LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, September 21, 2021
1:00PM-3:00PM (PST)

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, SEPTEMBER 21, 2021|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/hzbrb6kx
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Planning, Priorities and Allocations Committee Members:			
Frankie Darling Palacios, Co-Chair	Kevin Donnelly, Co-Chair	Everardo Alvizo, LCSW	Al Ballesteros, MBA
Felipe Gonzalez	Joseph Green	Karl T. Halfman, MS	William King, MD, JD
Miguel Martinez, MPH, MSW	Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD
Damone Thomas	Guadalupe Velasquez, (LOA)	DHSP Staff	
QUORUM:	8		

AGENDA POSTED: September 16, 2021

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NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it

was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.
If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

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

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

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

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

II. PUBLIC COMMENT 1:04 P.M – 1:15 P.M.

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

III. COMMITTEE NEW BUSINESS 1:15 P.M. – 1:20 P.M.

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:20 P.M. – 1:25 P.M.

a. County/Commission Operational Updates
b. Commission and Committee Updates

6. CO-CHAIR REPORT 1:25 P.M. – 1:35 P.M.

a. Comprehensive HIV Plan (CHP)
b. "So, You Want to Talk about Race" by I. Oluo Reading Activity
Excerpts only from Chapters 12 or 13

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:35 P.M. – 1:50 P.M.

a. Minority AIDS Initiative (MAI) Expenditure and Client Demographics
b. Emergency Financial Assistance Expenditure and Client Demographics

V. DISCUSSION 1:50 P.M. – 2:45 P.M.

a. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Rankings **MOTION #3**
b. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Funding Allocations **MOTION #4**

VI. NEXT STEPS 2:45 P.M. – 2:55 P.M.

a. Task/Assignments Recap
b. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:55 P.M. – 3:00 P.M.

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

VIII. ADJOURNMENT 3:00 P.M.

a . Adjournment for the Meeting of September 21, 2021.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**
MOTION #3:	**Approve Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Rankings, as presented, or revised, and move to the Executive Committee for Approval.**
MOTION #4:	**Approve Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Funding Allocations, as presented, or revised, and move to the Executive Committee for Approval.**

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COMMISSION ON HIV

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

August 17, 2021

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

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

Meeting agenda and materials can be found on the Commission's website at
http://hiv.lacounty.gov/LinkClick.aspx?fileticket=t9DHzITsNEc%3d&portalid=22

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Kevin Donnelly, Committee Co-Chair, called the meeting to order at approximately 1:08 PM. Members introduced themselves and stated their conflicts of interest. K. Donnelly emphasized the purpose of stating conflicts is to provide transparency not to prohibit participants from fully participating in the planning process.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

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

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approved the July 20, 2021 Planning, Priorities and Allocations Committee Meeting Minutes, as presented ***(Passed by Consensus)***. It was noted members have up to one year to make corrections to the minutes.

II. PUBLIC COMMENT

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

There were no public comments.

II. COMMITTEE NEW BUSINESS ITEMS

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

There were no new business items identified.

III. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Operational Updates

C. Barrit emphasized the committee's tasks for the meeting which included ranking Health Resources and Services Administration (HRSA) service categories and determining funding percentage allocations for Program Year (PY) 32 Part A and Minority AIDS Initiative (MAI) funds. C. Barrit encouraged the committee to ask questions and try to ensure all members understand the decisions made.

C. Barrit informed the committee DHSP would present RW Part A and MAI PY 30 expenditures as well as funding allocation recommendations for PY 32.

The approval process was reviewed.

1. The PP&A committee approves service rankings and funding allocation percentage for recommendations to the Executive Committee.
2. The recommendations are presented to the Executive Committee for approval at the August 26, 2021 meeting.
3. Upon Executive Committee approval the recommendations are presented to the full Commission on September 9, 2021 for approval.
4. The Commission approves recommendations.
5. Recommendations are submitted to DHSP for inclusion in the RW Part A application due to HRSA in October 2021.

Cheryl Barrit, Executive Director reminded the committee that an additional PP&A meeting is scheduled for August 24, 2021 if PY 32 recommendations are not completed at today's meeting.

b. Priority Setting and Resource Allocation (PSRA) Process Brief Overview

C. Barrit reviewed information provided to date to assist the committee in today's task. The review included the

Data Summit and Planning Services Resource Allocation (PSRA) process.

The committee was encouraged to consider consumer testimony from the Consumer Caucus while making decisions during the planning process. Page 28 of the PSRA PowerPoint reviewed the decision-making process. (Refer to the meeting packet for details.)

Meeting packet worksheets were identified as a tool to assist in ranking services and determining funding allocations. The worksheets reflect multiple program years. It was recommended for the meeting committee members focus on PY 32. Further recommendations for PY 33 and 34 can be completed at the committee's September 2021 meeting.

6. CO-CHAIR REPORT

a. Membership Updates

K. Donnelly noted Co-Chair, Frankie Palacios Darling was unable to attend today's meeting.

Maribel Ulloa will no longer be a member of the committee due to a change in responsibilities with the Housing Opportunities for Person with AIDS (HOPWA).

Alexander Luckie Fuller has requested a committee reassignment due to work conflicts. However, Luckie will remain an active member of the Prevention Planning Workgroup (PPW).

b. Committee Reflections and Follow-up Questions to Data Presented 07/20/2021

K. Donnelly briefly reviewed the DHSP presentation given at the July 20, 2021 meeting and open the floor for questions not previously answered. (See meeting packet for detail data.)

It was noted, the planning activity does not include Part B or Net County Cost (NCC) funds. The services ranked are safety net services that include Ryan White Core and Supportive services for PLWH.

It was explained that percentages are used in the funding allocation process because the actual award amount is unknown. Once the allocation is awarded, percentages will be applied to the funding. Additionally, the committee will review allocations at the time of the funding award and again at the end of the program year.

C. Barrit emphasized committee members affiliated with providers must put agency interest aside in the planning process. The role of the Commissioner is to plan for all of the County of Los Angeles. Decisions should prioritize needs of consumers. When ranking services and allocating funds specific agencies are not to be discussed or considered in the decision-making process.

To further clarify the committee's planning role it was noted, DHSP administers the recommendations provided by the Commission through contract administration and monitoring. The Commission's role is the planning of services and funding allocations. This is per HRSA guidelines which calls for a separation of duties. Additionally, DHSP is responsible for reporting back to the Commission on service delivery efforts and associated expenditures. The information is reported in aggregate form by service category not by specific providers.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Fiscal and Programmatic Report

i. Ryan White (RW) Part A Program Year (PY) 30 Expenditure Report

Pamela Ogata provided initial information regarding PY 30 expenditures. The program year began March 1, 2020 and ended February 28, 2021. The expenditures include RW Part A and MAI expenditures. HIV costs exceed Part A funds. Part B and NCC funded the overages.

M. Perez, Director of DHSP identified 3 areas of focus.

- How funding was expended.
- An overview of the first 6 months of PY 31 (3/2021 – 8/2021) and refinements or improvements DHSP is attempting to make to the RW delivery system in Los Angeles County (LAC).
- Recommendations for PY 32 funding percentage allocations based on PY 30 and 31 actual expenditures.
- Funds used to provide HIV Services in LAC. (Funding amounts are approximate.)
    - $50 million in Part A, Part B and MAI funded 16 services categories.
    - $10 million Part C funds provided directly by HRSA to providers. (These funds complement the services provided directly to the County and contractors should be considered when allocating funding percentages.)
    - $9 million in HOPWA funds for housing services living with HIV (administered by the City of Los Angeles)
    - $6 million in End the Epidemic (EHE) funds.
    - Millions in State of California funds providing HIV services through Medicaid/Medi-Cal.

- The following are highlights from slide 42 (Summary -RWP Expenditure Report as of April 8, 2021; RW Part A, MAI PY 30, and Part B PY 30; Exp by RWP Service Categories) (included in the meeting packet).
    - Part A funds expended approximately $40.5 million
    - MAI funds expended approximately $4 million. This included rollover funds from PY 29 and PY 30 allocation. All MAI funds were expended in PY 30. (There are no rollover funds included in PY 31 MAI funding.)
    - $5 million in Part B funds were expended
    - $3.9 million in NCC funding supported expenditures that could not be funded with RW funds.
- RW funds have expenditure limitations. DHSP shifts funds to maximize resources.

    - Medical Case Management (MCC) and Ambulatory Outpatient Medical (AOM) costs were approximately $21 million of PY 30 expenditures. DHSP is analyzing these services to determine their effectiveness at linking people to care and reducing viral suppression. Specifically, are target populations being served effectively through these services?
    - It was noted MCC costs increased due to:
        - More fully staffed teams
        - MCC contracts are cost reimbursement (which reimburses fixed costs such as employee benefits.)
        - DHSP decided not to reduce any contracts due to COVID.
    - Oral Care costs increased due to the expansion of specialty dental services.
    - The Department of Mental Health Services (DMH) partnered with DHSP to provide mental health services. Medi-Cal funds the majority of Mental Health costs. The ability to hire qualified mental health staff was limited.

- Home and Community Based Health Services was assessed by DHSP to determine continued need. It was found the need for the service still exist.
- Early Intervention Services (EIS) are mainly HIV testing services funded through CDC HIV testing grants.
- Outreach/Linkage and Retention Program (LRP) Services are administered by DHSP staff. Costs decreased due to the reassignment of staff due to COVID.
- Transportation Services funds are allocated to service providers. Providers distribute services based on client need. There was a decrease in costs due to COVID.
- Food services had substantial growth due to increased demand.
- Legal Services were provided through the Inner City Law Center. PY 30 expenditures were low due to it being a service assessment year. PY 31 expenditures are anticipated to increase as the assessment ends and service delivery begins.
- 10% of RW funding is expended for administration expense that include meeting grant award conditions and the Commission's budget.

Fiscal Report Questions and Discussions

General Contract Information Provided by DHSP

- Ambulatory Outpatient Medical services are fee for service contracts paid based on performance. Performance based providers are paid based on units of services and a fixed rate for the service.
- Fee for Service providers that do not meet their fixed cost may cease to provide services. It was noted this occurred in PY 30.
- The method of payment influences the grant amount expended.
- Committee members expressed concerns about monitoring and measuring contract performance. M. Perez provide the following DHSP contract checks and balances to improve and maintain quality services.
  - DHSP provides consistent provider performance monitoring. If providers are not performing, they are required to submit corrective action plans.
  - When reviewing Request for Proposals (RFPs) past performance is included in provider scoring.
  - DHSP can recommend specific requirements to the Board of Supervisors (BOS) as part of rewarding contracts.
  - Part A and MAI PY 30 actual expenditure percentages were identified as a guide for planning PY 32 allocations because the expenses provide a general sense of service needs.
  - The variance between actual percentages and the Commission recommendations were reviewed.
- The Committee requested clarification on the expenditure information and whether it indicates the effectiveness of services provided.
  - M. Perez indicated further analysis is needed to determine service effectiveness.
- The Committee requested clarification on the service ranking exercise and its relationship to funding allocations.
  - C. Barrit explained service rankings are based on planning council priorities and are not related to resource allocations. Resources for services are reviewed in a separate exercise. Thus, the allocation of funding percentages has no correlation to the ranking of services.

ii. Recommendations for Ryan White Part A PY 32 Service Category Funding Allocation

M. Perez reviewed DHSP funding allocation recommendations. The following highlights included.

- An estimated funding ceiling of approximately $46 million was identified for PY 32
- $42 million for Part A and $3.8 million for MAI
    - $10% or $4.6 million funds are allocated for administrative costs. Actual costs are $7 million, and overage are funded with NCC.
    - $36 million in Part A and $3.4 million in MAI will fund direct services.
- Part B funds will increase for PY 32 to $6.1million. The funds are restricted to fee for service contracts and limited to certain service categories and providers. The majority of the funds will be used for housing services.
- Part A recommendations (The recommendations are projections.)
    - Increase percentage of funding for AOM services is recommended because services access is expected to increase.
    - Oral Health and Home-Based Case Management services are anticipated to remain at PY 30 expenditure percentages.
    - Mental Health services are anticipated to increase due to DHSP finalizing agreement with DMH for mental health services and the expansion of services with a new provider.
        - The Committee requested clarification on services provided by mental health. They include psychiatry, psychotherapy, and neurological assessments. Medication coverage is not currently covered.
    - MCC percentage is decreased from PY 30 due to opportunities for program refinement.
    - Benefits Specialty percentage is decreased based on the use of a new model developed by Dr. Cohen which is being implemented.
    - Although childcare services are allocated a percentage of funding, it was noted level of use of the service cannot be predicted at this time.
    - Food Bank/Home-delivered Meals percentages will be maintained.
    - A small percentage of Part A funds will be allocated to Housing Services Residential Care Facilities for the Chronically Ill (RCFCI)/ Transitional Residential Care Facilities (TRCF) because Part B funds cannot be used for some provider services in this category.
    - Legal services allocation percentage will increase in PY 32. This is due to teams being established to deliver legal services to PLWH. The teams will include attorneys, paralegals, and support staff.)
- MAI will continue to support housing services and Jail Transitional Case Management (TCM).

The Committee requested information on services that received no allocation recommendations. The highlights are as follows.

- ADAP is funded by the State of California
- Early Intervention Services are mainly testing services funded by other sources.
- Health Insurance is cover through California's healthcare program
- Home Health Care is provided through other providers and funding sources.
- Service utilization of Hospice services has significantly decreased.
- Medical Nutrition Therapy is funded through the Food Bank/Home delivered Meals contracts.
- Substance Abuse Outpatient Medical are funded through Substance Abuse Prevention and

Control (SAPC) grant funds and the State of California's Drug Medical Expansion program.
- Emergency Financial Assistance is funded through EHE funds.
- Health Education/Risk Reduction (HERR) is funded through CDC and NCC funds
- Outreach/LRP is funded through other grant funds
- Psychosocial Services are in discussion
- Referral, Rehabilitation, Respite and Treatment Adherence Counseling services are not provided/administered by DHSP

8. DISCUSSION:

a. Ryan White Part A PY 32 Service Category Ranking Exercise
The Committee reviewed PY 32 service rankings approved 9/20/2020. It was noted that although 16 service categories are funded the Committee historically has ranked all 27 HRSA services.

Miguel Martinez summarized the process followed by the Committee during the last planning cycle. The steps included the following.
- Meeting participants offered changes to the ranking with a supporting argument.
- The Committee discussed the suggestion, and a consensus was obtained.
- Additionally, M. Martinez posted the following question/statement to assist the Committee in the decision-making process.
  - What services have the most impact over the life of someone living with HIV?
  - The Committee should not be concerned with funding allocations or sources during this process.

Clarification was provided on HRSA expenditure requirements. HRSA requires grant funds to be expended as follows. Seventy-five percent (75%) of Part A funds are expended on core medical services and 25% on supportive services. A waiver can be requested to vary from the requirements. DHSP has requested a waiver prior to submission of the Part A grant application for the past 5 PYs. The waiver was not needed due to AOM and MCC robust expenditures.

The Committee requested information on how service rankings impact funding. It was explained rankings are for the purpose of planning for service delivery based on consumer need. It is not used as a method of determining funding.

It was noted housing instability and a lack of housing are major determinates of health in the management of HIV. Additionally, the moratorium on evictions due to the pandemic ends September 30, 2021 and that may lead to additional PLWH becoming homeless thus increasing the need for housing. For those reasons the committee agreed to maintain Housing as number 1 in the ranking of services.

It was recommended Substance Abuse Outpatient ranking change from 16 to 9. It was noted adherence to care and virally surpassed are a challenge to those with substance use/abuse issues. Further, meth use was identified as a significant factor for those currently living with HIV and have substance abuse issues. Further, the pandemic has intensified substance abuse and mental health issues. It was noted Mental Health services should work hand in hand with Substance Abuse services.

A recommendation was made to assign a higher ranking to Medical Nutrition Therapy because PLWH experience co-morbidities such as diabetes, high cholesterol and hypertension which impact nutritional needs. DHSP noted the current Nutrition Support program, ranked at #11, has existing contracts that include nutrition assessment and supplements. Additionally, meal deliveries are made to clients in need. Current contracts total $3.3 million. The Committee agreed to not change the ranking of Medical Nutrition Therapy.

The Committee requested DHSP provide a definition of the Linkage and Re-engagement Program (LRP) and how it compares to MCC. LRP was defined as a team that finds those living with HIV who have dropped out of care to re-engage them in care. MCC is defined as a clinical based intervention using a Registered Nurse (RN), Social Worker (SW), Case Aide and Retention Navigator to address psychosocial issues for PLWH that are in care to maintain them in care.

It was recommended Outreach services ranking change from #10 to #3. It was noted the data presented at the July PPA meeting reflected 10% of RW clients as homeless, having the lowest viral suppression rates and a decrease in suppression retention in PY 30. The crisis of housing insecurity, the needs of the marginalized or those in danger of losing their housing warrants moving the service to a higher ranking. The Committee noted their rankings should have an emphasis on services that retain people in housing and engage them in care. It was noted Outreach (LRP) should be ranked among the top 10 services. It was ranked at number 8.

Psychosocial services maintained a ranking of #5 because it was felt those newly diagnosed with HIV needed peer-based counseling to reduce the feeling of isolation and loneliness. Additionally, it was noted consumers indicated this as a high priority in the last planning cycle.

Please see the approved Service Category Rankings for PY 32 (FY 2022-23) for a detail listing of the rankings.

b. Ryan White Part A PY 32 Service Category Allocation Exercise

The Ryan White Part A PY 32 Service Category Allocation exercise will take place August 24, 2021.

c. Category Rankings

The committee voted on Motion #3 to approve Proposed Ryan White Part A Program Year PY 32 Service Category Rankings, as revised, and move to the Executive Committee for approval. The vote was (7- yea), (0-no) and (2-abstain).

d. Funding Allocations

Funding Allocations were not determined at this meeting. The committee agreed to defer the activity to the special virtual meeting scheduled for August 24th.

VI. NEXT STEPS

9a. Determine if additional meeting in August is needed

Upon consensus the Committee will meet virtually on August 24, 2021 from 1 to 5PM to determine allocation percentages for PY 32.

9b. Task/Assignments Recap

The committee was encouraged to review the DHSP financial report and proposed funding allocation percentages recommended for PY 32 in preparation for the August 24th meeting.

- Staff will prepare the meeting agenda and packet for the August 24th meeting.

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

a. Adjournment:
The meeting ended at approximately 4:29PM

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

August 24, 2021

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Frankie Darling Palacios, Co-Chair	A	William King, MD, JD (Leave of Absence)	A
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Everardo Alvizo, LCSW	P	Anthony M. Mills, MD	A
Al Ballesteros, MBA	P	Derek Murray	P
Felipe Gonzalez	P	Mario Perez	P
Bridget Gordon	P	LaShonda Spencer, MD	P
Joseph Green	A	Damone Thomas	P
Michael Green, PhD, MHSA	P	Guadalupe Velasquez	A
Karl T. Halfman, MS	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Carolyn Echols-Watson, and Sonja Wright			
DHSP STAFF			
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CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Kevin Donnelly, Committee Co-Chair, called the meeting to order at approximately 1:05 PM. Members introduced themselves and stated their conflicts of interest.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

K. Donnelly amended the agenda to remove the approval of minutes from the agenda. No objection was made to the agenda revision.

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

2. APPROVAL OF MEETING MINUTES

MOTION #2: No minutes were presented at the meeting.

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

There were no new business items identified.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Comprehensive HIV Plan (CHP)

C. Barrit noted the Health Resource and Services Administration (HRSA), and Center for Disease Control (CDC) joint guidance on the Integrated HIV Plan (locally referred to as the Comprehensive HIV Plan (CHP)) was emailed to Commission members. The development of the CHP is a shared activity with DHSP, with the PP&A Committee leading the Commission's engagement and input to the plan. The plan is due to HRSA by December 22, 2022.

Commission staff met with the Division of HIV/STD Programs (DHSP) to determine a timeline for completing the plan. It was noted the plan should be completed for Commission/DHSP approval processes by October 2022. The Commission has enlisted A.J. King to manage and write the plan. A.J. King previously served on the Commission and led the CHP workgroup for developing the plan for2017-2021.

C. Barrit recommended the use of existing plans and relevant documents when completing the new CHP such as aligning the plan with Ending the Epidemic (EHE) and Los Angeles County (LAC) HIV/AIDS Strategic Plan efforts making this a collaborative effort.

b. Priority Setting and Resource Allocation (PSRA) Process Brief Overview

C. Barrit addressed the PSRA process, and the July data summit held to facilitate the planning discussion which included Program Year (PY) 29 and 30 data. The PYs were clarified. PY 30 ended 02/28/2021 and PY 31 began March 1, 2021 and ends February 28, 2022. PY 32 will begin March 1, 2022 and end February 28, 2023. The goal of this meeting is to determine allocation percentages for PY 32.

The September 21, 2022 meeting will be used to determine service rankings and allocation percentages for PYs 33 and 34.

6. CO-CHAIR REPORT

a. Follow-up Questions on Fiscal Data Presented 8/17/2021

K. Donnelly noted the Prevention Planning Workgroup will meet Wednesday, August 25, 2021 at 5:30

PM. They will discuss increasing the participation of women in the planning process and intentionally looking at women-specific data that speak to their needs and challenges.

V. DISCUSSION

a. Ryan White Part A Program Year PY 32 Service Category Funding Allocations Exercise

In preparation for the allocation exercise. Perez reviewed the PY 32 allocation percentage recommendations. The percentages are based on PY 30 expenditures, system changes and PY 31 year to date (YTD) expenditures. Highlights as follows.

- A slight increase in Outpatient medical service costs due to anticipated increases in in-person visits.
- Oral Health service costs are anticipated to remain stable noting contract expansion of specialty services in PY 30.
- Mental Health services will increase in PY 31 over PY 30 expenses. This change is due to additional programs beginning in PY 31.
- Non-Medical Case Management services costs may be impacted by DHSP program refinements.
- Child Care services are funded at the direction of the Commission in response to consumer needs.
- Nutrition Support services costs will increase due to greater food insecurities among PLWH.
- It was noted, Part A housing funds represent a fraction of housing services. Part B funds approximately $6 million in housing services.
- Growth in Legal Services is anticipated due to a change from assessing legal needs to providing legal services.
- Medical Transportation services are anticipated to increase as clients return to provider in-person visits.

DHSP anticipates a grant amount of $42 million. It was reiterated that once PY 32 funding is awarded the allocation percentages will be revisited. Further, percentages are applied during this exercise because funding has not been awarded and allocations are needed for the Part A grant application due in October. At the end of PY 32 a review/analysis of expenditures and associated percentages will be conducted.

It was noted, if there are significant changes in service needs, costs, or award amount, DHSP will bring that information to the Commission for directions. Once the actual award is received, the Commission has significant latitude to make changes based on current circumstances.

The Committee reviewed the Service Category Funding Allocation worksheet for PY 32. The review included a summary of the worksheet layout which included PY 32 Commission allocations approved September 20, 2020. The percentages allocations represented Part A and Minority AIDS Initiative (MAI) in aggregate by service category. The worksheet included DHSP percentage recommendations by funding source and service category. The document include a column indicating the variances between the Commission's approved percentages and DHSP PY 32 recommendations.

Committee members voiced concerns regarding mental health and substance abuse services.
DHSP noted that a large portion of these services are funded through Medi-Cal. DHSP reviewed these services and noted a small fraction of clients eligible for RW services are being serviced. There are concerns all those needing mental health services are actually being served adequately and/or for the length of time the service is needed.

DHSP included neural psychological evaluations and testing into contracts. The volume of psychological assessments has been extremely low. Psychiatry and psychotherapy are pieces that DHSP put in place but are not being fully utilized. DHSP is seeking to learn more about why these services are underutilized. DHSP noted private sector community-based partners are needed to implement these services.
DHSP is continuing to work with Substance Abuse and Prevention Control (SAPC) to ensure drug treatment is financed to provide culturally responsive services to subpopulations.

In September 2021, DHSP is meeting with SAPC to discuss how resources can be used for prevention and how to address those currently not served or underserved.

It was noted Los Angeles County (LAC) does not address the lasting trauma associated with being diagnosed HIV positive and the stigma associated with the diagnosis. The trauma can and does have long term affects that can last decades. Self-medicating was identified as a reaction to the trauma, and stigma. It was further noted mental health services have a significant place in preventing HIV transmission.

K. Donnelly polled the meeting attendees for there comments/recommendations regarding the allocation percentages for PY 32.

There was some discussion on how percentage recommendations should be made. Should it be separated by funding sources and services category or just by service category. C. Barrit noted recommended percentages be presented by funding source as well as service category.

C. Barrit noted the Committee needs to be aware of the recommend percentages by funding source because the Commission has had discussions regarding the use of MAI funds. Committee members want to ensure MAI funds are responding to the needs of minorities as intended. It was noted the data receive on housing has been provided in aggregate form only with no distinction between funding sources.

The Committee expressed the need for simplified information to increase the understanding of the data presented. Large volumes of information are difficult to review and require large amounts of time. It does not facilitate good decision making if the data is not decipherable or voluminous. Information needs to be available for consumers' consumption.

DHSP noted clients served through the Housing for Health program consisted of 83% of people of color and 17% White. The Committee was concerned specifically with housing data and the percentage of Black/African Americans represented in the data. There was concern about the planning body allocating funds when there is no guarantee that equity is being addressed in the allocation recommendations.

DHSP indicated that racial ethnic groups are self-reported and because of that some multi-racial groups may select white.

- DHSP will verify if racial ethnicities are self-reported and provide demographics on those receiving housing services.
- The Committee made a request to obtain demographics on those receiving HOPWA services. It was noted the Commission does not currently have a HOPWA representative, but will request the information once the new representative is on board.
- The Committee requested demographics and program expenditures for all MAI allocations.

It was noted that DHSP's MAI recommendations for PY 32 are exclusively for funding Housing and non-Medical Case Management Services.
The Committee was reminded the planning process was now a multi-year process and the current approved PY 32 allocations is based on PY 29 data as it was approved September 2020.

The Committee was concerned that DHSP did not recommend an allocation for Psychosocial Support services. The Commission recommended 2% to support consumers who identified this service as a priority. DHSP stated the RFP for these services are in development but may not be implement by PY 32. The Committee agreed to include directives specific to Psychosocial Support services to DHSP. Additionally, the Committee agreed to revisit this allocation once the PY 32 award is received.

Emergency Financial Assistance (EFA) was discussed. DHSP has funded the service through EHE funds in the amount of $1.5million.

Non-medical Case Management funded through Part A includes Benefit Specialty and Transitional Case Management Jail services.

a. Propose Ryan White Part A and MAI Program Year 32 Service Category Funding Allocations
Motion #3
The Committee approved the Motion. The vote was as follows.
(Yes – 7) (Abstain -2)

VI. NEXT STEPS

a. Task/Assignment Recap
- Agendize DHSP Directives for PY 32 to the October 19, 2021 meeting agenda.
- Provide EFA expenditures to date and demographics.
- PY 32 Proposed Ryan White Part A and MAI PY 32 Services Category Funding Allocations move to the Executive Committee for approval.

b. Agenda Development for the Next Meeting
- The following will be included on the September 21, 2021 agenda.
  - Propose PY 33 and 34 Service Category Rankings and Allocation Percentages
  - Discuss CHP activities
  - DHSP report on EFA and MAI expenditures and demographics

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

a. Adjournment:
The meeting ended at approximately 3:32 PM.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We strive for consensus and compassion in all our interactions.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **We give and accept respectful and constructive feedback.**
7) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
8) **We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).**
9) **We give ourselves permission to learn from our mistakes.**

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19)**

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/09/21

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng 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
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach

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)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
THOMAS	**Damone**	No Affiliation	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VEGA	**Rene**	Via Care Community Clinic	Biomedical HIV Prevention
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022- 2026

Division of HIV/AIDS Prevention

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

HIV/AIDS Bureau

Health Resources and Services Administration

June 2021

Executive Summary

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed this guidance to support the submission of the Integrated HIV Prevention and Care Plan (hereafter referred to as Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026 (hereafter referred to as Integrated Plan Guidance). This guidance builds upon the previous guidance issued in 2015 when the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV AIDS Bureau (HAB) published its first Integrated HIV Prevention and Care Guidance, including the SCSN for CY 2017-2021. This guidance allowed funded health departments and planning groups to submit one integrated HIV plan to lead the implementation of both HIV prevention and care services. As in 2015, the Integrated Plan Guidance for CY 2022-2026 meets all programmatic and legislative requirements associated with both CDC and HRSA funding. It reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. The Integrated Plan Guidance necessitates engagement from a wide range of stakeholders including people at risk for HIV and people with HIV. The Integrated Plan Guidance intends to accelerate progress towards meeting national goals while allowing each jurisdiction to design a HIV services delivery system that reflect local vision, values, and needs.

CDC and HRSA funded recipients will notice several key changes in the Integrated Plan Guidance for CY 2022-2026 from the Integrated Plan Guidance for CY 2017-2021. These changes reflect feedback from recipients and people with HIV as well as priorities detailed in the HIV National Strategic Plan published January 2021 and the implementation strategies outlined in the Ending the HIV Epidemic in the U.S. (EHE) initiative. Specifically, recipients who have already conducted extensive planning processes as part of the development of their EHE awards and in conjunction with CDC's *Strategic Partnerships and Planning to Support the Ending the HIV Epidemic in the United States(PS19-1906*) program or through other jurisdictional efforts (e.g., Getting to Zero plans, Fast Track Cities, Cluster and Outbreak Detection and Response plans) may submit portions of those plans to satisfy this Integrated Plan Guidance as long as the Integrated Plan submission addresses the broader needs of the geographic jurisdiction and applies to the entire HRSA and CDC HIV funding portfolio. To that end, the Integrated Plan Guidance for CY 2022-2026 includes the *CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* (See *Appendix 1*). This checklist details submission requirements and allows each jurisdiction to determine which elements may require new content and which elements were developed as part of another jurisdictional plan.

Additionally, jurisdictions should submit plans that follow the goals and priorities as described in the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025* and in the updated HIV strategy that will be released later this year, and use data to devise strategies that reduce new HIV infections by 90% by 2030. Proposed strategies should include the implementation of activities that will diagnose all people with HIV as early as possible, treat all people with HIV rapidly and effectively to reach sustained viral suppression, prevent new HIV transmissions by using proven

interventions, and respond quickly to potential outbreaks to get needed prevention and treatment services to people who need them.

Section I: Introduction

In the United States, we have the tools to end the HIV epidemic. During 2015–2019, the annual number and rate of diagnoses of HIV infection decreased in both the United States and six dependent areas. Although numbers and rates decreased overall, diagnoses of HIV infection increased in some subgroups and decreased in others. The work of dedicated individuals across HIV prevention and care delivery systems have contributed to the number of HIV diagnoses decreasing nine percent among adults and adolescents between 2015 and 2019[1], and viral suppression rates for clients in the Ryan White HIV/AIDS Program (RWHAP) increased from 69.5 percent in 2010 to 88.1 percent in 2019[2]. However, health disparities persist among gay, bisexual and other men who have sex with men, particularly Black, Latino, and American Indian/Alaska Native men; Black women; transgender women; youth aged 13-24 years; and people who inject drugs[3]. To reach the national goals of reducing new HIV infections by 75 percent by 2025 and by 90 percent by 2030, our systems of HIV prevention and care must work together in unprecedented ways to address health inequities that remain. This includes providing equal access to all available tools so that no population or geographic area is left behind and efforts to end the HIV epidemic are accelerated.

The Integrated Plan Guidance for CY 2022-2026 is the second five-year planning guidance, developed by CDC and HRSA. This Integrated Plan Guidance builds on the first iteration of the Integrated Plan Guidance by allowing each jurisdiction to develop new goals and objectives that align public and private sectors to leverage strengths from the last five years and to add or revise services to address local health inequities that may remain. The Integrated Plan Guidance speaks to the need for aggressive actions necessary to achieve the HIV National Strategic Plan 2025 goals and targeted efforts to end the HIV epidemic by the year 2030.

Specifically, the Integrated Plan Guidance was designed to:

1. Coordinate HIV prevention and care activities by assessing resources and service delivery gaps and needs across HIV prevention and care systems to ensure the allocation of resources based on data;

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[1] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2019*; vol.32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021.

[2] Health Resources and Services Administration. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019.* https://hab.hrsa.gov/data/data-reports. Published December 2020.

[3] Black is defined as African American or Black and Latino is defined as Latino or Hispanic (U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025. (Pp 9) Washington, DC , https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

2. Address requirements for planning, community engagement and coordination established by the RWHAP legislation as well as programmatic planning and community engagement requirements established by both HRSA and CDC through guidance;

3. Improve health outcomes along the HIV care continuum by using data to prioritize those populations where systems of care are not adequately addressing high HIV morbidity and/or lower than average viral suppression rates;

4. Promote a status neutral approach[4], where testing serves as an entry point to services regardless of a positive or negative result, to improve HIV prevention and care outcomes;

5. Reduce recipient burden by allowing recipients to submit portions of other significant planning documents (e.g., EHE Plans, Fast Track Cities, Getting to Zero, or Cluster and Outbreak Detection and Response plans) to meet Integrated Plan requirements and by aligning submission requirements and dates across HIV prevention and care funding; and,

6. Advance health equity and racial justice by ensuring that government programs promote equitable delivery of services and engage people with lived experience in service delivery system design and implementation.

Relationship to other National Plans and Initiatives

HRSA and CDC recognize that many jurisdictions have established and implemented extended planning processes as part of other local initiatives including but not limited to EHE funding, Fast Track Cities, locally funded Getting to Zero initiatives, or Cluster and Outbreak Detection and Response Plans. To minimize burden and align planning processes, the jurisdiction may submit portions of these plans to satisfy the Integrated Plan Guidance requirements. It is important to note that all submitted plans must address the national HIV goal of reducing the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030. Jurisdictions should review the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025* or subsequent updates to the current national plan by visiting www.hiv.gov and subscribing to receive updates.

National Framework for Ending the HIV Epidemic

It is important to think about this Integrated Plan Guidance within the framework of national objectives and strategic plans that detail the principles, priorities, and actions that direct the national public health response and provide a blueprint for collective action across the federal government and other sectors (see *Appendix 5*). HRSA and CDC support the implementation of these strategies.

[4] A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated in the same way. Source: Julie E Myers, Sarah L Braunstein, Qiang Xia, Kathleen Scanlin, Zoe Edelstein, Graham Harriman, Benjamin Tsoi, Adriana Andaluz, Estella Yu, Demetre Daskalakis, Redefining Prevention and Care: A Status-Neutral Approach to HIV, Open Forum Infectious Diseases, Volume 5, Issue 6, June 2018, ofy097, https://doi.org/10.1093/ofid/ofy097

In January 2021, the U.S. Department of Health and Human Services (HHS) released the *HIV National Strategic Plan: A Roadmap to End the Epidemic 2021- 2025* which creates a collective vision for HIV service delivery across the nation. Each jurisdiction should create Integrated Plans that address four goals[5]:

- Prevent new HIV infections
- Improve HIV-related health outcomes for people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders

To achieve these goals, the HIV National Strategic Plan identifies key priority populations, focus areas, and strategies. All plans submitted in response to the Integrated Plan Guidance should incorporate the national goals and strategies detailed in the HIV National Strategic Plan. This should include activities that:

- Leverage public and private community resources toward meeting the goals;
- Address health inequities for priority populations including inequities related to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral health issues including but not limited to substance use disorders;
- Create strategic partnerships across a broad spectrum of service systems as a means to lessen the impact of social and structural determinants of health such as systemic racism, poverty, unstable housing and homelessness, stigma, and/or under- or un-employment;
- Implement innovative program models that integrate HIV prevention and care with other services and other service organizations as a means to address comorbid conditions and to promote a status neutral approach to care; and,
- Coordinates HIV prevention and care systems around key focus areas to strengthen the local response.

For more information on the HIV National Strategic Plan, visit: https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf.

In 2019, HHS announced the EHE initiative in the United States coordinated around four strategies – diagnose, treat, prevent, and respond – that leverage highly successful programs, resources, and infrastructure. The EHE initiative aligns with the HIV National Strategic plan goal of 90 percent reduction in new HIV diagnoses in the United States by 2030, decreasing the number of new HIV infections to fewer than 3,000 per year. The EHE initiative focuses resources, expertise and technology in jurisdictions hardest hit by the HIV epidemic. For more information on the EHE initiative, visit: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview .

[5] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 2-3) Washington, DC. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

The Integrated Plan Guidance utilizes the HIV care continuum model and the status neutral approach. The HIV care continuum depicts the stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to reach viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner, thus providing an additional strategy to prevent new HIV infections. Strategies to address racism and discrimination that threatens HIV public health goals within HIV prevention care, and treatment systems are needed to increase the number of people with HIV that reach and maintain viral suppression.

The adoption of a status neutral approach can improve HIV prevention and care service delivery and outcomes. Persons with positive test results should be linked to HIV care, treatment, and other social support services; and, persons testing negative should be linked, as needed, to biomedical HIV prevention services, such as PrEP, and other social support services.

The HIV care continuum allow recipients and planning groups to measure progress and to direct HIV resources most effectively. HRSA and CDC encourage jurisdictions to use the HIV care continuum to identify populations for whom the service system may not adequately prevent exposure to HIV or may not support improved HIV health outcomes. Additionally, all jurisdictions should include performance measures in their Integrated Plan submission including the core performance measures that measure progress along the HIV care continuum for all priority groups. Please see *Appendix 4* for links to suggested CDC and HRSA data sources, performance measures, and indicators.

Section II: Planning Requirements and Submission Guidelines

HIV Planning Requirements

All CDC DHAP and HRSA HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a system-wide plan for the delivery of HIV prevention and care services and the establishment of an HIV planning group, planning council, or advisory group, also known as a planning body. By design, the HIV planning body must engage people with different interests, responsibilities, and involvement with HIV to inform and support the development and implementation of an Integrated Plan submission that guides the delivery of HIV prevention and care services.

For the development of the Integrated Plan, jurisdictions should include and use their existing local prevention and care HIV planning bodies, as consistent with CDC and HRSA planning group requirements, and engage traditional stakeholders and community members (e.g., AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics and local education agencies (LEAs)) to get input. In addition, recipients should broaden their existing group of partners and stakeholders to include other federal, state, and local HIV programs, local organizations, and community groups not previously engaged for the purposes of improving data sources, leveraging services, and assisting with key portions of the plan, such as the HIV prevention and care inventories.

When developing the Integrated Plan submission, the planning body should collaborate with the recipient to analyze data for program action and decisions, prioritize resources to those jurisdictions at highest risk for HIV transmission and acquisition, and address health equity by improving both individual and population based HIV health outcomes in those jurisdictions. Through strategic collaborations among stakeholders, HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention and care service delivery needs and priorities. Please refer to CDC's most recent HIV Planning Guidance (HPG) and the RWHAP Part A and Part B Manual for more details about HIV planning processes.

Integrated Plan Development

Integrated planning is a vehicle for jurisdictions to identify HIV prevention and care needs, existing resources, barriers, and gaps and outline local strategies to address them. The Integrated Plan submission should articulate existing and needed collaborations among people with HIV, service providers, funded program implementers, and other stakeholders, including but not limited to other programs funded by the federal government, such as the Housing Opportunity for Persons with AIDS (HOPWA) program and providers from other service systems such as substance use prevention and treatment providers. The Integrated Plan submission should reflect current approaches and use the most recent data available. To ensure coordinated implementation of their Integrated Plan submission, each jurisdiction should include information on the persons or agencies responsible for developing the plan, implementing the plan, coordinating activities and funding streams, and monitoring the plan.

To submit the Integrated Plan, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission. As part of the Integrated Plan submission, jurisdictions will need to outline the communities and stakeholders represented in the planning and concurrence process (e.g., community members, people with HIV, providers, governmental entities). Please see *Appendix 6* for a sample letter of concurrence.

The Integrated Plan submission should include all funding sources, service delivery, and system integration (entire system of HIV prevention and care). It should include the following sections:

1. Executive Summary
2. Community Engagement and description of Jurisdictional Planning Process
3. Contributing Data Sets and Assessments, including:
    a. Epidemiologic Snapshot
    b. HIV Prevention, Care and Treatment Resource Inventory
    c. Needs Assessment
4. Situational Analysis Overview, including priority populations/groups
5. CY 2022-2026 Goals and Objectives to be organized by the goals in the HIV National Strategic Plan and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See *Appendix 2* for examples.

In addition to these sections, please use the checklist attached, as *Appendix 1*, to ensure the jurisdiction submits all of the documents needed to meet submission requirements,

including existing materials and newly developed materials needed for each required section.

Submission

While there is not a standard template for the Integrated Plan submission, the plan submitted must include all the components outlined in this guidance and include a completed *CY2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be broad enough to ensure that all HIV prevention and care funding work together to reduce new HIV infections by 90% by 2030. The new written plan should not redevelop existing products such as epidemiologic profiles, if these products are current and up-to-date. Existing versions of these documents may be updated or modified if needed for the current integrated planning process.

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan.

- The Integrated Plan should include information on who is responsible for developing the Integrated Plan within the jurisdiction (i.e., RWHAP Part A planning councils/body(ies), RWHAP Part B advisory groups, and CDC HIV planning bodies).

- The Integrated Plan should define and provide the goal(s), which allows the jurisdiction to articulate its approach for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the goals of the HIV National Strategic Plan.

All funded jurisdictions (funded by both CDC DHAP and HRSA HAB) must submit an Integrated Plan responsive to this guidance. State and/or local jurisdictions (municipalities) have the option to submit to CDC and HRSA:

1. Integrated state/city prevention and care plan,
2. Integrated state-only prevention and care plan, and/or
3. Integrated city-only prevention and care plan.

NOTE: All submissions should integrate prevention and care as a mechanism to better coordinate a response to HIV among all partners and stakeholders.[6] Per legislative and programmatic requirements, regardless of the option used, CDC and HRSA expect coordination among funded entities and community stakeholders in the development of Integrated Plan and its submission.

The Integrated Plan submission may include several jurisdictions (e.g., the state, the RWHAP Part A jurisdiction(s) in that state, CDC directly funded cities in that state), but each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of the Integrated Plan. For jurisdictions submitting city-only or state-only Integrated Plans, the city Integrated Plan should complement the state Integrated Plan, including the SCSN. Additionally, both the

[6] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 45-47) Washington, DC. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

city-only and state-only Integrated Plans should describe how the jurisdictions will coordinate actions to prevent duplication and should depict and address the HIV epidemic within its jurisdiction.

The jurisdiction's Integrated Plan submission is due to CDC DHAP and HRSA HAB ***no later than 11:59 PM ET on December 9, 2022***. Submissions should be no longer than 100 pages not including the completed checklist and no smaller than 11pt font. The submission package must contain a completed Integrated Plan that includes the sections detailed above; a *CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* detailing where CDC and HRSA may find each of the required elements; and a signed letter from the HIV planning group/body indicating concurrence, concurrence with reservations, or non-concurrence with the plan. Further details on how to submit your jurisdiction's Integrated Plan are forthcoming.

Monitoring

The Integrated Plan provides an overarching vehicle to coordinate approaches for addressing HIV at the state and local levels. Monitoring the Integrated Plan will assist recipients and planning bodies with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information, and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction.

Jurisdictions must identify how they will provide regular updates to the planning bodies and stakeholders on the progress of plan implementation, solicit feedback, and use the feedback from stakeholders for plan improvements. Each jurisdiction also will need to use surveillance and program data to assess and improve health outcomes, health equity, and the quality of the HIV service delivery systems, including strategic long-range planning.

The Integrated Plan is a "living document" and must be reviewed and updated at least annually or as needed. The process for annual review should include the identification of relevant data and data systems, analysis of data on performance measures, the inclusion of planning bodies in the ongoing evaluation of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process.

To ensure progress on Integrated Plan activities and the Integrated Plan's alignment with funding strategies, CDC and HRSA will engage in monitoring activities both independently and jointly. Recipients will use established reporting requirements (i.e., applications, annual progress reports) to document progress on achieving the objectives presented in the Integrated Plan. These reporting updates should include the jurisdiction's plan to monitor and evaluate implementation of the goals, strategies, and objectives included in the Integrated Plan. Additionally, CDC and HRSA project officers will continue to monitor progress during regularly scheduled calls and will conduct periodic joint monitoring calls with recipients.

CDC DHAP and HRSA HAB remain committed to our ongoing partnership and the provision of technical assistance (TA) services. For TA services around integrated planning, please contact your respective project officers.

Appendix 1

CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section I: Executive Summary of Integrated Plan and SCSN	*Purpose:* To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission Tips for meeting this requirement 1. Be sure to write the summary with enough detail to ensure the reader understands how you have met Integrated Plan requirements. 2. If you are using a combination of new and existing materials, be sure to describe how submitted materials relate to each other.		
1. Executive Summary of Integrated Plan and SCSN	Provide an overall description of the Integrated Plan, including the SCSN, and the extent to which previous/other plans/SCSNs inform this plan/SCSN, or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below.	*New material required*	

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Approach	Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.).	*New material required*	
b. Documents submitted to meet requirements	List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement.	*New material required*	
Section II: Community Engagement and Planning Process	*Purpose:* To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. Review of the HIV National Strategic Plan and the updated HIV strategy, when released. 2. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. 3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The community engagement process should reflect the local demographics. 5. The planning process should include key stakeholders and broad-based communities that include but are not limited to: people with HIV, funded-service providers, and stakeholders, especially new stakeholders, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of stakeholders to be included. 6. Explain how the jurisdiction will build collaborations among systems of prevention and care relevant to HIV in the jurisdictions (e.g., behavioral health and housing services). 7. Include community engagement related to "Respond" and support of cluster detection activities.		
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		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
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 list of required and suggested stakeholders		
b. Role of the 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.		
c. Role of Planning Bodies and Other Entities	Describe the role of 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 occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
d. Collaboration with RWHAP Parts – SCSN requirement	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.		
e. Engagement of people with HIV – SCSN requirement	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.		
f. Priorities	List key priorities that arose out of the planning and community engagement process.		
g. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 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 as a result of updates assessments and community input. 4. Any changes made to the planning process as a result of evaluating the planning process.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section III: Contributing Data Sets and Assessments	*Purpose:* To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps in the service delivery system. This section fulfills several legislative requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. *Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county*. 2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements. 3. Include both narrative and graphic depictions of the HIV-related health disparities in the area including information about HIV outbreaks and clusters.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction. 5. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.		
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.		
2. Epidemiologic Snapshot	Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 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		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	linked to these clusters. Priority populations for prevention and care should be highlighted and align with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction showing burden of HIV in the jurisdiction.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
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. • 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.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
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.		
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.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
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 service – Accessibility		
a. Priorities	List the key priorities arising from the needs assessment process.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
b. Actions Taken	List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.		
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.*		
Section IV: Situational Analysis	Purpose: To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III. Tips 1. New or existing material may be used; however, existing material will need to be updated if used. 2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN. 3. Jurisdictions may submit the Situational Analysis submitted as part of their EHE Plan to fulfill this requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system.* If using EHE plans to fulfill this		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	requirement, be sure to include updates as noted below.		
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 impacting 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		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	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.		
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.		
Section V: **2022-2026 Goals and Objectives**	*Purpose:* To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding. Tips for meeting this requirement: *2. Recipients may submit plans (e.g., EHE, Getting to Zero, Cluster and Outbreak Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area.* 3. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following: 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		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. 4. The plan should include goals that address both HIV prevention and care needs and health equity.		
1. Goals and Objectives Description	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 3 goals and objectives for each of these four areas. See *Appendix 2* for suggested format for Goals and Objectives. *Please note jurisdictions may submit other plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and care service delivery system and geographic area.*		
a. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.		

Section VI: **2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up**	*Purpose:* To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: 1. Implementation 2. Monitoring 3. Evaluation 4. Improvement 5. Reporting and Dissemination Tips for meeting this requirement 1. This requirement may require the recipient to create some new material or expand upon existing materials. 2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process. 3. If you are submitting portions of a different jurisdictional plan to meet this requirement, you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases.		
1. 2022-2026 Integrated Planning Implementation Approach	1. Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met		

a. Implementation	2. 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 jurisdictions 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.		
b. Monitoring	3. Describe the process to be used 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. *Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.*		
c. Evaluation	4. 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 analysis of the performance measures and presents data to the planning group.		

d. Improvement	5. 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.		
e. Reporting and Dissemination	6. Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan.		
f. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 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 made based on work completed.		
Section VII: **Letters of Concurrence**	Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. See *Appendix 6* for a sample Letter of Concurrence.		
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)			
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)			

3. RWHAP Part B Planning Body Chair or Representative			
4. Integrated Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.		
5. EHE Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.		

Appendix 2

Examples of Goal Structure

Note: There is not a required format for submission of Integrated HIV Prevention and Care goals. This format is provided as an example.

Diagnose (EXAMPLE)

Goal 1: To diagnose XX people with HIV in 5 years.

Key Activities and Strategies:
1) Increase routine testing in XX ERs, acute care settings, etc.
2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venue to reach demographic XX

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, sexual health clinics, women's health services/prenatal services providers, hospitals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, RWHAP, Bureau of Primary Health Care (Health Centers), State and/or Local Funding, Medicaid, etc.

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): # of newly identified persons with HIV

Monitoring Data Source: EMR data, surveillance data

Expected Impact on the HIV Care Continuum: Increase the number of people who know their HIV diagnosis by XX% and linked to medical care within 90 days by XX%

Treat (EXAMPLE)

Goal 1: To engage XX people with HIV in ongoing HIV care and treatment in 5 years.

Key Activities and Strategies:
1) Increase linkage to care activities in XX populations
2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venues to reach demographic XX

Key Partners: FQHCs, medical care providers, hospitals, community-based organizations, school-based clinics, various professional health care associations, etc.

Potential Funding Resources: RWHAP, State Local Funding, SAMHSA, HOPWA, Medicaid expenditures, Bureau of Primary Health Care (Health Centers), Administration for Children and Families, and other public and private funding sources

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): Linkage to HIV care within 30 days of less for # of newly identified persons with HIV; Linkage to HIV care within 30 days or less for # of persons with HIV identified as not in care

Monitoring Data Source: Surveillance, RWHAP, CDC testing linkage data

Expected Impact on the HIV Care Continuum: Increase the number of people receiving ART by XX% and improve viral suppression rates in targeted populations by XX%

Prevent (EXAMPLE)

Goal 1: To increase access to PrEP by X% for priority populations in 5 years.

Key Activities and Strategies:
1) Increase number of providers trained to prescribe PrEP
2) Increase PrEP prescriptions among priority populations

Key Partners: Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care (Health Centers), State and/or Local Funding, Minority AIDS Initiative (MAI), SAMHSA, HOPWA, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, and other public and private funding sources, etc.

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): # of providers trained; # of prescriptions for PrEP

Monitoring Data Source: Local databases, medical records data, pharmacy records

Expected Impact on Status Neutral Approach: Increase by XX number the people prescribed PrEP, Increase by XX number the people linked to PrEP services, Increase by XX% in the number of syringe services programs available

Respond (EXAMPLE)

Goal: To increase capacity and implementation of activities for detecting and responding to HIV clusters and outbreaks in 5 years.

Key Activities and Strategies:
1) Increase involvement of health department staff, community members, and community organizations in response planning, implementation, and evaluation
2) Increase flexible funding mechanisms capable of supporting HIV cluster response efforts

Key Partners: Community members, community-based organizations, HIV care providers, FQHCs, correctional facilities, hospitals, social services providers, people with HIV, health departments, public health professionals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, STD Funding, RWHAP, SAMHSA, HUD/HOPWA, Medicaid, Bureau of Primary Health Care (Health Centers), viral hepatitis funding, opioid/substance use funding, State and/or Local Funding

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): Establishment of strengthened cluster and outbreak detection and response plans; protocols for flexible funding mechanisms; number of clusters detected; number and description of cluster responses and lessons learned; incorporation of strategies from Diagnose, Treat, and Prevent pillars into responses to clusters.

Monitoring Data Source: Local protocols and reports

Expected Impact on Status Neutral Approach: Increase the number of people in networks affected by rapid transmission who know their HIV diagnosis, are linked to medical care, and are virally suppressed, or who are engaged in appropriate prevention services (e.g., PrEP, syringe services programs)

Appendix 3

Examples of Key Stakeholders and Community Members

Community engagement is a key expectation of the Integrated Planning Guidance. Community engagement involves the collaboration of key stakeholders and broad-based communities who work together to identify strategies to increase coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. Each community should select stakeholders including persons with HIV who reflect the local demographics of the epidemic with lived experience and can best help align resources and set goals that promote equitable HIV prevention and health outcomes for priority populations. This should include not only traditional stakeholders but engagement with new partners and non-traditional organizations. While the Integrated Plan submission should be done in collaboration with identified Integrated Planning body(s), community engagement may also include assessment processes (e.g., focus groups, population-specific advisory boards) that take place outside of or in conjunction with the Integrated HIV Care and Prevention body(s) and to inform the Integrated Plan submission.

Please Note: Persons or groups with a "*" must be included in the planning process to meet HRSA and/or CDC's legislative or programmatic requirements.

Key Stakeholders to Consider for Planning Group Membership

- Health department staff*
- Community- based organizations serving populations affected by HIV as well as HIV services providers*
- People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C*
- Populations at risk or with HIV representing priority populations
- Behavioral or social scientists
- Epidemiologists
- HIV clinical care providers including (RWHAP Part C and D)*
- STD clinics and programs
- Non-elected community leaders including faith community members and business/labor representatives*
- Community health care center representatives including FQHCs*
- Substance use treatment providers*
- Hospital planning agencies and health care planning agencies*
- Intervention specialists
- Jurisdictions with CDC- funded local education agencies/academic institutions (strongly encouraged to participate).
- Mental health providers*
- Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*
- Representatives from state or local law enforcement and/or correctional facilities
- Social services providers including housing and homeless services representatives*

- Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners

Examples of Key Stakeholders to Consider for Community Engagement

- Existing community advisory boards
- Community members resulting from new outreach efforts
- Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.)
- Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC
- STD clinics and programs
- Other key informants
- City, county, tribal, and other state public health department partners
- Local, regional clinics, and school-based healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners and private payors
- Correctional facilities, juvenile justice, local law enforcement and related service providers
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions
- Other key informants

Examples of Community Engagement Activities

- Focus groups or interviews
- Town hall meetings
- Topic-focused community discussions
- Community advisory group or ad hoc committees or panels
- Collaboration building meetings with new partners
- Public planning body(s) meetings or increased membership
- Meetings between state and local health departments
- Social media events

Appendix 4

Suggested Data Sources

Suggested Data Sources:

- Behavioral surveillance data, including databases such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)
- HIV surveillance data, including clinical data (e.g., CD4 and viral load results) and HIV cluster detection and response data. HIV Surveillance Report, Supplemental Reports, and Data Tables: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html
- STI surveillance data
- HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees; CDC HIV testing data)
- NCHHSTP AtlasPlus (HIV, STD, Hepatitis, TB, and Social Determinants): https://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=ss_AtlasPlusUpdate001
- Medical Monitoring Project: https://www.cdc.gov/hiv/statistics/systems/mmp/index.html
- Ryan White HIV/AIDS Program data (Ryan White HIV/AIDS Program Services Report; ADAP Data Report): https://hab.hrsa.gov/data/data-reports
- AHEAD: America's HIV Epidemic Analysis Dashboard: https://ahead.hiv.gov/
- HOPWA EHE Planning Tool: https://ahead.hiv.gov/resources
- Other relevant demographic data (i.e., Hepatitis B or C surveillance, tuberculosis surveillance, and substance use data)
- Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)
- Vital statistics data (e.g., state office of vital statistics, National Death Index, Social Security Death Master File)
- Other Federal Data Sources (e.g., Medicaid Data, HOPWA Data, VA Data)
- Local Data Sources (e.g., Department of Corrections, Behavioral Health services data including information on substance use and mental health services)
- Other Relevant Program Data: (e.g. Community Health Center program data).

Note: An update to the Integrated Guidance for Developing Epidemiologic Profiles is forthcoming in late 2021.

References for CDC DHAP and HRSA HAB Performance Measures:

- HRSA HAB Performance Measure Portfolio: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio
- Core Indicators for Monitoring the Ending the HIV Epidemic: https://ahead.hiv.gov/

Appendix 5

Federal Strategic Plans and Resources

Federal Strategic Planning Documents

- Healthy People 2030: Sets data-driven national objectives to improve health and well-being over the next decade.
- HIV National Strategic Plan: A Roadmap to End the HIV Epidemic (2021– 2025): Roadmap for ending the HIV epidemic in the United States, with a 10-year goal of reducing new HIV infections by 90% by 2030.
- Sexually Transmitted Infections National Strategic Plan for the United States (2021– 2025): Groundbreaking, first ever five-year plan that aims to reverse the recent dramatic rise in STIs in the United States
- Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025: Provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030.
- HHS Ending the HIV Epidemic (EHE): A Plan for America Initiative: EHE aims to reduce the number of new HIV infections in the United States by at least 90% to fewer than 3,000 per year.

Federal HIV Funding Resources

This non-exhaustive list provides web sites to assist with identifying federal HIV funding resources in U.S. jurisdictions.

General

- USA Spending
- Federal HIV Budget

Health Resources and Services Administration (HRSA)

- HRSA HIV/AIDS Programs – Grantee Allocations & Expenditures
- HRSA Bureau of Primary Health Care Health Center Recipients Locator
- HRSA Federal Office of Rural Health Policy, Rural Assistance Center, Rural HIV and AIDS Funding & Opportunities

Centers for Disease Control and Prevention (CDC)

- CDC Division of HIV/AIDS Prevention (DHAP) Funding and Budget
- Notice of Funding Opportunity (NOFO) PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States Component B: Accelerating State and Local HIV Planning to End the HIV Epidemic
- Ending the Epidemic (EHE): Scaling Up HIV Prevention Services in STD Specialty Clinics
- CDC DIS Workforce Development Funding

U.S. Department of Housing and Urban Development (HUD)

- HUD Community Planning and Development Program Listing
- HUD Community Planning and Development – Cross-Program Funding Matrix and Dashboard Reports

Substance Abuse and Mental Health Services Administration (SAMHSA)

- SAMHSA's Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities
- SAMHSA Grant Awards by State
- SAMHSA's Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders

HHS, Office on Minority Health (OMH)

- HHS Office of Minority Health Active Grant Award Locator

National Institutes of Health

- Centers for AIDS Research (CFAR) program

CDC/HRSA Project Officer

Appendix 6

Sample Letter of Concurrence or Concurrence with Reservations between Planning Body and State or Local Health Department or Funded Agency

Dear (Name):

The [insert name of Planning Body, e.g. planning council, advisory council, HIV planning group, planning body] [insert ***concurs or concurs with reservations***] with the following submission by the [insert name of State/Local Health Department/ Funded Agency] in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body (e.g. planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [insert ***concurs or concurs with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

[Insert the process used by the planning body to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process.]

The signature(s) below confirms the [insert ***concurrence or concurrence with reservations***] of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Date:

Planning Body Chair(s)

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Service Category Rankings Worksheet

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

11			Medical Transportation	S	Medical Transportation
12			Nutrition Support	S	Food Bank/Home Delivered Meals
13			Oral Health Services	C	Oral Health Care
14			Child Care Services	S	Child Care Services
15			Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
16			Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
17			Health Education/Risk Reduction	S	Health Education/Risk Reduction
18			Home Based Case Management	C	Home and Community Based Health Services
19			Home Health Care	C	Home Health Care
20			Referral	S	Referral for Health Care and Support Services
21			Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
22			Language	S	Linguistics Services
23			Medical Nutrition Therapy	C	Medical Nutrition Therapy
24			Rehabilitation Services	S	Rehabilitation Services
25			Respite	S	Respite Care
26			Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27			Hospice	C	Hospice

Footnote:
1 – Service rankings approved by the Commission on 9/9/2021.

Los Angeles County Commission on HIV Planning, Priorties and Allocations Committee Ryan White Part A and MAI Allocations Percentage Recommendations Worksheet			Approved Allocation PY 32 (FY 2022-23)				Recommendation (PY 33) (FY 2023-24)			Recommendation (PY 34) (FY 2024-25)	
PY 32 SERVICE RANKINGS[1]	Core/ Support Services	Service Category	Part A %	MAI %	TOTAL PART A/MAI %		Part A %	MAI %		Part A %	MAI %
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%						
2	S	Non Medical Case Management	2.44%	12.61%	3.30%						
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%						
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%						
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%						
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%						
7	C	Mental Health Services	4.07%	0.00%	3.72%						
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%						
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%						
10	C	Early Intervention Services	0.00%	0.00%	0.00%						
11	S	Medical Transportation	2.17%	0.00%	1.99%						
12	S	Nutrition Support (Food Bank/Home-delivered Meals)	8.95%	0.00%	8.19%						
13	C	Oral Health Services	17.6%	0.00%	16.13%						
14	S	Child Care Services	0.95%	0.00%	0.87%						
15	S	Other Professional Services (Legal Services)	1.00%	0.00%	0.92%						
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%						
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%						
18	C	Home Based Case Management	6.78%	0.00%	6.21%						
19	C	Home Health Care	0.00%	0.00%	0.00%						
20	S	Referral	0.00%	0.00%	0.00%						
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%						
22	S	Language	0.65%	0.00%	0.60%						
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%						

24	**S**	Rehabilitation Services	0.00%	0.00%	0.00%							
25	**S**	Respite Care	0.00%	0.00%	0.00%							
26	**C**	Local Pharmacy Assistance	0.00%	0.00%	0.00%							
27	**C**	Hospice	0.00%	0.00%	0.00%							
		Overall Total	**100.0%**	**100.0%**	**100.0%**		**0.0%**	**0.0%**		**0.0%**	**0.0%**	

Footnote:

1 - Service Rankings Approved by the Commission on 09/09/2021.