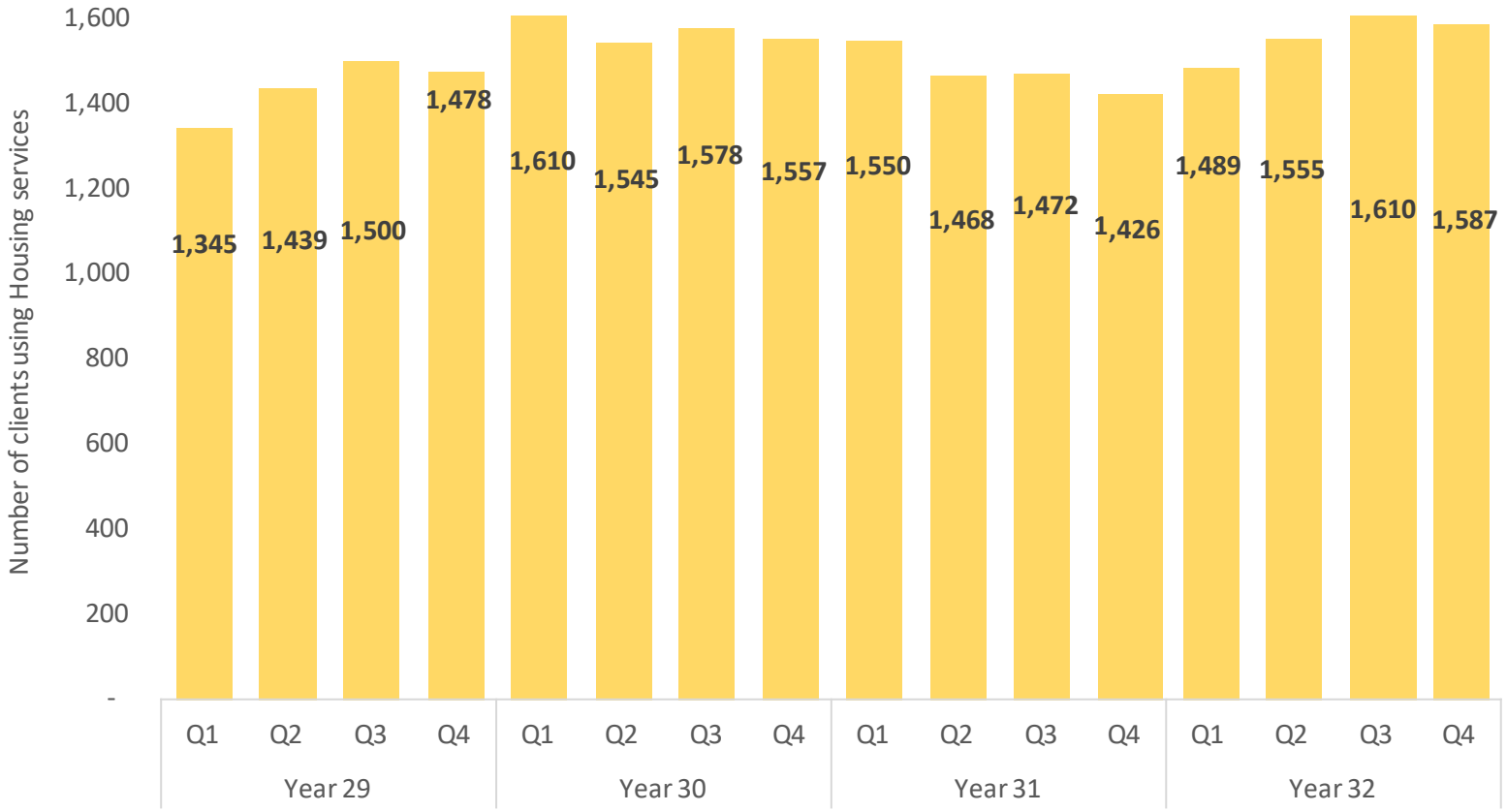
Figure 5. Demographic Characteristics and Priority Populations among Nutrition Service Clients in LAC, Year 32



Service Utilization

All NS services must be accessed in-person. As shown below in Figure 6, the number of NS clients has increased from Year 29 to Year 32.

Figure 6. RWP Clients Accessing Nutrition Services (NS) by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
- Percentage of RWP Clients Accessing NS services in Year 32: **14%**
- Unit of Service: **Meals** and **Bags of groceries**

Table 5. Nutrition Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total Units	% of Total Units	Units per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
*Total Nutrition Support clients**	***2,117***	***100%***	***450,679***	***100%***	***213***	***$1,767***	***$3,740,480***
Delivered Meals	*541*	*26%*	*286,984*	*64%*	*530 meals*	*$4,403*	*$2,381,868*
Food Bank	*1,724*	*81%*	*163,695*	*36%*	*95 bags*	*$788*	*$1,358,612*
PLWH ≥ age 50	1,436	**68%**	358,676	**80%**	**250**	***$2,073***	*$2,976,887*
Latinx MSM	701	33%	140,577	31%	201	*$1,664*	*$1,166,741*
Black MSM	286	14%	52,063	12%	182	*$1,511*	*$432,105*
Unhoused in the contract year	273	**13%**	30,582	**7%**	112	***$930***	*$253,820*
Women of Color	262	12%	58,014	13%	221	*$1,838*	*$481,496*
Persons who inject drugs (PWID)	128	6%	29,379	7%	**230**	***$1,905***	*$243,836*
Transgender Persons	73	3%	13,265	3%	182	*$1,508*	*$110,095*
Youth aged 13-29	62	**3%**	3,222	**1%**	**52**	***$431***	*$26,741*

*Clients used an average of 1.5 meals per day and 1.8 bags of groceries per week in Year 32.

Table 5 Highlights

- *Population Served:* PLWH ≥ age 50 (68%) made up most of NS clients, followed by Latinx MSM (33%) in Year 32.
- *Service Utilization:*
  - Meals/bags per client were the highest among PLWH ≥ age 50 and PWID compared to total NS clients and other subpopulations.
  - Meals/grocery bags per client were lowest among youth aged 13-29.
  - Clients ≥ age 50 represented 68% of clients but used 80% of total NS units demonstrating higher utilization than other subpopulations.
  - Clients who were unhoused in the contract year represented 13% of NS clients but only used 7% of total NS units, suggesting lower access to need.
- *Expenditures:*
  - PLWH ≥ age 50 had the highest expenditures per client, followed by PWID, and is consistent with their higher per client utilization.
  - Youth aged 13-29 represented the smallest number of NS client and had the lowest expenditures per client ($431). Per client expenditures were also low among clients who were unhoused in the contract year ($930) as service units were low relative to population size.

HIV Care Continuum (HCC) Outcomes

Table 6 below compares HCC outcomes for RWP clients who did and did not use NS services in Year 32. A larger percent of clients in NS services were engaged in care, retained in care, and achieved viral suppression compared to those clients not using NS services.

Table 6. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use Nutrition Support Services in LAC, Year 32

HCC Measures	NS clients		Non-NS clients	
	N=2,117	Percent	N=12,655	Percent
Engaged in HIV Care[a]	2,018	95%	11,828	93%
Retained in HIV Care[b]	1,681	79%	8,700	69%
Suppressed Viral Load at Recent Test [c]	1,793	85%	10,484	83%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

Overlap of Services Provided

RWP service categories may not mutually exclusive; there can be overlap in clients accessing these services during the contract year. To explore the degree of overlap across HS, EFA and NS services in Year 32, we constructed the cross tabulation shown below in Table 7. The data should be read across from left to right. We can see among EFA clients, approximately 28% also accessed NS but very few accessed HS. Among those clients in HS, nearly one-third (32%) also accessed NS but few accessed EFA. Finally, among NS clients we see the least overlap with few accessing EFA or HS.

Table 7. Cross tabulation of RWP Clients Received Emergency Financial Assistance, Housing and Nutrition Support Services in LAC, Year 32

Count (%)	Emergency Financial Assistance	Housing Services	Nutrition Support
Emergency Financial Assistance	*378*	4 (1%)	105 (28%)
Housing Services	4 (2%)	*241*	76 (32%)
Nutrition Support	105 (5%)	76 (4%)	*2,117*

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

Acknowledgements

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- Planning, Development and Research (Michael Green, PhD)
- Program Monitoring and Evaluation (Wendy Garland, MPH , Janet Cuanas, MPP)
- HIV/STD Surveillance

Ryan White Program Agencies, Providers and Clients

Thank you

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 33 AND PART B YR 33 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by September 28, 2023

1	2	3	4	5	6	7	8	9	10
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 2,446,802	$ -	$ 2,446,802	$ 5,885,952	$ -	$ 5,885,952	$ -	$ -	$ 2,446,802
MEDICAL CASE MGMT (Medical Care Coordination)	$ 3,528,829	$ -	$ 3,528,829	$ 8,689,862	$ -	$ 8,689,862	$ -	$ -	$ 3,528,829
ORAL HEALTH CARE	$ 3,020,146	$ -	$ 3,020,146	$ 7,252,530	$ -	$ 7,252,530	$ -	$ -	$ 3,020,146
MENTAL HEALTH	$ 51,438	$ -	$ 51,438	$ 208,964	$ -	$ 208,964	$ -	$ -	$ 51,438
EARLY INTERVENTION SERVICES	$ 1,790,216	$ -	$ 1,790,216	$ 3,053,460	$ -	$ 3,053,460	$ -	$ -	$ 3,053,460
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 1,091,531	$ -	$ 1,091,531	$ 2,816,107	$ -	$ 2,816,107	$ -	$ -	$ 1,091,531
CHILD CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 621,524	$ -	$ 621,524	$ 1,478,588	$ -	$ 1,478,588	$ -	$ -	$ 621,524
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 483,181	$ 483,181	$ -	$ 491,939	$ 491,939	$ -	$ -	$ 483,181
HOUSING-RCFCI, TRCF	$ 222,911	$ -	$ 222,911	$ 308,076	$ -	$ 308,076	$ 1,433,731	$ 4,239,220	$ 1,656,642
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,126,396	$ 1,126,396	$ -	$ 3,997,205	$ 3,997,205	$ -	$ -	$ 1,126,396

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 33 AND PART B YR 33 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by September 28, 2023

SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	$ 374,100	$ 670,000	$ 374,100
MEDICAL TRANSPORTATION	$ 217,811	$ -	$ 217,811	$ 460,470	$ -	$ 460,470	$ -	$ -	$ 217,811
LANGUAGE SERVICES	$ 3,300	$ -	$ 3,300	$ 5,198	$ -	$ 5,198	$ -	$ -	$ 3,300
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 1,237,517	$ -	$ 1,237,517	$ 3,741,136	$ -	$ 3,741,136	$ -	$ -	$ 1,237,517
EMERGENCY FINANCIAL ASSISTANCE	$ 731,144	$ -	$ 731,144	$ 2,045,472	$ -	$ 2,045,472	$ -	$ -	$ 731,144
LEGAL	$ 228,420	$ -	$ 228,420	$ 540,652	$ -	$ 540,652	$ -	$ -	$ 228,420
SUB-TOTAL DIRECT SERVICES	$ 15,191,589	$ 1,609,577	$ 16,801,166	$ 36,486,467	$ 4,489,144	$ 40,975,611	$ 1,807,831	$ 4,909,220	$ 19,872,241
YR 33 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	2,853,518	$ 179,782	$ 3,033,300	$ 4,298,488	$ -	$ 4,298,488	$ 170,580	$ 537,589	$ 3,203,880
YR 33 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	282,855	$ -	$ 282,855	$ 713,795	$ -	$ 713,795	$ -	$ -	$ 282,855
TOTAL EXPENDITURES	18,327,962	$ 1,789,359	$ 20,117,321	$ 41,498,750	$ 4,489,144	$ 45,987,894	$ 1,978,411	$ 5,446,809	$ 23,358,976
TOTAL GRANT AWARD				**$ 42,984,882**	**$ 3,675,690**	**$ 46,660,572**		**$ 5,446,809**	
VARIANCE				$ (1,486,132)	813,454			0	
MAI Carryover from YR 32 to YR 33	$	685,010							

PREVENTION PLANNING WORKGROUP

Proposed Status Neutral Framework

Presentation to the Planning, Priorities and Allocations Committee

9/19/23 – For Review/Feedback

LOS ANGELES COUNTY
COMMISSION ON HIV

Objectives

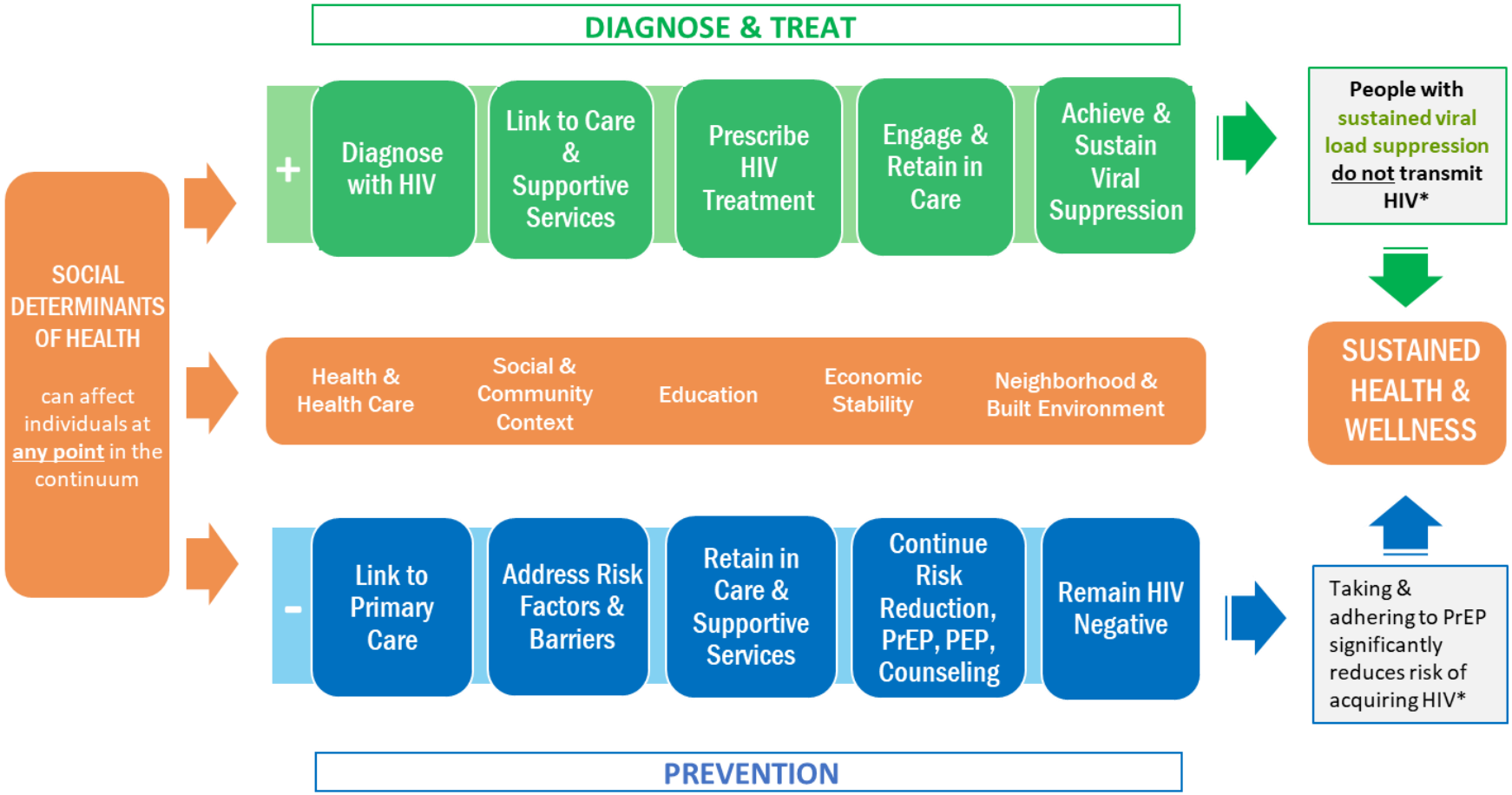
- Provide an update on the work and activities of the Prevention Planning Workgroup
- Seek input on a status neutral framework for HIV/STI services
- Discuss integration of prevention into the Planning, Priorities and Allocations Committee
- Promote ongoing awareness and community conversations on HIV/STI prevention needs

Background | Prevention Planning Workgroup (PPW)

- Formed Prevention Planning Workgroup in October 2020
- Goal of the workgroup is to improve and fully integrate prevention in the planning, priority setting and resource allocation process
- Workgroup has focused on assessing capacity building needs of the larger body, development of a framework to support integration of status neutral “concept” into the commission, and review of existing Prevention Standard of Care for recommendations.

Comprehensive HIV Continuum Framework

The HIV Continuum is a framework for people to stay healthy, have improved quality of life, and live longer. The Commission on HIV adapted the Continuum to demonstrate HIV, sexual health, and overall health are influenced by individual, social, and structural determinants of health. Individuals can enter and exit at any point in the Continuum. The Continuum guides the Commission on community planning and standards of care development.



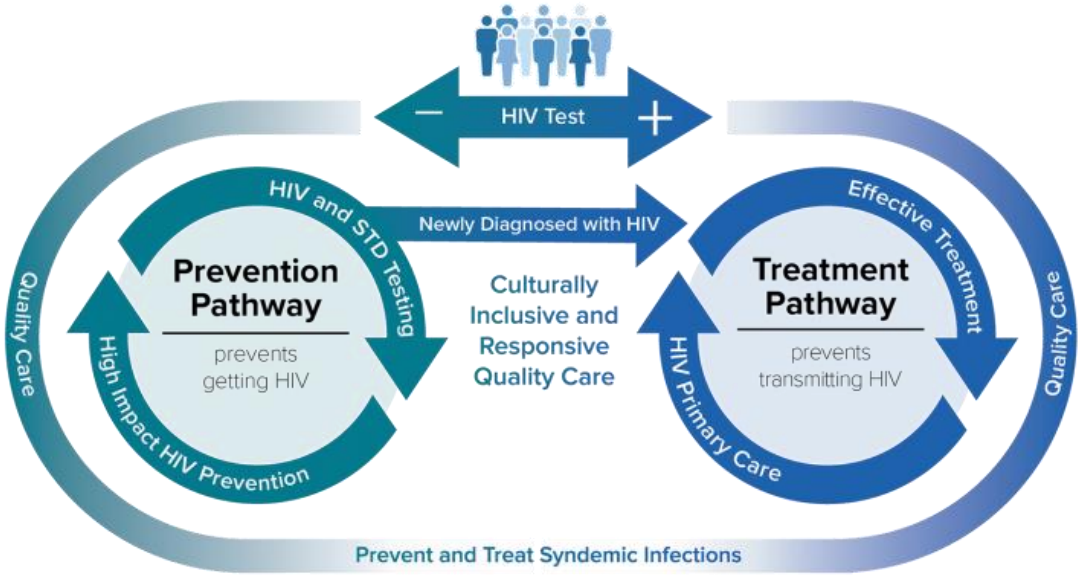
Revised 9/10/19; 11/17/20
Commission approved 9/12/19

*For more information visit https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

CDC Status Neutral HIV Prevention and Care

Status Neutral HIV Prevention and Care is a *whole person* approach to HIV prevention and care that emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being.

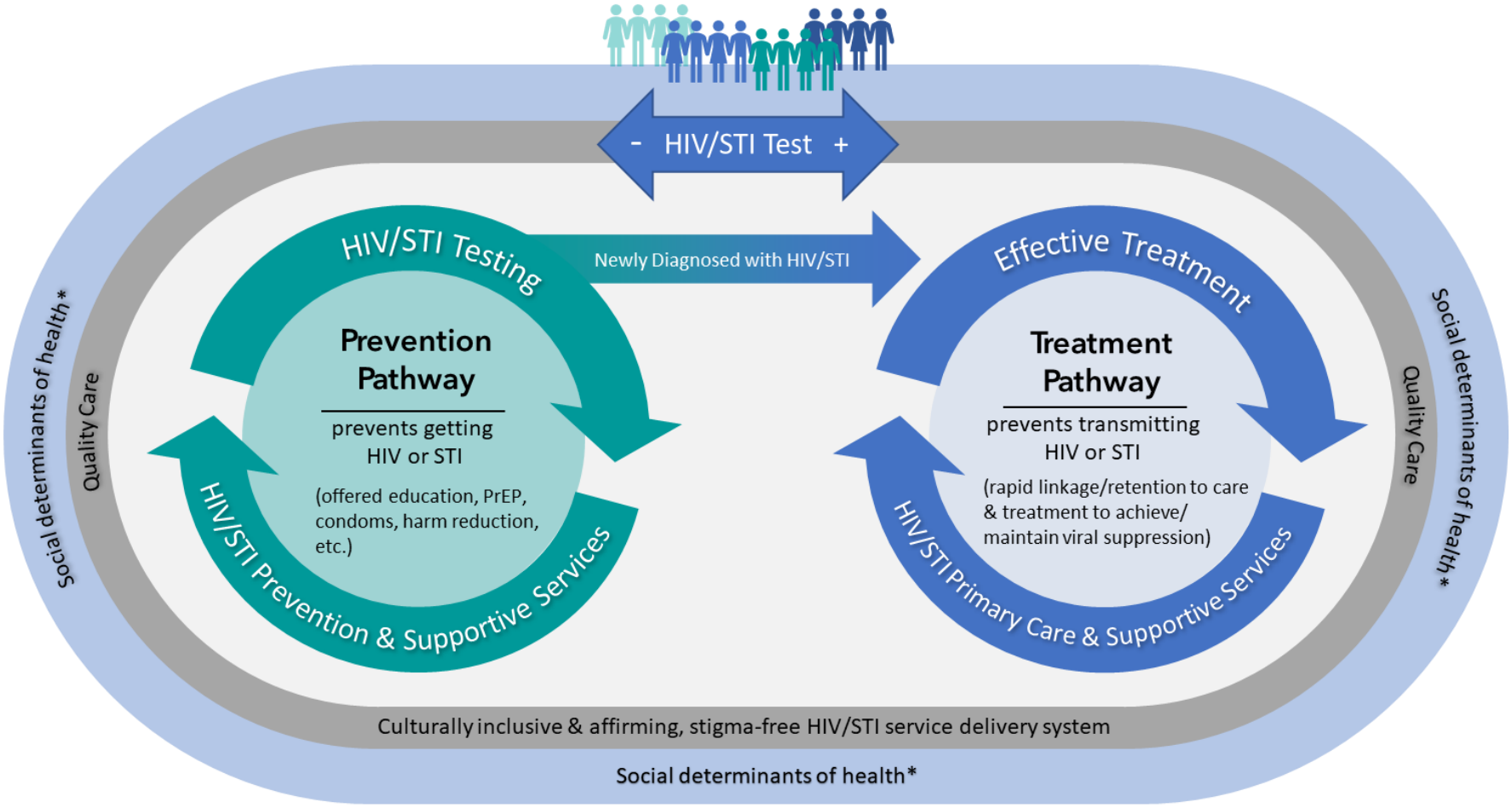
People whose HIV tests are negative are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.



People whose HIV tests are positive enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 6/1/23

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

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

Key Recommendations

- Focus on the Service Delivery System
- Expand beyond HIV to include STIs
  - HIV and STI testing, treatment, and prevention services
  - Biomedical and nonbiomedical strategies
- Emphasis on person-first, not disease first
  - Address the holistic needs of a person
  - Not centered solely on meeting disease-specific needs
- Supportive services provided regardless of HIV status
  - Resources to support high-risk HIV- individuals in need of supportive services (e.g., housing, mental health, etc.)
  - Address the social determinants of health

Key Recommendations

- Focus on priority populations identified via data (CHP)
  - Latinx men who have sex with men (MSM)
  - Black/African American MSM
  - Transgender persons
  - Cisgender women of color
  - People who inject drugs (PWID)
  - People under the age of 30
  - People living with HIV who are 50 years of age or older
- Culturally affirming, stigma-free HIV and STI delivery system
  - Goes beyond supportive providers trained to recognize and address implicit racial/ethnic, sexual orientation, and other biases
  - Calls for racially, culturally, & ethnically diverse providers and staff and individuals with lived experience

Key Recommendations

- Requires diverse funding streams
  - Multiple funding streams
  - Do not have disease specific eligibility requirements
- Requires diverse partners
  - Collaboration and coordination with community partners outside of HIV systems who also serve priority populations

Other Suggestions

- *Restructure the Planning, Priorities and Allocations Committee to intentionally include prevention*
- Utilize Status Neutral Framework in all COH discussions
- Assess prevention funding and services within Los Angeles County to help inform PSRA process
- Update Prevention Standards to incorporate status neutral framework
- Identify opportunities to increase prevention efforts within existing DHSP programs
- Identify opportunities to increase prevention efforts within substance use disorder strategies/interventions

Discussion

- What do you think about the proposed Status Neutral framework?
- Are there elements that we need to add that address the needs of priority populations?
- How do we structure agenda of PP&A to reflect proposed framework?

Los Angeles County Commission on HIV Subgroup Descriptions

Type	Description	
Caucus(es):	The Commission establishes caucuses, as needed, to provide a forum for Commission members of designated "special populations" to discuss their Commission-related experiences and to strengthen that population's voice in Commission deliberations. Caucuses are not, by definition, Brown Act-covered bodies, and are not required to comply with open meeting, public participation and other, related "sunshine" requirements. With Commission consent, caucuses determine their membership, meeting conduct and timelines, work plans, and activities.	• Not Brown Act covered • Requires a motion at Executive Committee and full body for approval • Long-term; recurring meetings
Ad-Hoc Committee(s):	The Commission, its Co-Chairs and/or the Executive Committee can create ad-hoc committees to address longer-term Commission special projects or initiatives that require more than one standing committee's input, involvement and/or representation. Once the project has been completed, the ad-hoc committee automatically sunsets. The Commission Co-Chairs are responsible for assigning Commission members to the ad-hoc committees, and during their tenure, ad-hoc committees maintain the same stature and reporting expectations as other standing committees. Ad-hoc committees are required to comply with all of the same Brown Act and other transparency requirements as the Commission and its standing committees.	• Must comply with the Brown Act • Project-based; the Ad-Hoc Committee sunsets once the project is completed. • Requires a motion at Executive Committee and full body for approval
Task Forces(s):	Task Forces can be created by the Commission, its Co-Chairs and/or the Executive Committee, and are intended to address a significant Commission priority that may entail multiple levels of work or activity and are envisioned as longer-term in nature. Task forces are similar to ad-hoc committees, except	• Task forces do not have to comply with Brown Act and other transparency requirements but it is encouraged that they do so in the spirit of the law. • Requires a motion at Executive

	that their membership is expected to include at least as many non-Commission members as Commission members. Task force decisions, work activities and plans must be reported to and approved by the Executive Committee. While, technically, task forces do not have to comply with Brown Act and other transparency requirements, it is encouraged that they do so in the spirit of the law. Various community task forces are **not** formal Commission working units, unless recognized as such by the Commission; however, they are invited to report and recommend actions to the Commission.	Committee and full body for approval
Work Group(s):	Work groups are primarily created by the committees for work on a single, short-term project that the committee cannot as thoroughly address during its regular meetings. By definition, work groups—which can come in many different forms—are only operational for short, time-limited periods. Commission and non-Commission members may participate in a work group, but no more Commission members than the originating committee's quorum. Work groups are not covered by the Brown Act and other transparency laws, and the final decisions/recommendations/work serve as a record of the work group's deliberations and must be forwarded to the originating committee for review, consideration and modification/approval.	• Not Brown Act covered • Intended for short-term projects