LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
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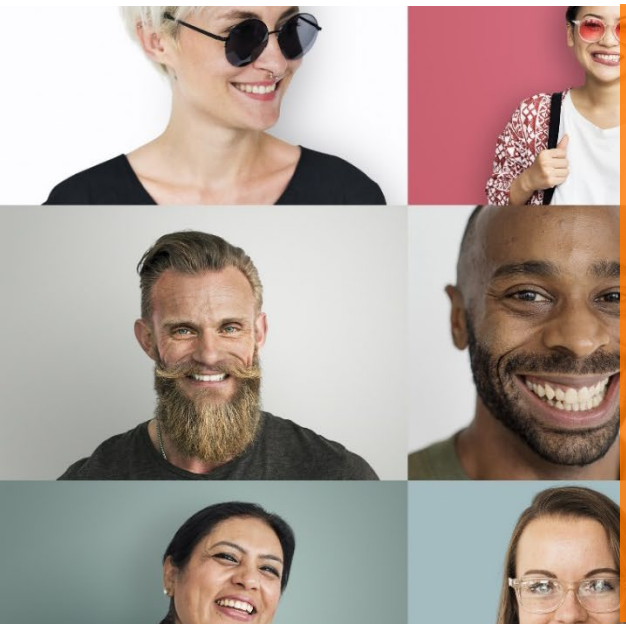

EXECUTIVE COMMITTEE MEETING

Thursday, January 23, 2025
1:00PM – 3:00PM (PST)

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

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

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r34d2db79fab9ba985732f7170d17d82d
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2530 561 1355

Public Comments

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

- Emailing hivcomm@lachiv.org
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

** Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting. All public comments will be made part of the official record.*

Accommodations

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

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

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

Apply to become a Commission member at: https://www.surveymonkey.com/r/COHMembershipApp
For application assistance, call (213) 738-2816 or email hivcomm@lachiv.org

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

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

EXECUTIVE COMMITTEE

Thursday, January 23, 2025 | 1:00PM-3:00PM

510 S. Vermont Ave, Terrace Level Conference, Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020
**As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting in order to access the Terrace Conference Room (9th flr) where our meetings are held.*

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
To Join by Telephone: 1-213-306-3065
https://lacountyboardofsupervisors.webex.com/weblink/register/r34d2db79fab9ba985732f7170d17d82d
Password: EXECUTIVE Access Code: 2530 561 1355

EXECUTIVE COMMITTEE MEMBERS			
Danielle Campbell, PhDc, MPH, Co-Chair	*Joseph Green, Co-Chair*	Miguel Alvarez (OPS Committee)	Alasdair Burton (Executive At-Large)
Erika Davies (SBP Committee)	Kevin Donnelly (PP&A Committee)	Bridget Gordon (Executive At-Large)	Lee Kochems (LOA) (Public Policy Committee)
Katja Nelson, MPP (Public Policy Committee)	Mario J. Peréz, MPH (DHSP)	Dechelle Richardson (Executive At-Large)	Daryl Russel (PP&A Committee)
Kevin Stalter (SBP Committee)	Justin Valero, MPA (OPS Committee)		
QUORUM: 7			

AGENDA POSTED: January 20, 2025

SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may submit in person, email to hivcomm@lachiv.org , or submit electronically here. All Public Comments will be made part of the official record.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT 1:10 PM – 1:13 PM

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

III. COMMITTEE NEW BUSINESS ITEMS 1:13 PM – 1:15 PM

6. Opportunity for Commission 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.

7. Standing Committee Report 1:15 PM – 1:45 PM

A. Planning, Priorities and Allocations (PP&A) Committee
   (1) Ryan White Program (RWP) Years 35-37 Directives Review
   (2) 2027-2031 Integrated HIV Planning

B. Operations Committee
   (1) Membership Management
      a. New Membership Applications Hold Due to Vacancy Limitations and Proposed Restructuring (REMINDER)
      b. 2025 Conflict of Interest Form and Parity, Inclusion & Reflectiveness (PIR) Survey (REMINDER)
   (2) 2025 Training Schedule
   (3) Recruitment, Retention & Engagement

D. Standards and Best Practices (SBP) Committee
   (1) Housing Service Standards Review
   (2) Service Standards Schedule
   (3) 2025 Meeting Schedule

E. Public Policy Committee (PPC)
   (1) Federal, State, County Policy & Budget
      a. 2025 Legislative Docket Development
      b. 2025 Policy Priorities Review
      c. 2025 Meeting Schedule

8. Caucus, Task Force, and Work Group Reports: 1:45 PM – 2:00 PM

A. Aging Caucus
   - Updated Meeting Schedule

B. Black/AA Caucus

C. Consumer Caucus
   - February 13, 2025 Consumer Resource Event | FLYER

D. Transgender Caucus

E. Women's Caucus
   - Updated Meeting Schedule

F. Housing Task Force

IV. REPORTS

9. Executive Director/Staff Report 2:00 PM – 2:15 PM

A. Commission (COH)/County Operational Updates
   (1) Consumers, Clients & Providers Impacted by the Wildfires
   (2) COH Effectiveness Review & Restructuring Project
   (3) Updated 2025 COH Workplan & Meeting Schedule

10. Co-Chair Report 2:15 PM – 2:35 PM

A. February 13, 2025 COH Meeting Agenda Development
B. 2025 Co-Chair Nominations & Elections Reminder

11. Division of HIV and STD Programs (DHSP) Report 2:35 PM – 2:50 PM

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI, and CDC/Ending the HIV Epidemic (EHE)

(2) Fiscal

(3) Other Updates

V. NEXT STEPS 2:50 PM – 2:55 PM

12. Task/Assignments Recap

13. Agenda development for the next meeting

VI. ANNOUNCEMENTS 2:55 AM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

15. Adjournment in memory of all those affected by the recent wildfires during the regular meeting on January 23, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

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

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

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

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial HERE or contact Commission staff at hivcomm@lachiv.org.

Updated 1/20/25

Meeting Schedule

LOS ANGELES COUNTY COMMISSION ON HIV

- All Commission and Committee meetings are held monthly, open to the public and conducted in-person at 510 S. Vermont Avenue, Terrace Conference Room, Los Angeles, CA 90020 (unless otherwise specified). Validated parking is conveniently located at 523 Shatto Place, Los Angeles, CA 90020.
- A virtual attendance option via WebEx is available for members of the public. To learn how to use WebEx, please click here for a brief tutorial.
- Subscribe to the Commission's email listserv for meeting notifications and updates by clicking here. **Meeting dates/times are subject to change.*

January - December 2025

2nd Thursday (9AM-1PM)	**Commission (full body)**	Vermont Corridor *subject to change
4th Thursday (1PM-3PM)	**Executive Committee**	Vermont Corridor *subject to change
4th Thursday (10AM-12PM)	**Operations Committee**	Vermont Corridor *subject to change
3rd Tuesday (1PM-3PM)	**Planning, Priorities & Allocations (PP&A) Committee**	Vermont Corridor *subject to change
1st Monday (1PM-3PM)	**Public Policy Committee (PPC)**	Vermont Corridor *subject to change
1st Tuesday (10AM-12PM)	**Standards & Best Practices (SBP) Committee**	Vermont Corridor *subject to change

The Commission on HIV (COH) convenes several caucuses and other subgroups to harness broader community input in shaping the work of the Commission around priority setting, resource allocations, service standards, improving access to services, and strengthening PLWH voices in HIV community planning. **The following COH subgroups meet virtually unless otherwise announced.*

Aging Caucus	Black Caucus	Consumer Caucus	Transgender Caucus	Women's Caucus	Housing Taskforce
1PM-3PM	4PM-5PM	1-3PM	10AM-11:30AM	2PM-3PM	9AM-10AM
**2nd Tuesday bi-monthly*	**3rd Thursday monthly*	**2nd Thursday monthly, following COH meeting*	**3rd Thursday quarterly*	**3rd Monday bi-monthly*	**4th Friday monthly*

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 1.3.25

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2024	June 30, 2026	
3	City of Long Beach representative			***Vacant***	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	SBP	Dahlia Ale-Ferlito	AIDS Coordinator's Office, City of Los Angeles	July 1, 2024	June 30, 2026	
5	City of West Hollywood representative	1	PP&A	Dee Saunders	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2024	June 30, 2026	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2024	June 30, 2026	
8	Part C representative	1	OPS	Leon Maultsby, DBH, MHA	Charles R. Drew University	July 1, 2024	June 30, 2026	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2023	June 30, 2025	
10	Part F representative	1	SBP	Sandra Cuevas	Pacific AIDS Education and Training - Los Angeles Area	July 1, 2024	June 30, 2026	
11	Provider representative #1			***Vacant***		July 1, 2023	June 30, 2025	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2024	June 30, 2026	
13	Provider representative #3	1	PP&A	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2023	June 30, 2025	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2024	June 30, 2026	
15	Provider representative #5	1	SBP	Byron Patel, RN	Los Angeles LGBT Center	July 1, 2023	June 30, 2025	
16	Provider representative #6	1	EXC|OPS	Dechelle Richardson	AMAAD Institute	July 1, 2024	June 30, 2026	
17	Provider representative #7			***Vacant***		July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2024	June 30, 2026	
19	Unaffiliated representative, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	Kerry Ferguson (SBP)
20	Unaffiliated representative, SPA 2	1	SBP	Russell Ybarra	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
21	Unaffiliated representative, SPA 3	1	OPS	Ish Herrera	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
22	Unaffiliated representative, SPA 4			***Vacant***		July 1, 2024	June 30, 2026	Lambert Talley (PP&A)
23	Unaffiliated representative, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
24	Unaffiliated representative, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
25	Unaffiliated representative, SPA 7	1	OPS	Vilma Mendoza	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
26	Unaffiliated representative, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
27	Unaffiliated representative, Supervisorial District 1	1	PP	Leonardo Martinez-Real	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Arburtha Franklin (PPC)
28	Unaffiliated representative, Supervisorial District 2	1	EXC|OPS	Bridget Gordon	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
29	Unaffiliated representative, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
30	Unaffiliated representative, Supervisorial District 4			***Vacant***		July 1, 2024	June 30, 2026	
31	Unaffiliated representative, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Rita Garcia (PP&A)
32	Unaffiliated representative, at-large #1	1	PP&A	Lilieth Conolly	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
33	Unaffiliated representative, at-large #2	1	PPC	Terrance Jones	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
34	Unaffiliated representative, at-large #3	1	PP&A	Daryl Russell, M.Ed	*Unaffiliated representative*	July 1, 2024	June 30, 2026	David Hardy (SBP)
35	Unaffiliated representative, at-large #4	1	EXC	Joseph Green	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2024	June 30, 2026	
37	Representative, Board Office 2	1	EXC	Danielle Campbell, PhDC, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2024	June 30, 2026	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2024	June 30, 2026	
41	Representative, HOPWA			***Vacant***		July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA ***(LOA)***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	EXC|OPS | PP	Alasdair Burton	No affiliation	July 1, 2024	June 30, 2026	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3	1	OPS	Erica Robinson	Health Matters Clinic	July 1, 2024	June 30, 2026	
47	HIV stakeholder representative #4	1	PP	Ronnie Osorio	Center for Health Justice (CHJ)	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2024	June 30, 2026	
49	HIV stakeholder representative #6			***Vacant***		July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2024	June 30, 2026	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2024	June 30, 2026	
	TOTAL:	**41**						

LEGEND: EXC=EXECUTIVE COMM | OPS=OPERATIONS COMM | PP&A=PLANNING, PRIORITIES & ALLOCATIONS COMM | PPC=PUBLIC POLICY COMM | SBP=STANDARDS & BEST PRACTICES COMM

LOA: Leave of Absence

Overall total: 46

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 1/3/25

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA	**Rita**	No Affiliation	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

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

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

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

Division of HIV and STDs Contracted Community Services

The following list and addendum present the conflicts of interest for Commission members who represent agencies with Part A/B and/or CDC HIV Prevention-funded service contracts and/or subcontracts with the County of Los Angeles. For a list of County-contracted agencies and subcontractors, please defer to Conflict of Interest & Affiliation Disclosure Form.

Service Category	Organization/Subcontractor
Mental Health	
Medical Specialty	
Oral Health	
AOM	
Case Management Home-Based	Libertana Home Health
	Caring Choice
	The Wright Home Care
	Cambrian
	Care Connection
	Envoy
Nutrition Support (Food Bank/Pantry Service)	AIDS Food Store
	Foothill AIDS Project
	JWCH
	Project Angel
Oral Health	Dostal Laboratories
STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)	
STD-Ex.C	
Biomedical HIV Prevention Services	
Case Management Home-Based	Envoy
	Caring Choice
	Health Talent Strategies
	Hope International
Mental Health	
Vulnerable Populations (YMSM)	TWLMP
Nutrition Support (Food Bank/Pantry Service)	
Vulnerable Populations (Trans)	CHLA
	SJW
HTS - Storefront	LabLinc Mobile Testing Unit Contract
Vulnerable Populations (YMSM)	

Service Category	Organization/Subcontractor
AOM	
Vulnerable Populations (YMSM)	APAIT
	AMAAD
HTS - Storefront	Center for Health Justice
	Sunrise Community Counceling Center
STD Prevention	
HERR	

AOM	
STD Infertility Prevention and District 2	
Linkage to Care Service forr Persons Living with HIV	EHE Mini Grants (MHF; Kavich- Reynolds; SJW; CDU; Kedren Comm Health Ctr; RLA; SCC
	EHE Priority Populations (BEN; ELW; LGBT; SJW; SMM; WLM; UCLA LAFANN
	Spanish Telehealth Mental Health Services
	Translation/Transcription Services
	Public Health Detailing
	HIV Workforce Development
Vulnerable Populations (YMSM)	Resilient Solutions Agency
Mental Health	Bienestar
Oral Health	USC School of Dentistry
Biomedical HIV Prevention Services	

Service Category	Organization/Subcontractor
Community Engagement and Related Services	AMAAD
	Program Evaluation Services
	Community Partner Agencies
Housing Assistance Services	Heluna Health
AOM	Barton & Associates
Vulnerable Populations (YMSM)	Bienestar
	CHLA
	The Walls Las Memorias
	Black AIDS Institute
Vulnerable Populations (Trans)	Special Services for Groups
	Translatin@ Coalition
	CHLA
AOM	AMMD (Medical Services)
Biomedical HIV Prevention Services	
Vulnerable Poplulations (YMSM)	
Sexual Health Express Clinics (SHEx-C)	AMMD - Contracted Medical Services
Case Management Home-Based	Caring Choice
	Envoy
AOM	
Mental Health	
STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)	

Service Category	Organization/Subcontractor
Residential Facility For the Chronically Ill (RCFCI)	
Transitional Residential Care Facility (TRCF)	
HTS - Social and Sexual Networks	Black AIDS Institute
AOM	
Case Management Home-Based	Envoy
	Cambrian
	Caring Choice
Oral Health	Dental Laboratory
AOM	
HTS - Storefront	
HTS - Social and Sexual Networks	
AOM	New Health Consultant
Case Management Home-Based	Always Right Home
	Envoy
Mental Health	
Oral Health-Endo	
Oral Health-Gen.	
Oral Health-Endo	Patient Lab - Burbank Dental Lab, DenTech
	Biopsies - Pacific Oral Pathology
Oral Health-Gen.	Patient Lab Services
AOM	UCLA
Benefit Specialty	UCLA
Medical Care Coordination	UCLA
Oral Health	

LOS ANGELES COUNTY
COMMISSION ON HIV

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DRAFT

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

EXECUTIVE COMMITTEE MEETING MINUTES

Thursday, December 12, 2024

COMMITTEE MEMBERS **P = Present | A = Absent | EA=Excused Absence | AB2449=Virtual | Public: Virtual *Not eligible for AB2449 | LOA=LeaveofAbsence**			
Danielle Campbell, MPH, PhDc, Co-Chair	P	Bridget Gordon	A
Joseph Green, Co-Chair	P	Lee Kochems	Public/LOA
Miguel Alvarez (EXEC At-Large)	P	Katja Nelson	Public
Alasdair Burton (EXEC At-Large)	P	Mario J. Pérez	P
Erika Davies	EA	Dechelle Richardson	P
Kevin Donnelly	P	Kevin Stalter	A
Felipe Gonzalez	P	Justin Valero	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Lizette Martinez, MPH; Dawn Mc Clendon; and Jose Rangel-Garibay, MPH			

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER & MEETING GUIDELINES/REMINDERS

Commissioners Joseph Green, COH Co-Chair, commenced the Executive Committee meeting at around 1:00PM and provided an overview of the meeting guidelines.

2. INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS

J. Green initiated introductions and requested that Committee members their state conflicts of interest. Cheryl Barrit, MPIA, Executive Director, led roll call.

ROLL CALL (PRESENT): Miguel Alvarez, Alasdair Burton, Kevin Donnelly, Felipe Gonzalez, Lee Kochems (virtual), Katja Nelson (virtual), Mario J. Pérez, Danielle Campbell, and Joseph Green.

3. **APPROVAL OF AGENDA**
   MOTION #2: Approve the Agenda Order, as presented or revised. *(APPROVEDv: Passed by consensus)*
4. **APPROVAL OF MEETING MINUTES**
   MOTION #3: Approve the Executive Committee minutes, as presented or revised.
   (APPROVEDv: Passed by consensus)

II. PUBLIC COMMENT

5. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.**
   No public comment.

III. COMMITTEE NEW BUSINESS ITEMS

6. **OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.**
   No new business.

IV. REPORTS

7. **Standing Committee Reports**
   - **A. Planning, Priorities & Allocations (PP&A) Committee** Kevin Donnelly, PP&A Co-Chair, reported the committee last met on December 17, 2024.
     - **(1) Paradigm and Operating Values (P&OV) Updates MOTION #3**
       (APPROVEDv: Yes: MAlvarez, ABurton, KDonnelly, FGonzalez, DRichardson, JGreen & DCampell; Abstain: MPerez)
     - **(2) Directives**. The Committee continued to develop the program directives by seeking additional recommendations from the Women's Caucus and incorporating the feedback from the October 28th AV listening session.
     - **(3) October 28, 204 Antelope Valley Sexual Health Listening Sessions.** A summary of the Antelope Valley Sexual Health Listening Session can be found HERE. As a follow-up, the Antelope Valley World AIDS Day community event was well attended by over 100 community members.

B. Operations Committee Miguel Alvarez, Committee Co-Chair, reported:

(1) Membership Management

a. New Membership Applications Hold Due to Vacancy Limitations and Proposed Restructuring. As a reminder, all incoming membership applications are on hold, except for those eligible for vacant seats. Beginning January 2025, the Commission will initiate discussions and activities aimed at potentially restructuring membership, informed by HRSA's findings. This process will be led by consultants Collaborative Research and Next Level Consulting. Members also noted that additional considerations around reorganization may arise should the Board of Supervisors expand as per the ballot initiative.

b. 2025 Conflict of Interest Form and Parity, Inclusion & Reflectiveness (PIR) Survey | REMINDER

Staff reminded the Committee to promptly submit required COI and PIR forms upon request. A follow-up email will be sent to the membership with further details.

(2) Assessment of the Effectiveness of the Administrative Mechanism (AEAM) | Survey Review. Staff shared the updated provider survey template which is more focused and narrower in scope, eliminating non-essential information per HRSA's findings. The Committee will address Ryan White Program (RWP) Years 33 and 34 to align with the current RWP year and use the same surveys to draw comparisons over time. Members suggested conducting a call campaign to providers to increase survey participation.

(3) 2025 Training Schedule. The 2025 Training Schedule is being finalized and will be shared with the membership, including topics suggested by members.

(4) Recruitment, Retention & Engagement.

- JGreen offered to create a simple, easy-to-read one-page FAQ to make the Mentorship Program guide more user-friendly.
- As a recruitment opportunity, the Consumer Caucus will host its annual retreat on December 17, 2024. All consumers of HIV and prevention services are invited to join.

C. Standards and Best Practices (SBP) Committee José Rangel-Garibay, COH Staff, reported:

(1) Emergency Financial Assistance (EFA) Service Standards | MOTION #4
(APPROVEDv: MAlvarez, ABurton, KDonnelly, FGonzalez, DRichardson, JGreen and DCampbell; Abstain: MPérez)

(2) Ambulatory Outpatient Medical (AOM) Service Standards | MOTION #5
(APPROVEDv: MAlvarez, ABurton, KDonnelly, FGonzalez, DRichardson, JGreen and DCampbell; Abstain: MPérez)

(3) Housing Service Standards | REVIEW IN PROCESS. The Committee is actively reviewing the Housing service standards and plans to invite housing providers for further discussions. Concerns were raised about the need for greater efforts to ensure PLWH have access to housing resources. While millions of dollars in funding are allocated for housing, a comprehensive plan is needed to help PLWH secure permanent supportive housing.

(4) Service Standards Schedule. *No updates.*

D. Public Policy Committee (PPC) Katja Nelson, PPC Co-Chair, reported:

- The Committee remains committed to advocacy, with a focus on protecting and preserving resources that are currently under threat.
- Starting in January, the Committee will begin reviewing the budget, legislative docket, and policy priorities.
- The Wall Las Memorias provided an update on the next steps for the ANAM initiative, which is transitioning into a broader harm reduction effort. They are planning a full-day conference in March and will provide ongoing updates.
- Next meeting will be January 6, 2025.

8. Caucus, Task Force, and Work Group Reports

A. Aging Caucus. KDonnelly, Caucus Co-Chair, reported:
The Caucus will continue to work on its 2025 workplan and has canceled its December meeting. The next meeting will be held virtually in January.

B. Black/AA Caucus. Danielle Campbell, Caucus Co-Chair, reported:

- In partnership with D2 and CDU, the Caucus hosted a successful World AIDS Day community event on December 6, 2024, which received a proclamation from Mayor Karen Bass and featured recorded remarks from Supervisor Holly J. Mitchell. The event was well-attended, with over 100 participants.
- The program honored past and present changemakers, showcased the history and evolution of the Black Caucus through a presentation by the co-chairs, and highlighted impactful community efforts.
- Notably, 30 individuals were tested during the event, and the Caucus received recognition in the LA Sentinel.
- The next meeting is scheduled for December 19, 2024. Nominations for the 2025 co-chairs are now open. Interested individuals are encouraged to contact staff for more information.

C. **Consumer Caucus.** Lilieth Conolly, Caucus Co-Chair, reported:
   - The Caucus will host its annual retreat on December 17, 2024, which will include discussions on planning the Consumer Resource Fair scheduled for February 13, 2025.
   - Updates from the Office of AIDS and the California Planning Group (CPG) were shared, including revisions to the SOGI survey and forthcoming information about Doxy PrEP and cisgender women. The CPG has confirmed plans to host an informational table at the Consumer Resource Fair.

D. **Transgender Caucus.** JRangel-Garibay, COH staff, reported:
   - The Caucus last met on September 24, 2024, to review their meeting schedule for the remainder of the year.
   - The Caucus will reconvene on January 28, 2025 at which time co-chair elections will be held. COH staff has met with co-chair nominees to provide an overview of the co-chair roles and responsibilities.

E. **Women's Caucus.** Lizette Martinez, COH staff, reported:
   - The Caucus last met on October 21, 2024, where they discussed feedback from the Loneliness and Isolation event panel discussion as well as held a discussion soliciting recommendations to include in the PP&A directives.
   - During the meeting, co-chair nominations were reopened, and Dr. Mikhaela Cielo and Shary Alonzo were both renominated.
   - Concerns were raised about a recent decline in interest and participation, and discussions are underway to explore strategies for reengaging the community.
   - The Caucus is scheduled to reconvene in January 2025, at which time they will address meeting frequency, scheduling, and revisit childcare services.

F. **Housing Taskforce (HTF).** KNelson, Co-Chair, reported:
   - The HTF last met on November 22, 2024 and received a presentation from HOPWA and addressed program funding challenges.
   - The HTF will identify next steps in developing a comprehensive needs assessment to guide future efforts.

V. REPORTS

9. EXECUTIVE DIRECTOR/STAFF REPORT Cheryl Barrit, MPIA, Executive Director, reported:

A. Commission (COH)/County Operational Updates

(1) Annual Conference. Feedback was overwhelmingly positive; refer to the conference evaluation included in the meeting packet. Staff will identify key themes and prepare a summary to guide future planning efforts.

(2) HRSA TA Site Visit Findings Report | UPDATES. Staff continues to meet with the HRSA TA team to provide progress updates on their site visit findings.

(3) COH Organizational Assessment & Restructure Proposal. As part of the bylaws update process and in response to the HRSA findings, staff has engaged consultants Collaborative Research and Next Level Consulting to lead a series of discussions and activities aimed at informing an organizational restructuring, in response to HRSA's site visit findings and our bylaws review. A kick-off discussion with the full body is scheduled for the January 9, 2025, COH meeting.

(4) 2025 Draft COH Workplan & Meeting Schedule | REVIEW & DISCUSSION. Refer to the proposed 2025 COH workplan and meeting schedule in the meeting packet; both are subject to updates. A suggestion was made to revive researched-based presentations, such as the CHIPTS Colloquia Series

B. CO-CHAIR REPORT J. Green and Danielle Campbell, Co-chairs, reported:

(1) 2024 At-A-Glance | REVIEW & REFLECTIONS

(2) 2025 COH & Committee Co-Chair Open Nominations & Elections | REMINDER. Nominations for the COH, committees, and caucuses are now open, with elections scheduled for January 2025. Nominations will remain open until the elections begin.

(3) 2024 BOS Executive Office Commissioner Forum | FEEDBACK. JGreen shared feedback from the EO Commissioner Forum, highlighting Supervisor Kathryn Barger's attendance and potential funding opportunities through the Quality and Productivity Commission. Quarterly forums are being planned, and all commissioners are encouraged to participate.

(4) Member Vacancies & Recruitment. All new applications are currently on hold pending the outcome of the COH restructuring project.

(5) 2024 Meeting Schedule. No additional meetings are scheduled for December, except for the Consumer Caucus Retreat on December 17, 2024.

10. Division of HIV and STD Programs (DHSP) Report. Mario J. Pérez, MPH, Director, reported:

A. Fiscal Updates

- Concerns have been raised about whether the continuing resolution will be extended to safeguard federal funding and spending bills. More information is expected by December 20, 2024.

B. Ryan White Program (RWP) Part A & MAI, and CDC/Ending the HIV Epidemic (EHE)

- The HRSA Ending the HIV Epidemic (EHE) application has been submitted, requesting the full funding amount. Additionally, the program is awaiting confirmation from the CDC on whether support for rollover EHE funds will be granted, although all funds have been obligated.
- The future of the EHE initiative remains uncertain as the final federal spending bill is pending. The Senate supports maintaining EHE funding, while the House has proposed budget cuts.
- The Prevention Services Request for Proposals (RFP) has been released, with a Bidder's Conference scheduled for next week. While all current prevention contracts are set to expire on February 28, 2025, no interruptions to services are anticipated.
- Additionally, the Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) RFPs have been released, targeting implementation by March 2025.
- DHSP actively participated in various World AIDS Day events, including Commission-sponsored events in the Antelope Valley and at Charles Drew University.

C. Mpox | UPDATES

DHSP reported three new mpox cases during Thanksgiving week, bringing the total number of cases to approximately 2,600. Vaccination coverage remains low among PLWH, with only 26% PLWH having received at least one dose of the vaccine.

V. NEXT STEPS

11. Task/Assignments Recap

A. All motions will be elevated for approval at the January 9, 2025, COH meeting.
B. Co-Chair elections and a community discussion on COH structure are scheduled for the January 9, 2025, COH meeting.
C. 12/17/24 Consumer Caucus Retreat invitation to all consumers of HIV and prevention services.

12. Agenda development for the next meeting. *Refer to minutes.*

VI. ANNOUNCEMENTS

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

VII. ADJOURNMENT

Adjournment for the meeting of December 12, 2024.

Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2027- 2031

Division of HIV Prevention

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

HIV/AIDS Bureau

Health Resources and Services Administration

December 2024

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) 2027-2031 (hereafter referred to as Integrated Plan Guidance). This guidance builds upon the previous guidance issued in 2015 and 2021. That 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 2021, the Integrated Plan Guidance for CY 2027-2031 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 collaborators and partners including communities disproportionately affected by the HIV epidemic 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 reflects local vision, values, and needs.

CDC and HRSA funded recipients will notice several key changes in the Integrated Plan Guidance for CY 2027-2031. These changes reflect feedback from internal and external collaborators, which include recipients and people with HIV as well as priorities detailed in the National HIV/AIDS Strategy 2022 – 2025 (NHAS) published in December 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 in response to the CDC's *High-Impact HIV Prevention and Surveillance Programs for Health Departments (PS24-0047)* program or through other jurisdictional efforts (e.g., Getting to Zero plans, Fast Track Cities, HIV Cluster 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, additional details on key changes can be found in the *CY 2027– 2031 CDC DHP 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.

Integrated Plan submissions address the broader needs of the geographic jurisdiction and apply to the entire HRSA and CDC HIV funding portfolio. Additionally, jurisdictions should submit plans that follow the goals and priorities as described in the NHAS 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 appropriate 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 and continue to make progress toward that goal. From 2018 to 2022, estimated HIV infections in the U.S. decreased by 12 percent largely attributed to the decrease in new HIV infections among people aged 13 to 24.[1] The work of dedicated individuals across HIV prevention and care delivery systems have contributed to this decrease in HIV diagnoses and the increase in viral suppression rates for clients in the Ryan White HIV/AIDS Program (RWHAP) from 69.5 percent in 2010 to 89.7 percent in 2022.

Although rates of new HIV incidence have decreased overall and viral suppression continue to increase, racial and ethnic differences in diagnoses and treatment outcomes of HIV persist. 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[2]. To reach the national goal of reducing new HIV infections, 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 2027-2031 is the third five-year planning guidance developed by CDC and HRSA. This Integrated Plan Guidance builds on the previous iterations 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 NHAS goals and targeted efforts to end the HIV epidemic in the U.S. 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 (e.g., other payors, number of ADAP-eligible clients on health insurance coverage, in-depth analysis of needs assessment of people with HIV and people who can benefit from HIV prevention services or are vulnerable to HIV acquisition);

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;

[1] HV Surveillance Supplemental Report: Estimated HIV Incidence and Prevalence in the United States, 2018–2022

[2] 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. National HIV/AIDS Strategy. (pp 19) Washington, DC

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 overall viral suppression rates;

4. Promote a whole-person approach[3] to help overcome structural and social barriers to care, eliminate stigma, and improve the health of people with HIV and people who can benefit from prevention services;

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

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

7. Leverage strategic partnerships to prioritize efforts, and focus resources and evidence informed interventions, to reach those who are diagnosed, but not engaged in care.

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 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. Jurisdictions should review the NHAS 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.

In January 2021, the U.S. Department of Health and Human Services (HHS) released the NHAS which creates a collective vision for HIV service delivery across the nation. Each jurisdiction should create Integrated Plans that address four goals[4]:

[3] A whole-person approach to HIV prevention and treatment considers the multitude of factors affecting a person's health. Source: https://www.cdc.gov/hiv/policies/strategic-priorities/hiv-and-whole-person-care/index.html#:~:text=A%20whole%2Dperson%20approach%20can,expand%20flexible%20and%20tailored%20interventions.

[4] U.S. Department of Health and Human Services. 2021. National HIV/AIDS Strategy (pp 3-10) Washington, DC.

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

To achieve these goals, the NHAS 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 NHAS. 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 whole-person approach to care; and,
- Coordinates HIV prevention and care systems around key focus areas to strengthen the local response.

For more information on the NHAS, visit: https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf.

In 2020, HHS began implementation of the Ending the HIV Epidemic in the United States initiative coordinated around four strategies – diagnose, treat, prevent, and respond – that leverage highly successful programs, resources, and infrastructure. The EHE initiative aligns with the NHAS plan to reduce new HIV diagnoses in the United States, 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.

The Integrated Plan Guidance utilizes the HIV care continuum model and the whole-person 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. Effective strategies to address barriers 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 whole-person 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 allows 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 be adequately engaging in HIV prevention services 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

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 collaborators, 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.

HIV Planning Requirements

All CDC DHP 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. CDC and HRSA recognize and understand the value of individuals who receive services actively participating in the planning process for HIV service delivery, as this drives services that are tailored to the needs of clients in the jurisdiction, and these individuals must be engaged in the development and implementation process.

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 collaborators and community members (e.g., people with HIV, people with certain risk factors for acquiring HIV, 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 collaborators 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 review and analyze data (e.g., resource inventory, needs assessments, satisfaction surveys, listening sessions) 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 collaborators, HIV planning is based on the principle 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 Components

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

1. Introduction
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 2027-2031 Goals and Objectives to be organized by the goals in the NHAS and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See *Appendix 2* for examples.
6. Integrated Plan Workplan

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.

As part of a complete Integrated Plan submission, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission. In RWHAP Part A jurisdictions that cross state lines, the Part A Planning Councils/Planning Bodies need to submit signed letters to all RWHAP

Part B jurisdictions included in the Part A jurisdiction. As part of the Integrated Plan submission, jurisdictions will need to outline the communities and collaborators represented in the planning and concurrence process (e.g., community members, people with HIV, service providers, governmental entities). Submissions that do not contain the required letters of concurrence will be deemed incomplete and returned for revisions.

See the table below for the required letters of concurrence depending upon the plan submission type. If there are additional planning bodies in the state/territory or jurisdiction, additional letters of concurrence should be submitted. Please see *Appendix 6* for a sample letter of concurrence.

Required Letters of Concurrence			
	Type of Plan		
Planning Body	Integrated State/City Prevention and Care Plan	Integrated State-Only Prevention and Care Plan	Integrated City-Only Prevention and Care Plan
RWHAP Part A Planning Council	✓	✓[5]	✓
RWHAP Part B Planning Group	✓	✓	
CDC Prevention Planning Group	✓	✓	✓

Submission

The Integrated Plan submission must include all the components outlined in this guidance and include a completed *CY 2027- 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be comprehensive to ensure that all HIV prevention and care funding work together to reduce new HIV diagnoses and to increase viral suppression among all people with HIV. The new plan should use existing documents such as an epidemiologic profile, if documents are current. Existing versions of documents may be updated or modified if needed during the current integrated planning process.

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan and must include the following:

- Detailed information of 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, Integrated Planning Bodies and CDC HIV planning bodies).

- Well defined goals and objectives. Each jurisdiction should provide a descriptive detail and process for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the goals of the NHAS.

[5] RWHAP Part A recipients needed to submit letters of concurrence to all states where 10% or more of the HIV cases in their jurisdiction reside.

All funded jurisdictions (funded by both CDC DHP and HRSA HAB) must submit an Integrated Plan and address all sections as outlined in the guidance. State and/or local jurisdictions (municipalities) have the option to submit to CDC and HRSA:

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

NOTE: All submissions should demonstrate an integrated prevention and care plan as a method to better coordinate a response to HIV among all partners and collaborators. Per legislative and programmatic requirements, CDC and HRSA expect coordination among funded entities and community collaborators in the development of the Integrated Plan.

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). Each HRSA and CDC-funded jurisdiction must participate in the completion and submission of the Integrated Plan.

- For jurisdictions submitting city-only plan, the city Integrated Plan should complement the state Integrated Plan, including the SCSN.
- Both the city-only and state-only Integrated Plans should describe how the jurisdictions will coordinate actions to prevent duplication.
- Both city-only and state-only plans should include and address the HIV epidemic within its jurisdiction.

The jurisdiction's Integrated Plan submission is due to CDC DHP and HRSA HAB ***no later than 11:59 PM ET on June 30, 2026***. Submissions should be no longer than 100 pages, not including the completed checklist, and no smaller than 11pt font.

The submission package must contain the following documents:

- A CY 2027 – 2031 Integrated Plan that includes all components outlined in this guidance;
- A completed *CY 2027 – 2031 CDC DHP 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 all jurisdictional HIV planning groups/bodies indicating concurrence, concurrence with reservations, or non-concurrence with the plan.

Further detailed instructions on how to submit your jurisdiction's Integrated Plan will be addressed during the upcoming webinar. You may also reach out to your CDC and HRSA project officers for questions or concerns regarding your Integrated Plan.

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 *CY 2027 – 2031 CDC DHP 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 diagnoses and to increase viral suppression among all people with HIV. 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.

Workplan Monitoring

The Integrated Plan Workplan provides an overarching vehicle to coordinate approaches for addressing HIV prevention and care needs at the state and local levels. The Integrated Plan Workplan must contain goals, SMART (specific, measurable, achievable, relevant and time-bound) objectives, specific activities, responsible parties, key partners, and performance measures that address both HIV prevention and care needs.

In addition, the goals and objectives must be in alignment with both the NHAS goals and the four EHE strategies, listed below:

- Diagnose all people with HIV as early as possible
- Treat people with HIV rapidly and effectively to reach sustained viral suppression
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs)
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Monitoring the Integrated Plan Workplan 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 collaborators on the progress of plan implementation, solicit feedback, and use the feedback from collaborators for plan improvements. Each jurisdiction also will need to use surveillance and program data to assess and improve health outcomes, health disparities, and the quality of the HIV service delivery systems, including strategic long-range planning.

The Integrated Plan, including the Integrated Plan Workplan, 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 workplan 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. Project Officers will also utilize the Integrated Plan Workplan as a tool in monitoring and supporting the jurisdiction's progress. 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 DHP 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 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Section I: Introduction 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

- **Write a detailed summary:** Ensure it shows how you have met the Integrated Plan requirements.
- **Combining materials**: Explain how new and existing materials relate.

Requirements	Materials	Title/File Name of materials	Page(s) for this section
1. Introduction **Describe the Integrated Plan** • Include SCSN • Explain how past 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 & Existing Mate		
a. Approach **Describe your approach to preparing the Integrated Plan submission.** • Update existing plan: Modify and enhance previously submitted plan. • Integrate Existing Documents: Combine sections from current plans and documents. • Develop a New Plan: Create an entirely new plan from scratch.	Develop New Plan		
b. Documents submitted to meet requirements. Fill out for each requirement per column provided: • New or existing material • Title/File Name for materials • Page numbers within the section			

Section II: Community Engagement and Planning Process

Purpose: To describe how the jurisdiction's planning approach engaged community members and collaborators, fulfilled legislative and programmatic requirements, and addresses the HIV care and prevention needs of people with HIV and people vulnerable to HIV.

Tips for meeting this requirement

1. Review of the National HIV/AIDS Strategy.
2. This requirement may include submission of portions of other submitted plans including the EHE plans, and other jurisdictional plans (e.g., Getting to Zero plans, Fast Track Cities, Cluster Detection and Response plans).
3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements, including:

a. SCSN
b. RWHAP Part A and B planning requirements including those requiring feedback from key collaborators and people with HIV
c. CDC planning requirements

4. The community engagement process should reflect the local demographics.
5. The planning process should include key collaborators and broad-based communities that include but are not limited to:
   a. People with HIV,
   b. People vulnerable to HIV,
   c. Funded-service providers, and
   d. Collaborators, especially new collaborators, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of collaborators to be included.
6. Explain how the jurisdiction will build collaborations including sharing of data and establishing/ maintaining services agreements, among:
   a. systems of prevention and care
   b. other service systems 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. Describe what happens when a potential cluster is detected and how community partners and affected communities are engaged.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
1. Jurisdiction Planning Process **Describe Jurisdiction's approach to planning** • **Planning Steps**: explain steps in planning process. • **Groups Involved**: list involved groups for needs assessment and goal setting. • **Usage of Data Sources:** detail data sources used. • **Representation from Priority Populations:** how were they included? Consider sections from other plans, like the EHE plan. Ensure you cover these points.	New & Existing Mate		
a. Entities involved in the process. List and describe the types of entities involved in the planning process. Be sure to include: • CDC and HRSA-funded programs, • New collaborators (e.g., new partner organizations, people with HIV, people vulnerable to HIV), and • 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 collaborators	New & Existing Mate		
b. Role of the RWHAP Part A Planning Council/Planning Body Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.	New & Existing Mate		

Note: Jurisdictions submitting a State-Only Plan are not required to complete this narrative section; however, letters of concurrence must be submitted.			
c. Role of Planning Bodies and Other Entities Describe how programs and planning bodies contributed. • CDC Prevention Program • RWHAP Part B • State/territory or jurisdiction prevention and care • EHE • Community members and other entities Describe collaboration efforts. • How did prevention and care bodies work together? **Provide documentation of the type of engagement occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.**	New & Existing Mate		
d. Collaboration with RWHAP Parts – SCSN requirement Describe how jurisdictions incorporate RWHAP Parts A-D providers and Part F recipients in the planning process. Describe how RWHAP Part A or Part B only plan: • Aligns with other Integrated Plans • Avoids service duplication. • Prevents gaps in service delivery systems.	New & Existing Mat		
e. Engagement of people with HIV – SCSN requirement Describe how jurisdictions engaged people with HIV in all stages of the process: • Needs assessment • Priority setting • Development of goals/objectives Describe how people with HIV will be involved in implementing the plan: • Implementation • Monitoring • Evaluation • Improvement process	New & Existing Mate		
f. Priorities List key priorities that arose out of the planning and community engagement process.	New & Existing Mat		

g. Updates to Other Strategic Plans Used to Meet Requirements If the jurisdiction is using portions of another local strategic plan (e.g., EHE, Ending the Epidemic, Getting to Zero) to satisfy this requirement, please describe: 1. How the jurisdiction uses annual needs assessment data to adjust that plan's priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV, people vulnerable to HIV, and collaborators in that plan. 3. Any changes due to updated assessments and community input. 4. Any changes made to that planning process as a result of evaluating the planning process.	New & Existing Mat		
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 across the HIV Prevention and HIV Care Continuums of Care. This section fulfills several legislative requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key collaborators and people with HIV 3. CDC planning requirements including those requiring feedback from key collaborators and populations vulnerable to HIV acquisition. 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 PS24-0047. *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 health disparities in the area for people with HIV and those vulnerable to HIV including information about HIV outbreaks and clusters. 4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction. 5. Please refer to the Integrated Guidance for Developing Epidemiologic Profiles (cdc.gov) for HIV Prevention and Ryan White HIV/AIDS Program Planning. 6. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.			
Requirements	**New/existing Materials**	**Title/File Name of materials**	**Page(s) for this section**
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.	New & Existing Mat		
2. Epidemiologic Snapshot Provide a snapshot summary using:	New & Existing Mat		

• **Current data**: by using both narrative and graphic depictions display trends using the most recent 5 years (most available data). • **Key descriptors**: people diagnosed with HIV (including newly diagnosed), people vulnerable to HIV, and those with HIV who do not know their HIV status. Highlight Priority populations for prevention and care and align with the NHAS. • **Types of data**: demographic, geographic, socioeconomic, behavioral, and clinical characteristics. • **HIV clusters:** outline key characteristics of HIV clusters and cases linked to these clusters. **Note:** Use the HIV prevention and care continuum in your graphic depiction showing burden of HIV in the jurisdiction.	New & Existing Mat		
3. HIV Prevention, Care and Treatment Resource Inventory Develop an inventory that includes a table and/or narrative but must address **all** of the following information: **Providers:** • Agencies providing HIV care and prevention services in the jurisdiction. • Agencies providing substance use prevention and treatment services: describe the coordination strategy with HIV prevention and care services. **Funding Sources:** • HRSA (all RWHAP parts) and CDC funding sources. Funding amounts not needed. • Additional funding sources: 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 foundations. **Provided Services:** • Services and activities by organizations • Priority population served • How services maximize the quality of health and support for those with certain risk factors of acquiring or with HIV	New & Existing Mat		
a. Assessment of Strengths and Gaps across the HIV Prevention and Care Continuum **Assessment of Strengths and Gaps Inventory should include:** • Health equity • Geographic disparities • Occurrences of HIV clusters/outbreaks	New & Existing Mat		

• Underuse of new HIV prevention tools (e.g., injectable antiretrovirals, environmental impacts) This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on the items listed.	New & Existing Mate		
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.	New & Existing Mate		
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: **HIV Testing Services:** 1. Services needed for HIV testing access. 2. Services for staying HIV negative (e.g., PrEP, Syringe Services Programs) 3. Rapid linkage to HIV care after positive diagnosis. **HIV Care and Treatment:** 4. Services for maintaining HIV care and achieving and sustaining viral suppression. **Barriers to access:** 1. HIV testing barriers 2. Challenges with State laws and regulations. 3. HIV prevention, care, and treatment service access issues.	New & Existing Mat		
a. Priorities List the key priorities arising from the needs assessment process.	New & Existing Mate		
b. Action Taken List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.	New & Existing Mate		
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 and people vulnerable to HIV in the process and how the jurisdiction included entities listed in Appendix 3.	New & Existing Mate		

Section IV: Situational Analysis

Purpose: To provide a snapshot summary that synthesizes information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III that in turn informs the goals and objectives of the Integrated Plan. The situational analysis provides an overview of strengths, challenges, and identified needs across the HIV prevention and care continuum.

Tips

1. New or existing material may be used; however, if existing material is used, it needs to be updated to reflect the most current information.
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 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 an updated or current version of your EHE plan to fulfill this requirement, be sure to include updates as noted below.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
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 across the HIV prevention and care continuum to include: • Strengths • Challenges • Identified needs. • Analysis of structural and systemic issues impacting disproportionately affected populations resulting in health disparities. Analysis should include 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. Note: Jurisdictions may submit other plans to satisfy this requirement, if they are current and applicable to the entire HIV prevention and care service system across the jurisdiction.	New & Existing Mat		
a. Priority Populations Based on the Community Engagement and Planning Process in Section II and the	New & Existing Mate		

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: 2027-2031 Goals and Objectives

Purpose: To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a comprehensive, 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, HIV Cluster Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care continuum 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 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 disparities.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
1. Goals and Objectives Description List and describe goals and objectives for the jurisdiction. Include 3 goals/objectives for each area: • Diagnose • Treat • Prevent • Respond to HIV Ensure goals address any barriers or needs identified during the planning process. See Appendix 2 for examples. Note: Jurisdictions may submit other updated 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.	New & Existing Mat		
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.	New & Existing Mate		

Section VI: 2027-2031 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.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
1. 2027-2031 Integrated Planning Implementation Approach 1. Describe the infrastructure, procedures, systems and/or tools that will be used to support the 5 key phases (see phases above) of integrated planning to ensure goals and objectives are met	New & Existing Mat		
a. Implementation 2. To achieve the jurisdictions Integrated Plan goals and objectives. Describe the process for coordinating partners: • New partners • People with HIV • People vulnerable to HIV • Providers and administrators from different funding streams Include how the plan will influence, leverage, and coordinate funding streams including but not limited to HAB and CDC funding.	New & Existing Mat		
b. Monitoring 3. Describe the process for monitoring progress on the Integrated Plan goals and objectives. Include how the jurisdiction will: • Coordinate different collaborators. • Use different funding streams to implement plan goals.	New & Existing Mate		

• Collaborate/coordinate monitoring of multiple different plans (e.g., city-only, state-only) to avoid duplication of effort and potential gaps in service provision. • Coordinate activities and timelines. Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.	New & Existing Mat		
c. Evaluation 4. Describe performance measures and methodology used to evaluate progress on goals and objectives. Include how often the jurisdiction: • Conducts analysis of the performance measures • Presents data to the planning group.	New & Existing Mat		
d. Improvement 5. Describe how the jurisdiction will: • Continue to use data. • Use community input to make revisions and improvements to the plan. • How revision decisions will be made and how often.	New & Existing Mat		
e. Reporting and Dissemination 6. Describe the process for informing collaborators, including people with HIV, about progress made to the plan. (implementation, monitoring, evaluation and improvements).	New & Existing Mat		
f. Updates to Other Strategic Plans to Meet Requirements If 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 • Report/disseminate plan activities. 2. Describe Achievements/challenges in implementing: • Strategies to resolve challenges. • Plan to replicate successes. 3. Revisions made based on work completed.	New & Existing Mat		

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. Please note, a letter of concurrence is required from Planning Councils regardless of the type of plan submitted. See *Appendix 6* for a sample Letter of Concurrence.			
Requirements	**New/existing Materials**	**Title/File Name of materials**	**Page(s) for this section**
1. CDC Prevention Program Planning Body Chair(s) or Representative(s) Required letter of concurrence	New & Existing Ma		
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s) Required letter of concurrence	New & Existing Mat		
3. RWHAP Part B Planning Body Chair or Representative Required letter of concurrence unless City-Only Plan is submitted	New & Existing Ma		
4. Integrated Planning Body Optional letter of concurrence	New & Existing Mat		
5. EHE Planning Body Optional letter of concurrence	New & Existing Mat		

Appendix 2

Examples of Workplan Components

Note: A workplan template is available on TargetHIV under the Integrated HIV/AIDS Planning & Technical Assistance Center (IHAP TAC) as a part of the Integrated Plan Toolkit.

Diagnose (EXAMPLE)

Goal 1: Diagnose all people with HIV as early as possible.

Objective: To increase the number of HIV tests conducted by XX% within the jurisdiction by 2031.

Key Activities/Strategies:
1) Increase capacity of health care delivery systems to offer routine testing in XX ERs, acute care settings, etc.
2) Plan and develop a wide dissemination of self-testing kits through system partners across the jurisdiction to improve access for testing.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, people with lived experience and those with certain risk factors for acquiring HIV, sexual health clinics, women's health services/prenatal services providers, hospitals, etc.

Performance Measures:

- # of HIV tests
- # of newly identified persons with HIV

Progress towards NHAS Goals: Increase the number of people who know their HIV diagnosis by XX% to prevent new HIV infections.

Treat (EXAMPLE)

Goal 1: Treat HIV timely and effectively.

Objective: To engage and provide access to care for XX people with HIV by 2028.

Key Activities/Strategies:
1) Identify and address mental health barriers for people who have never engaged in care or who have fallen out of care by partnering with mental health providers
2) Develop and implement at least one effective, evidence-based, or evidence-informed interventions that improve retention in care

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient

Key Partners: FQHCs, medical care providers, hospitals, people with lived experience and those with certain risk factors for acquiring HIV, community-based organizations, mental health providers, various professional health care associations, etc.

Performance Measures:

- # of newly identified persons with HIV linked to care within 30 days
- # of persons with HIV identified as not in care linked to care within 30 days

Progress towards NHAS Goals: Increase the number of people receiving care by XX% to improve HIV-related health outcomes.

Prevent (EXAMPLE)

Goal 1: Prevent new HIV transmissions.

Objective: To increase access to PrEP by X% for priority populations by 2031.

Key Activities/Strategies:
1) Increase number of providers trained each year by X% to prescribe PrEP
2) Increase PrEP prescriptions among priority populations to reduce health disparities

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

Key Partners: Community-based organizations, people with lived experience and those with certain risk factors for acquiring HIV, FQHCs, sexual health clinics, hospitals, private providers, social service providers, primary care providers, etc.

Performance Measures:

- # of providers trained
- # of prescriptions for PrEP

Progress towards NHAS Goals: Reduce HIV-related disparities and health inequities by reducing new HIV infections

Respond (EXAMPLE)

Goal 1: Respond quickly to potential HIV clusters and/or outbreaks.

Objective: To develop a Cluster Detection and Response (CDR) Plan that can be executed effectively by 2028.

Key Activities/Strategies:
1) Identity and engage all key collaborators in the plan development process, including people with lived experience and those with certain risk factors for acquiring HIV
2) Convene existing communities of practice to share outbreak best response practices and known gaps to guide development and key strategies in the plan

Responsible Parties: CDC Recipient

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.

Performance Measures: Completion of CDR plan

Progress towards NHAS Goals: Achieve integrated and coordinated efforts that address the HIV epidemic

Appendix 3

Examples of Key Collaborators and Community Members

Community engagement is a key requirement of the Integrated Planning Guidance. Community engagement involves the collaboration of key collaborators 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 collaborators 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 collaborators 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 Collaborators 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 with certain risk factors for acquiring HIV 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
- Area Agencies on Aging and other aging oriented organizations

Examples of Key Collaborators 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
- Area Agencies on Aging and other aging oriented organizations
- 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/about/atlasplus.html?CDC_AAref_Val=https://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=ss_AtlasPlusUpdate001
- Medical Monitoring Project: https://www.cdc.gov/hiv-data/mmp/?CDC_AAref_Val=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://ryanwhite.hrsa.gov/data/reports
- AHEAD: America's HIV Epidemic Analysis Dashboard: https://ahead.hiv.gov/
- 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).

References for CDC DHP and HRSA HAB Performance Measures:

- HRSA HAB Performance Measure Portfolio: https://ryanwhite.hrsa.gov/grants/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.
- National HIV/AIDS Strategy (2022 - 2025): Roadmap to accelerate efforts to end the HIV epidemic in the country 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 Prevention (DHP) Funding and Budget
- High-Impact HIV Prevention and Surveillance Programs for Health Departments (PS24-0047) 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 Grant Awards by State
- SAMHSA's Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders

National Institutes of Health

- Centers for AIDS Research (CFAR) program

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 Prevention (DHP) 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) 2027-2031.

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
510 S. Vermont Ave. Floor 14, Los Angeles, CA 90020
(213) 738-2816 | hivcomm@lachiv.org

2025 PUBLIC POLICY PRIORITIES

For over 40 years, HIV has raged in communities across the world disproportionately impacting marginalized populations with higher rates of disease and death. The Public Policy Committee (PPC) and Commission on HIV are committed in supporting and encouraging innovative efforts to reduce bureaucracy and barriers to accessing services, increase funding, and enhance HIV and Sexually Transmitted Infection (STI) care and prevention service delivery in Los Angeles County.

With a renewed urgency, the PPC remains steadfast in its commitment to preserve, protect, and maintain services critical to ending the HIV epidemic. The rising rates of STIs the past few years is alarming and necessitates urgent action by local, state, and federal policy makers and service delivery agencies to help mitigate the spread of HIV/STIs. Early diagnosis and treatment of STIs is vital to interrupting transmission of HIV/STIs. Nevertheless, the COVID-19 Global pandemic demonstrated that with political will, funding, and most important of all urgency, the development of rapid and safe vaccines is possible. The time to find a cure to HIV is now. The time to end the HIV epidemic is now.

The PPC recommends the Commission on HIV endorse the prioritization of the following issues. The PPC will identify and support legislation, local policies, procedures, and regulations that address the following priorities in 2025 (listed in no order):

Funding

a. Preserve federal funding for Medicaid, Medicare, and HIV/AIDS programs such as the Ryan White HIV/AIDS Program (RWHAP) and the Ending the HIV Epidemic (EHE) initiative.
b. Maintain and preserve the RWHAP at current or increased funding levels and, where appropriate and strategically viable, support stronger compatibility and greater effectiveness between the RWHAP, Medicaid, and other health systems of care.

Systemic and Structural Racism

a. Establish health equity through the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e., homophobia, transphobia, and misogyny); housing; mental health; substance abuse; income/wealth gaps; and criminalization.
b. Reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in the Black/African American community. To include the identification of and rooting out of systemic and systematic racism as it affects Black/African American communities.
c. Address the impact of humanitarian crises on the HIV continuum of care and service delivery including HIV/STI prevention services.

Racist Criminalization and Mass Incarceration

a. Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g., Commercial Sex Work).
b. Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through redistribution of funding for policing and incarceration.

Housing

a. Focus items b, c, and d below especially in service to LGBTQIA+ populations.
b. Improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS.
c. Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
d. Promote Family housing and emergency financial assistance as a strategy to maintain housing.

Mental Health

a. Expand and enhance mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.
b. Support the building of community-based mental health services.
c. Support the placement in mental health facilities of the estimated 4,000+ individuals currently incarcerated and in need of mental health services and support closing of Men's Central Jail.

Sexual Health and Wellness

a. Increase access to care and treatment for People Living with HIV/AIDS (PLWHA).
b. Increase access to prevention services such as Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), for the prevention of HIV, and Doxycycline PEP (Doxy PEP) for the prevention of STIs. Prevention services include HIV/STI screening, biomedical interventions, non-biomedical/behavioral interventions, social services, and harm reduction.
c. Increase comprehensive HIV/STI counseling, testing, education, outreach, research, harm reduction services including syringe exchange, and social marketing programs.
d. Maximize HIV prevention to reduce and eliminate syphilis and gonorrhea cases; especially among young Men who have Sex with Men (MSM), African American MSM, Latino MSM, transgender persons and women of color.
e. Advance and enhance routine HIV testing and expanded linkage to care.
f. Maintain and expand funding for access and availability of HIV, STI, and viral hepatitis services.
g. Promote women-centered prevention services including domestic violence and family planning services for women living with and at high-risk of acquiring HIV/AIDS.

h. Preserve full funding and accessibility to Pre-Exposure Prophylaxis Assistance Program (PrEP-AP).

Substance Use and Harm Reduction

a. Advocate for substance abuse services to PLWHA.
b. Advocate for services and programs associated with methamphetamine use and HIV transmission.
c. Expand alternatives to incarceration/diversion programs to provide a "care first" strategy and move those who need services away from incarceration to substance use programs.
d. Expand harm reduction services (including and not limited to syringe exchange, safe administration sites, over-dose prevention strategies) across all of Los Angeles Count.,
e. Support trauma informed services for substance users.

Consumers

a. Advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWH/A) and those at risk of acquiring HIV. Focusing on young MSM (YMSM), African American MSM, Latino MSM, transgender persons (especially of color), women of color, and the aging.
b. Incentivize participation by affected populations in planning bodies and decision-making bodies.

Aging (Older Adults 50+)

a. Create and expand medical and supportive services for PLWHA ages 50 and over.

Women's Health and Wellness

a. Create and expand medical and supportive services for women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare, and substance abuse.
b. Advocate for women's bodily autonomy in all areas of health care services including and not limited to full access to abortions, contraception, fertility/infertility services and family planning.

Transgender Health and Wellness

a. Create and expand medical and supportive services for transgender PLWHA.
b. Promote and maintain funding for the Transgender Wellness Fund.

General Health Care

a. Provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Fund and expand eligibility for Medicaid, Medicare, and HIV/AIDS programs and health insurance coverage for individuals with pre-existing conditions.

c. Increase and enhance compatibility and effectiveness between RWP, Medicaid, Medicare, and other health systems. This includes restructuring funding criteria to not disincentives contractors from referring clients to other contractors.
d. Expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
e. Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.
f. Provide trauma informed care and harm reduction strategies in all HIV health care settings.

Service Delivery

a. Enhance the accountability of healthcare service deliverables.
b. Incorporate COVID strategies to reduce administrative barriers, increase access to health services and encourage the development of an HIV vaccine.

Data

a. Use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.
b. Promote distribution of resources in accordance with the HIV burden within Los Angeles County.

Workforce

a. Support legislation and policies that combat workforce shortage crisis and protect and increase workforce capacity.
b. Support legislation and policies that incentivize people to join/stay in the HIV workforce.

LOS ANGELES COUNTY COMMISSION ON HIV

Service Standards Revision Date Tracker as of 01/21/25 FOR PLANNING PURPOSES

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
1	AIDS Drug Assistance Program (ADAP) Enrollment	AIDS Drug Assistance Program (ADAP) Enrollment	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	n/a	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS (CDPH/OA).
2	Benefits Specialty Services	Benefits Specialty Services (BSS)	Assistance navigating public and/or private benefits and programs (health, disability, etc.)	Last approved by COH on Sep. 8, 2022.	Upcoming solicitation—release Nov. 2024.
3	Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Pay for rent, utilities (including cell phone and Wi-Fi), and food and transportation.	Last approved by COH on Jun. 11, 2020.	SBP approved on 11/12/24. EC approved on 12/12/24. For COH review/approval on 2/12/25.
4	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	Last approved by COH on Apr. 11, 2024.	Not a program—standards apply to prevention services.
5	Home-Based Case Management	Home-Based Case Management	Specialized home care for homebound clients.	Last approved by COH on Sep. 9, 2022.	Active solicitation
6	Language Interpretation Services	Language Services	Translation and interpretation services for non-English speakers and deaf and.org hard of hearing individuals.	Last approved by COH in 2017.	
7	Legal Services	Legal Services	Legal information, representation, advice, and services.	Last approved by COH on Jul. 12, 2018.	

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
8	Medical Care Coordination	Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.	Last approved by COH on Jan. 11, 2024.	
9	Medical Outpatient Services	Ambulatory Outpatient medical (AOM) Services	HIV medical care accessed through a medical provider.	Last approved by COH on Jan. 13, 2006.	SBP approved on 8/6/24. EC approved on 12/12/24. For COH review/approval on 2/12/25.
10	Medical Specialty	Medical Specialty Services	Medical care referrals for complex and specialized cases.		
11	Mental Health Services	Mental health Services	Psychiatry, psychotherapy, and counseling services.	Last approved by COH in 2017.	
12	Nutrition Support	Nutrition Support Services	Home-delivered meals, food banks, and pantry services.	Last approved by COH on Aug. 10, 2023.	
13	Oral Health Care	Oral Health Services (General and Specialty)	General and specialty dental care services.	Last approved by COH on Apr. 13, 2023.	
14	Psychosocial Support	Psychosocial Support/Peer Support Services	Help people living with HIV cope with their diagnosis and any other psychosocial stressors they may be experiencing through counseling services and mental health support.	Last approved by COH on Sep. 10, 2020.	
15	Substance Use Residential and	Substance Use Disorder Transitional	Housing services for clients in recovery from drug or alcohol use disorders.	Last approved by COH on Jan. 13, 2022.	

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
	Treatment Services	Housing (SUDTH)			
16	Temporary Housing Services	Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that providers 24-hour care.	Last approved by COH on Feb. 8, 2018.	Currently under review
17	Temporary Housing Services	Transitional Residential Care Facility (TRCF)	Short-term housing that providers 24-hour assistance to clients with independent living skills.	Last approved by COH on Feb. 8, 2018	Currently under review
18	Transitional Case Management Services, Youth	Transitional Case Management—Youth	Client-centered, comprehensive services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and support services.	Last approved by COH on Apr. 13, 2017.	Committee decided to develop a global Transitional Case Management service standard document which will include sections for priority populations such as youth, older adults (50+), and justice-involved individuals.
19	Transitional Case Management Services—Justice-Involved Individuals	Transitional Case Management	Support for incarcerated individuals transitioning from County Jails back to the community.	Last approved by COH on Dec. 8, 2022.	See notes section for item #18.
20	Transitional Case Management—Older Adults	n/a	To be developed.	n/a	See notes section for item #18.

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
21	Transportation	Transportation Services	Ride services to medical and social services appointments.	Last approved by COH in 2017.	SBP approved on 10/1/24. EC approved on 10/24/24. For COH review/approval on 2/12/25.
22	Universal Standards and Client Rights and Responsibilities	n/a	Establish the minimum standards of care necessary to achieve optimal health among people living with HIV, regardless of where services are received in the County. These standards apply to all services.	Last approved by COH on Jan. 11, 2024.	Not a program—standards apply to all services. The Committee will review this document on a bi-annual basis or as necessary per community stakeholder, partner agency, or Commission request.

LOS ANGELES COUNTY
COMMISSION ON HIV

PUBLIC POLICY COMMITTEE 2025 MEETING CALENDAR (Updated 1/8/25)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 6, 2025 10am to 12pm TK02	*** Time change due to room unavailability at 1pm*** Elect co-chairs. Review 2025 COH workplan and 2025 Committee meeting calendar Overview of PPC Core Responsibilities
Feb. 3, 2025 10am to 12pm TK02	***Time change due to room unavailability at 1pm***
Mar. 3, 2025 10am to 12pm TK02	***Time change due to room unavailability at 1pm***
Apr. 7, 2025 10am to 12pm TK02	***Time change due to room unavailability at 1pm***
May 5, 2025	**MEETING CANCELLED**
Jun. 2, 2025 10am-12pm TK02	***Time change due to room unavailability at 1pm***
Jul. 7, 2025 1pm to 3pm TK02	
Aug. 4, 2025 TBD	
Sep. 8, 2025 TBD	Consider cancelling or rescheduling due to Labor Day holiday on 9/1/25.
Oct. 6, 2025 TBD	Review Legislative Docket outcomes
Nov. 3, 2025 TBD	Commission on HIV Annual Conference 11/13/2025
Dec. 1, 2025 TBD	Consider rescheduling due to World AIDS Day events. Reflect on 2025 accomplishments. Co-Nominations for 2026.

LOS ANGELES COUNTY COMMISSION ON HIV

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#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
21	Transportation	Transportation Services	Ride services to medical and social services appointments.	Last approved by COH in 2017.	SBP approved on 10/1/24. EC approved on 10/24/24. For COH review/approval on 2/12/25.
22	Universal Standards and Client Rights and Responsibilities	n/a	Establish the minimum standards of care necessary to achieve optimal health among people living with HIV, regardless of where services are received in the County. These standards apply to all services.	Last approved by COH on Jan. 11, 2024.	Not a program—standards apply to all services. The Committee will review this document on a bi-annual basis or as necessary per community stakeholder, partner agency, or Commission request.

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR (Updated 1/21/25)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 7, 2025 1pm to 3pm TK02	• Hold co-chair nominations. • Review 2025 COH workplan and 2025 meeting calendar • Continue review of Temporary Housing service standards
Feb. 4, 2025 10am to 12pm TK02	• Elect co-chairs for 2025 term. • Establish standards review schedule for 2025. • Complete review of Temporary Housing service standards (RCFCI and TRCF) • Continue review of Permanent Housing service standards
Mar. 4, 2025 10am-12pm TK02	
Apr. 1, 2025 10am-12pm TK14	
May 6, 2025 10am-12pm 14K16	
Jun. 3, 2025 10am-12pm 14K16	
Jul. 1, 2025 10am to 12pm TK02	
Aug. 5, 2025 *TBD*	
Sep. 2, 2025 *TBD*	Consider rescheduling due to Labor Day holiday on 9/1/25.
Oct. 7, 2025 *TBD*	
Nov. 4, 2025 *TBD*	Commission on HIV Annual Conference 11/13/2025
Dec. 2, 2025 *TBD*	Consider rescheduling due to World AIDS Day events. Reflect on 2025 accomplishments. Co-Nominations for 2026.

LOS ANGELES COUNTY
COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV CAUCUSES PRESENT:

2025 Consumer Resource Fair

"Love Begins with Me"

Empowering Wellness, Advocacy and Community Beyond HIV

THURSDAY, FEBRUARY 13, 2025

12:00PM - 5:00PM

THE CALIFORNIA ENDOWMENT

1000 N. ALAMEDA STREET, LOS ANGELES, CA 90012

****FREE PARKING ON-SITE** MAP/DIRECTIONS HERE**

Explore a variety of resources, including engaging workshops and presentations, interactive activities like Zumba, free food, exciting giveaways, and more! Don't miss this opportunity to connect with services that support holistic health and wellness beyond HIV.

Are you a vendor or service provider and would like to participate? Register HERE.

For more information, email hivcomm@lachiv.org

LOS ANGELES COUNTY
COMMISSION ON HIV

WOMEN'S CAUCUS
TENTATIVE 2025 MEETING CALENDAR

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 27, 2025* 2pm – 3pm **meeting rescheduled due to MLK holiday on 1/20*	Review and Adopt 2025 Caucus key activities and meeting calendar Co-chair elections
Mar. 17, 2025 2pm – 3pm	Discuss listening session goals and potential locations Review and approve listening session discussion questions
May 19, 2025 2pm – 3pm	Solidify listening session locations and dates/times *Begin hosting listening sessions
Jul. 21, 2025 2pm – 3pm	TBD *Continue hosting listening sessions
Sep. 15, 2025 2pm – 3pm	Review findings of listening sessions Draft recommendations to DHSP for women-centered programming
Nov. 17, 2025 2pm – 3pm	Announce co-chair nominations for 2024. Finalize recommendations to DHSP for women-centered programming

Los Angeles County Commission on HIV (COH)
2025 Meeting Schedule and Topics - Commission Meetings

FOR DISCUSSION /PLANNING PURPOSES ONLY
12.04.24; 12.30.24; 01.06.25

- **Bylaws:** Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (Meetings and committees), the Commission shall meet at least ten (10) times per year. Commission meetings are monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee. The Commission's Annual Meeting replaces one of the regularly scheduled monthly meetings during the fall of the calendar year.

2025 Meeting Schedule and Topics - Commission Meetings	
Month	**Key Discussion Topics/Presentations**
~~1/9/25 @ The California Endowment~~ Cancelled due to Day of Mourning for former President Jimmy Carter	Commission on HIV Restructure ***facilitated by Next Level Consulting and Collaborative Research*** ~~Brown Act Refresher (County Counsel)~~ Replaced with training hosted by EO on Jan. 30.
2/13/25 @ The California Endowment *Consumer Resource Fair will be held from 12 noon to 5pm	Commission on HIV Restructure ***facilitated by Next Level Consulting and Collaborative Research***
3/13/25 @ The California Endowment	Unmet Needs Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
4/10/25 @ St. Anne's (tent)	Year 33 Utilization Report for All RWP Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
5/8/25 @ Location TBD	Year 33 Utilization Report for RW Core Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)

6/12/25 @ Location TBD	Year 33 Utilization Report for RW Support Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
7/10/25 @ Vermont Corridor	PURPOSE Study (Requested by Suzanne Molino, PharmD, Gilead Sciences, Inc.) *Anchor presentation as part of prevention-focused conversation and planning
8/14/25 @ Location TBD	Medical Monitoring Project (Dr. Ekow Sey, DHSP)
9/11/25 @ Location TBD	America's HIV Epidemic Analysis Dashboard (AHEAD)
11/14/24 @ Location TBD	ANNUAL CONFERENCE
12/12/24 @ Location TBD	

***Consider future or some of the presentation requests as a special stand-alone virtual offerings outside of the monthly COH meetings.**

2025 COMMISSION ON HIV WORKPLAN
Ongoing 12-26-24

#	DUTY/ROLE	LEAD (S)	NOTES/TIMELINE
1	Conduct ongoing needs assessments	PP&A Shared task with DHSP	• Review, analyze and hold data presentations (Feb-August COH meetings)
2	Integrated/Comprehensive Planning Comprehensive HIV Plan Development	PP&A Shared task with DHSP	• Review CDC/HRSA guidance • Develop project timeline based on CDC/HRSA guidance • CHP Due June 2026 • Plan dedicated status-neutral and/or prevention-focused planning summit in collaboration with DHSP.
3	Priority setting	PP&A	• July-September
4	Resource allocations/reallocations	PP&A	• July-September • Receive and review expenditure data – quarterly
5	Directives	PP&A	• Complete by February 2025; secure COH approval by March 2025
6	Development of service standards	SBP Shared task with DHSP	• Housing services • Transitional case management
7	Assessment of the Efficiency of the Administrative Mechanism	Operations	• PY 33 & PY 34 AEAM recipient and subrecipient surveys will be disseminated in January/February 2025. Reports completed by April 2025
8	Planning Council Operations and Support	Operations	• Membership training • Membership recruitment and retention • Fill vacancies • Mentorship program • Bylaws and policies update

9	Complete restructuring framework and key principles and align with bylaws/ordinance updates.	Executive and Operations	• January- April 2025
10	MOU with DHSP	Co-Chairs and Executive Committee	• Complete by March 2025 (awaiting DHSP feedback)
11	Ongoing community engagement and non-member involvement of PLWH	Consumer Caucus and Operations	

Engage all caucuses, committees and subgroups in all functions.

Commission on HIV Comprehensive Effectiveness Review and Restructuring Scope of Work

Collaborative Research (CR) and Next-Level Consulting (NLC) will conduct Comprehensive Effectiveness Review and Restructuring on behalf of the Los Angeles County Commission on HIV ("Commission"). The objective of this project is to conduct a comprehensive review, assessment, and restructuring of the Commission for effectiveness and efficiency. The CR and NLC project will include the following activities:

- Review past assessments, sunset reviews, HRSA site visit reports and feedback from stakeholders
- Assess Commissioner knowledge of current Commission purpose, functions, and structure
- Provide training to educate Commission members in understanding the purpose of the Commission and Ryan White Part A legislative requirements for Planning Bodies
- Engage members and key stakeholders in defining effectiveness and efficiency
- Conduct member and key community stakeholder surveys and interviews. Identify past members for interviews
- Host a series of meetings with Commissioners and the community to discuss restructuring of the Commission for effectiveness. Include size, scope, duty statement(s), committees and subgroups, meeting frequency and cycles
- Revise and update all Commission documents pertaining to operational components and ordinances based on assessments and community discussion

CR and NLC Staff Assigned to Project

Jeff Daniel
He, Him, His
Founder and Chief Executive Officer
COLLABORATIVE RESEARCH FOUNDATION

Jeff has 20 years' worth of experience in the public health field, primarily focused on Ryan White HIV entities. Areas of expertise include: 1) Operational development of local HIV/AIDS programs including implementation of HIV services and cost effectiveness evaluations; 2) Facilitating community-based organizations' strategic planning initiatives; 3) Client satisfaction survey development and administration; and 4) project management. Jeff served on the Austin Transitional Grant Area's Planning Council as Vice Chair and Chair of the Needs Assessment and Priority Setting Committee. In 2017, Jeff supported the LA County HIV Commission in drafting the EMA's Prevention Service Standards; in 2022, creating an addendum to the EMA's Oral Healthcare Service Standard; and in 2024, completing a Targeted Assessment of the Administrative Mechanism (AAM) for Program Year 32-Ryan White Grant Year 2022/23.

Melissa Rodrigo
She, Her, Hers
Director of Integration and Strategy
COLLABORATIVE RESEARCH
CELEBRATING 20 YEARS

Melissa is the former Deputy Director of HIV Prevention and Care programming at the Cuyahoga County (Cleveland, OH) Board of Health (CCBH). Melissa was the Project Director for the Cleveland Transitional Grant Area Ryan White Part A, Cuyahoga County's EHE initiatives, HIV/STI Prevention program as well as CARES ACT funding. As project director of the Ryan White Part A program, Melissa managed the program's Continuous Quality Improvement efforts. Melissa conducted subrecipient monitoring visits to ensure compliance with the Health Resource Services Administration's HIV/AIDS Bureau's health outcomes and performance measures. Additionally, Melissa conducted numerous Plan, Do, Study, Act projects to increase health outcomes along the TGA's HIV Care Continuum. Melissa has 11 years' experience working in the HIV field and 19 years in city and county government. In 2024, Melissa supported CR's project for the Commission—Targeted Assessment of the Administrative Mechanism (AAM) for Program Year 32-Ryan White Grant Year 2022/23.

AJ King is the Director of Next-Level Consulting, Inc., an independent consulting firm specializing in nonprofit capacity building and human resources services. AJ has over 25 years of experience in the field of public health and nonprofit management. His work focuses on developing and delivering training and workshops; developing and implementing evaluation plans and community-based assessments; grant-proposal writing, research and report writing, and planning processes. A strong advocate for collaborative approaches, AJ has facilitated such processes for government agencies, universities, coalition groups and community-based organizations. He has written successful grant proposals at the federal, state, and local level, securing millions of dollars from both government and private funders. As a seasoned trainer, AJ has developed numerous curricula and engaged a variety of audiences ranging from public health officials to community level providers. AJ has served in leadership roles on the Los Angeles County Commission on HIV, HIV Prevention Planning Council, and currently serves as a Senior Trainer for The Grantsmanship Center and an Associate of Community Works Consulting, Inc. and the Aspire Group.

Commission on HIV Comprehensive Effectiveness Review and Restructuring Scope of Work

COMPONENT	COMPONENT ACTIVITIES	HOURS		
1	Review past assessments, sunset reviews, HRSA site visit reports, CDC HIV/STI prevention reports and project strategy meetings	45		
2	Assess Commissioner knowledge of current Commission purpose, functions, and structure	75		
3	Provide training to update/educate members in understanding the purpose of the Commission and Ryan White Part A and CDC legislative requirements for Planning Bodies	75		
4	Engage members and key stakeholders in defining effectiveness and efficiency	75		
5	Conduct member and key community stakeholder surveys and interviews. Identify past members for interviews	60		
6	Host a series of meetings with Commissioners and the community to discuss restructuring of the Commission for effectiveness. Include size, scope, duty statement(s), committees and subgroups, meeting frequency and cycles	60		
7	Revise and update all Commission documents pertaining to operational components and ordinances based on assessments and community discussion	43		

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

December 20, 2024

Dear Ryan White HIV/AIDS Program Colleagues,

As many of you know, earlier this year the Health Resources and Services Administration's (HRSAs) HIV/AIDS Bureau (HAB) introduced **Ryan White Program 2030 (RWP 2030),** a renewed vision for the Ryan White HIV/AIDS Program (RWHAP). Building on 35 years of success and innovation, RWP 2030 integrates lessons learned from the RWHAP and the Ending the HIV Epidemic in the U.S. (EHE) initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP **while expanding efforts to identify and engage individuals with HIV who are undiagnosed or out-of-care[1].**

Achieving this goal will require a comprehensive, collaborative approach that builds upon existing successes and resources while fostering innovation[2]. At its core, RWP 2030 reflects our shared commitment to improving health outcomes for people with HIV. This vision calls on the HIV community to establish and strengthen partnerships, prioritize community engagement, and utilize focused interventions to end the HIV epidemic.

Since 2010, viral suppression among people receiving HIV medical care through the RWHAP has increased significantly, from 69.5% to 90.6% in 2023. Thanks to advancements in treatment, HIV is now a manageable chronic condition for individuals who remain engaged in care, allowing them to live long, healthy lives while preventing transmission to others. Despite this progress, we recognize that approximately 40% of people with HIV in the U.S. are either undiagnosed or not receiving regular care, contributing to most new HIV infections. Addressing these gaps is essential to achieving our goal of ending the epidemic.

Through EHE, we have seen the power of targeted investments and innovative strategies. In 2022, EHE-funded providers served over 22,000 individuals who were new to care and re-engaged more than 19,000 individuals who were out of care. Remarkably, 79.2% of individuals new to care achieved viral suppression, underscoring the effectiveness of our collective efforts. These successes highlight the importance of combining strategic investments with community-driven planning to achieve high-impact outcomes.

Ryan White Program 2030 emphasizes the importance of sustaining care for those already engaged in the RWHAP, while expanding our reach to ensure timely diagnosis and sustained treatment for underserved communities. This will require collaboration across sectors, innovation in care delivery, and a commitment to addressing barriers to care. We must also engage individuals with lived experience and non-traditional partners to inform program planning[3] and care models that are responsive to the needs of diverse communities.

[1] Legal authority: §§ 2602(b)(4), 2617(b), 2664(a), and 2671(c) of the Public Health Service (PHS) Act.
[2] Legal authority: §§ 2603(b)(2)(B), 2620, 2654(c), and 2691 of the PHS Act.
[3] Legal authority: § 2681 of the PHS Act.

Ryan White HIV/AIDS Program recipients play a critical role in advancing the goals of RWP 2030 and are responsible for employing sound planning and decision-making processes to determine which HIV related services are prioritized and how much to fund them. As part of these responsibilities, RWHAP recipients must continue to base service priorities and resource allocation decisions on the size, demographics, and needs of people with or affected by HIV. RWP 2030 specifically entails a renewed focus on reaching those who are undiagnosed or out of care. This may necessitate a re-evaluation of existing resource allocations to ensure outreach, engagement, and support efforts are effectively scaled to meet the needs of these especially high-need populations while still addressing the needs of individuals who are currently receiving care through the RWHAP.

We encourage you to begin engaging your partners in discussions about this vision and its implications for your work. Over the next several months, HRSA HAB will work to develop additional guidance and tools to support your efforts in implementing RWP 2030. The RWHAP Best Practices Compilation contains effective innovative interventions and best practices on outreach, linkage to and engagement in care. TargetHIV also contains a number of trainings, resources, and reference guides to support recipients and subrecipients in providing care to people with HIV. HAB is also planning a series of listening sessions in 2025 to ensure that RWP 2030 is informed by diverse perspectives and to better understand the challenges and barriers to implementing this vision.

We are confident that, with your continued partnership, we can realize the goals of RWP 2030 and bring us closer to ending the HIV epidemic. If you have questions, please contact your HRSA HAB Project Officer.

Thank you for your unwavering dedication to improving the lives of people with HIV.

Sincerely,

/Laura W. Cheever/

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