LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS COMMITTEE MEETING

Tuesday, September 17, 2024
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/planning-priorities-and-allocations-committee

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/rf3afe0710d5b5e57dccc154da2976def

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

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

together.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, SEPTEMBER 17, 2024 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room, Los Angeles, CA 90020

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/rf3afe0710d5b5e57dccc154da2976def

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2536 756 0897

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Felipe Gonzalez Co-Chair	Al Ballesteros, MBA	Lilieth Conolly
Rita Garcia (Alternate)	Michael Green, PhD	William King, MD, JD	Miguel Martinez, MPH, MSW
Matthew Muhonen (LOA)	Daryl Russell	Harold Glenn San Agustin, MD	Dee Saunders
LaShonda Spencer, MD	Lambert Talley (Alternate)	Jonathan Weedman (LOA)	
QUORUM: 7			

AGENDA POSTED: September 12, 2024

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

7. Executive Director/Staff Report 1:15 PM – 1:22 PM
    a. HRSA Technical Assistance Site Visit Updates

b. 2024 Annual Conference Planning
c. FY 2025 RWP Part A Notice of Funding Opportunity Preparation (HRSA 25-054)
d. CDC-HRSA-EHE Planning Council Cross-Walk

8. Co-Chair Report 1:22 PM – 1:40 PM
   a. Antelope Valley Listening Sessions
   b. Committee-Only Application: Rob Lester
      MOTION #3: Approve the Committee-only application for Rob Lester and elevate to the Operations Committee and the Executive Committee.

9. Division of HIV and STD Programs (DHSP) Report 1:40 PM – 2:00 PM

V. DISCUSSION ITEMS 2:00 PM—2:55 PM

10. Ryan White Program Year (PY) 35 Allocation and Allocation Forecasting PY 36-37
    MOTION #4: Approve the Service Rankings and Allocations for Program Year (PY) 35 Ryan White Program Part A and Minority AIDS Initiative (MAI) Funds.
11. Directives Development Refresher

VI. NEXT STEPS 2:55 PM – 2:57 PM

12. Task/Assignments Recap
13. Agenda Development for the Next Meeting
    a. Begin review of Committee/Caucus Directives

VII. ANNOUNCEMENTS 2:57 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

15. Adjournment for the meeting of September 17, 2024.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order, as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.
MOTION #3	Approve the Committee-only application for Rob Lester and elevate to the Operations Committee and the Executive Committee, as presented or revised.
MOTION #4	Approve Service Rankings and Allocations for Program Year (PY) 35 Ryan White Program Part A and Minority AIDS Initiative (MAI) Funds, as presented or revised.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 6.12.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Public comment is limited to 2 minutes per person. Please note that all attendees are muted unless otherwise unmuted by staff.*

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
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Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/10/24

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated 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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
August 27, 2024

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez, Co-Chair	EA	Matthew Muhonen	LOA
Al Ballesteros, MBA	A	Daryl Russell	P
Lilieth Conolly	P	Harold Glenn San Agustin, MD	AB 2449
Rita Garcia	A	Dee Saunders	P
Joseph Green	EA	LaShonda Spencer, MD	EA
Michael Green, PhD, MHSA	P	Lambert Talley	P
William King, MD, JD	AB 2449	Jonathan Weedman	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Jose Garibay, Lizette Martinez			
DHSP STAFF			
Pamela Ogata, Paulina Zamudio, Victor Scott, Anahit Nersigian			

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

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

I. ADMINISTRATIVE MATTERS

- **CALL TO ORDER AND MEETING GUIDELINES/REMINDERS**
  Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:10pm.

- **ROLL CALL & CONFLICT OF INTEREST STATEMENTS**
  K. Donnelly conducted roll call vote and committee members were reminded to state their conflicts.

  ROLL CALL (PRESENT): L. Connelly, M. Green, M. Martinez, D. Saunders, D. Russel, H. San Agustin, L. Talley, K. Donnelly

- **Approval of Agenda**
  MOTION #1: Approve the Agenda Order **(✓Passed by Consensus)**

- **Approval of Meeting Minutes**
  MOTION #2: Approval of Meeting Minutes **(✓Passed by Consensus)**

II. PUBLIC COMMENT

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

  There were no public comments.

III. COMMITTEE NEW BUSINESS

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

  There were no committee new business items.

IV. REPORTS

- **Executive Director/Staff Report**

  a. HRSA Technical Assistance Site Visit Updates

  - C. Barrit, Executive Director, reported that Commission staff are still waiting for the Health Resources and Services Administration (HRSA) to submit their report from the May Technical Assistance Site Visit. Commission staff anticipate receiving the report soon and will share the report with commissioners once it is received. She noted that the Commission is actively working on recommendations including an updated MOU with the Division of HIV and STD programs (DHSP), ongoing recruitment efforts and updates to the Commission's by-laws.

  b. Priority Setting and Resource Allocation (PSRA) Ground Rules for Discussion

  - C. Barrit reviewed ground rules for priority setting and allocation discussion. She noted that priority setting and resource allocation is the most important activity of the planning council that focuses on community/consumer input while being data driven.
  - C. Barrit reported that the Ryan White Part A Notice of Funding Opportunity (NOFO) is due on Oct. 1, 2024 to HRSA. She announced that the service rankings and allocations for Program Year (PY) 35 decided by the committee will go forward to the full Commission for final voting/approval during their September 12, 2024 meeting. The approved PY35 allocations will be included as part of the Part A NOFO. She noted that the committee will also forecast ranking and allocations for PY36 and PY37 but will revisit and revise the rankings and allocations annually to ensure they align with consumer needs.

- C. Barrit reminded the group that distribution of allocations is focused on services, not provider agencies and that agency names should not be included in discussions. She noted that decisions should be data-driven and based on consumer needs. Prior to voting, commissioners must state their conflicts and services will be voted on as a slate rather than individual services.

- **Co-Chair Report**
  - **a. New Member Welcome**
    - K. Donnelly welcomed new committee member, Dee Saunders, to the group and thanked Derek Murray for his commitment and participation on the Committee and the Commission during his tenure. D. Saunders will replace D. Murray as the City of West Hollywood representative within the Commission.

  - **b. National Ryan White Conference on HIV Care and Treatment Takeaways**
    - K. Donnelly opened the floor for committee members to discuss highlights from attending (virtually or in person) the 2024 National Ryan White Conference on HIV Care and Treatment.
    - Members shared their key takeaways from the conference including discussions on social isolation, updates to how data is collected and key areas of focus, impact of mental health on viral suppression and a special plenary from Ginnie White Bender, Ryan White's mother.
    - It was noted that there was lack of presentations and opportunities to engage planning councils which was a missed opportunity to engage people with lived experience.

  - **c. Program Year (PY) 35 Service Rankings Review**
    - K. Donnelly provided a brief review of PY35 Service Rankings that were voted on during the previous months committee meeting. See meeting packet for details. He noted that service rankings do not reflect how funds will be allocated.

- **Division of HIV and STD Programs (DHSP) Report**
  - **a. Ryan White Program Year 33 Expenditure Report**
    - P. Ogata, DHSP staff, provided a report on PY33 Expenditures. Total expenditures for PY33 exceeded the total allocated amounts by over $10.6 million. Overspending occurred in most funded service categories with the largest overages in Housing Services, Medical Case Management, Oral Health Services and Ambulatory/Outpatient Medical (AOM) services. There was also underspending in a handful of services including Mental Health Services and Language Services. There were no expenditures under Child Care Services because there were applications received by DHSP when RFP was released. Other funding sources were used to cover over expenditures including $5 million of HRSA Part B, HRSA Ending the Epidemic (EHE) funds, Substance Abuse Prevention and Control (SAPC) Non-Drug Medi-Cal

funds, and County HIV Funds (Net County Costs). See meeting packet for more details.

V. DISCUSSION - PREPARATION FOR FY 2025 RWHAP PART A NOTICE OF FUNDING OPPORTUNITY

- **Review Paradigms and Operating Values**
  - The committee reviewed its existing paradigms and operating values for decision-making. The paradigms and operating values are a unique tool used by the PP&A Committee to guide its decision making when selecting service rankings and allocating Ryan White Program funds.
  - After a round of discussions, the committee agreed, by consensus, to add retributive justice, making up for past inequities, to the paradigms and access, assuring access to the process for all stakeholders and/or constituencies, to the operating values.
  - Although not added, the group noted that sustainability, should be a guiding paradigm for all COH decisions to ensure continuity of care for people living with HIV within Los Angeles County.

- **Review Utilization Reports**
  - Commission staff provided a brief review of PY32 Service Utilization Reports and Needs Assessment findings from the 2022-2026 Comprehensive HIV Plan. See meeting packet for more details.
  - Commission staff shared the myMedi-Cal document that outlines what health and support services are offered under Medi-Cal. Services funded under Medi-Cal should be considered when allocating funds under Ryan White.

- **Approve Service Rankings and Allocations for Program Years (PY) 35-37 Ryan White Program Part A and Minority AIDS Initiative (MAI) Funds - MOTION #3 (A vote was not taken due to lack of quorum)**
  - The Committee participated in an interactive activity to prepare for allocation of services. All attendees were given $500 dollars to allocate towards any services category. Participants were encouraged to review the data, including expenditure reports and utilization data and engage in discussion to help determine allocation amounts. Online attendees were encouraged to participate but submitting their proposed allocations via chat.
  - The Committee completed its service ranking and allocation for Program Year (PY) 35 in preparation for the Ryan White HIV/AIDS Program Part A grant application which is due on October 1. See meeting packet for service rankings and allocation details. Allocations are distributed in percentage amounts as total funding is unknown until awards are announced. Utilization reports, needs assessments, expenditure reports and alternative funding sources were taken into consideration when allocating funds.
  - Allocation amounts were increased from PY 34 allocations in the following services due to high utilization rates in PY32 and increased expenditures in PY33:
    - Medical Case Management (aka Medical Care Coordination)

    - Oral Health Services
    - Emergency Financial Assistance
    - Nutrition Support (Home-Delivered Meals, Food Bank Services were moved to another funding stream)
    - Legal Services
- Allocation amounts were decreased from PY 34 allocations in the following services due to low utilization rates in PY32, under spending in PY33, or funding from other sources:
    - Early Intervention Services (aka Testing Services)
    - Mental Health Services
- Allocation amounts remained the same from PY34 to PY35 in the following services:
    - Outpatient/Ambulatory Medical Health Services (aka Ambulatory Outpatient Medical)
    - Home and Community-Based Health Services
    - Non-Medical Case Management including
        - Benefits Specialty Services, and
        - Transitional Case Management Jails
    - Medical Transportation
    - Housing including
        - Housing Services RCFCI/TRCF (Home-Based Case Management)
        - Housing for Health (100% of Minority AIDS Initiative Award)

			FY 2024 (PY 34) [1]		FY 2025 (PY 35) [2]	
Service Type	Service Ranking	Service Category	Part A %	MAI %	Part A %	MAI %
Core	6	Medical Case Management (Medical Care Coordination)	27.15%	0.00%	29.00%	0.00%
Core	8	Oral Health	20.79%	0.00%	21.30%	0.00%
Core	20	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	17.11%	0.00%	17.11%	0.00%
Core	11	Early Intervention Services (Testing Services)	6.58%	0.00%	0.00%	0.00%
Core	17	Home and Community-Based Health Services	6.50%	0.00%	6.50%	0.00%
Support	2	Emergency Financial Assistance	6.32%	0.00%	8.00%	0.00%
Support	7	Nutrition Support (Food Bank/Home-delivered Meals)	5.79%	0.00%	7.79%	0.00%
Support	5	Non-Medical Case Management				
		Benefits Specialty Services	3.95%	0.00%	3.95%	0.00%
		Transitional Case Management - Jails	1.58%	0.00%	1.58%	0.00%
Support	10	Medical Transportation	1.84%	0.00%	1.84%	0.00%
Support	23	Legal Services	1.42%	0.00%	2.00%	0.00%
Support	1	Housing				
		Housing Services RCFCI/TRCF (Home-Based Case Management)	0.91%	0.00%	0.91%	0.00%
		Housing for Health	0.00%	100.00%	0.00%	100.00%
Core	3	Mental Health Services	0.29%	0.00%	0.02%	0.00%
Core	9	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	0.00%	0.00%
Core	22	Local AIDS Pharmaceutical Assistance Program (LPAP)	0.00%	0.00%	0.00%	0.00%
Core	15	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	0.00%	0.00%
Core	16	Home Health Care	0.00%	0.00%	0.00%	0.00%
Core	28	Hospice Services	0.00%	0.00%	0.00%	0.00%
Core	26	Medical Nutritional Therapy	0.00%	0.00%	0.00%	0.00%
Core	12	Substance Abuse Services Outpatient	0.00%	0.00%	0.00%	0.00%
Support	18	Child Care Services	0.00%	0.00%	0.00%	0.00%
Support	13	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%
Support	27	Linguistic Services (Language Services)	0.00%	0.00%	0.00%	0.00%
Support	14	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%
Support	4	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%
Support	24	Referral	0.00%	0.00%	0.00%	0.00%
Support	25	Rehabilitation	0.00%	0.00%	0.00%	0.00%
Support	21	Respite Care	0.00%	0.00%	0.00%	0.00%
Support	19	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%
		Overall Total	100%	100.00%	100.00%	100.00%

Footnotes:

(1) Approved by COH on 8/8/24

(2) Agreed by PP&A on 8/28/24

Green font indicates allocation increase from PY34

Red font indicates allocation decrease from PY34

VI. NEXT STEPS

- **Task/Assignments Recap**
  - **a.** Commission staff will compile final PY35 allocations and prepare the document for final review and approval at the September Commission on HIV meeting.
  - **b.** Commission staff will update the meeting packet to include the DHSP PY35 Expenditure Report and will notify committee members when the updated packet is available.

- **Agenda Development for the Next Meeting**
  - **a.** Review Rob Lester Committee-only application.
  - **b.** Begin drafting program directives.

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

- **Adjournment for the Meeting of August 27, 2024.**
  The meeting was adjourned by K. Donnelly at 4:50pm.

LOS ANGELES COUNTY COMMISSION ON HIV

CALL FOR ABSTRACTS 2024 ANNUAL CONFERENCE

Breakout session tracks:

- Innovations in Prevention
- Building Community & Fostering Relationships
- Best Practices & Creative Approaches to Integrated HIV Care
- Meaningful and Impactful Planning Council and Community Engagement

Deadline: September 27

MLK Behavioral 12021 S. Wilmington Ave, Los Angeles, CA 90059
9am to 4pm | November 14, 2024

Breakout sessions will occur in the afternoon.

Scan QR Code to submit an abstract.

The Commission on HIV is accepting breakout session abstracts that support the Annual Conference theme of ***Bold Transformation to Confront and End HIV***. Click **HERE** to submit your breakout session abstract. Breakout sessions will occur in the afternoon after lunch.

Topic ideas

Innovations in Prevention

- PrEP navigation in the context of social determinants of health and broadly in areas of social deprivation.
- Doxy PEP and DoxyPrEP
- PrEP and other advances in HIV prevention science
- Digital and remote/telehealth and how technology plays a role in HIV/STD service navigation.
- Strategic outreach for priority populations

Building Community and Fostering Relationships

- Medical mistrust and distrust within the context of the experiences of various priority populations such as communities of color and older adults living with HIV.
- Effective and culturally/age-appropriate prevention and care services for priority populations
- STI prevention and the intersection with medical mistrust and distrust.
- Intersectionality and reducing stigma
- HIV workforce and consumer partnerships – Power sharing and opening lines of communication

Best Practices and Creative Approaches to Integrated HIV Care

- Treatment advances and clinical trials
- Effective models of comprehensive care
- Intersectionality and innovative approaches in integrated HIV care
- HIV as primary care
- Culturally tailored wellness approaches for priority populations
- Non-traditional approaches to engaging and retaining individuals in prevention and care

Meaningful and Impactful Planning Council and Community Engagement

- Using intersectionality to inform the work of the Commission
- Harnessing the power of community advisory boards
- Fostering positive client and provider relationships
- High-impact community planning models and strategies

"Crosswalk" of CDC and HRSA Planning Body Roles in Integrated Planning and Related Activities

Adopted from Roles and Responsibilities for Prevention and Care Planning Bodies and Integrated Planning (targethiv.org)

Commission on HIV Ordinance

HIV Prevention	Ryan White – Part A	CDC-RFA-PS24-0047
1. Planning Body: "All CDC/DHAP and HRSA/HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a Comprehensive Plan and the establishment of either an HIV Planning Group, Planning Council, or Advisory Group, hereafter, referred to as 'planning body.'" (Integrated Plan Guidance 2022-2026, p 6)		
Jurisdictional HIV Prevention Planning Group (HPG) "If there is more than one HPG in the State, the Health Department is responsible for deciding the best way to integrate state, regional, and local HIV Planning Group activities… For states with regional planning groups, planning efforts should be combined." (2012 HIV Planning Guidance, p 27)	HIV Health Services Planning Council (Planning Council) [Section 2602(b)(1)] A Planning Council is a legislatively mandated jurisdiction-wide planning bodies for Ryan White Part A programs in Eligible Metropolitan Areas (EMAs). It has legislatively defined responsibilities for planning and decision making. The 2006 Ryan White legislation requires Transitional Grant Areas (TGAs), Part A programs with a smaller number of AIDS cases, to have a community planning process, but made Planning Councils as described in the legislation optional for newly established TGAs. In the absence of reauthorization since the 2009 Ryan White HIV/AIDS Treatment Extension Act, TGAs are no longer required to have Planning Councils as their planning bodies, though the HIV/AIDS Bureau's Division of Metropolitan HIV/AIDS Programs (DMHAP) has strongly urged them to maintain their Planning Councils.	Strategy 6. Support community engagement and HIV planning (CDC-RFA-PSA24-047, page 10) 6A. Conduct strategic community engagement 6B. Establish and maintain an HIV planning group 6C. Conduct and facilitate the HIV planning process and the development of integrated HIV prevention and care plan (*locally known as the Comprehensive HIV Plan).* CDC-RFA-PSA24-047, pages 12-13) Short-term Outcome: • Increased collaborations and engagement with local partners (both traditional and non-traditional organizations), people with HIV and communities to inform HIV and sexual health services • Increased coordination, availability, and access to comprehensive HIV prevention, treatment, and support services Intermediate Outcome: • Sustained community partnerships to inform strategic planning and implementation
2. Planning Body's Accountability		
HPG is advisory and **reports** to the recipient.	The PC **works in partnership with the recipient**, **but not under its direction**. The PC must be given full authority and support to carry out its legislatively mandated roles and responsibilities. While the authority to appoint the PC is clearly vested in the CEO, the PC is not advisory in nature. The PC has legislatively provided authority to make determinations and carry out its duties, independent from but in coordination with the recipient. [Part A Manual, p 26]	Broad community engagement and planning functions, advisory and **reports** to the recipient.
3. Planning Body's Primary Functions		
"**Primary Goal:** To **inform** the development or update of the Integrated HIV Prevention and Care Plan that will contribute to the reduction of HIV infection in the jurisdiction.	Section 2602(b)(4)(C) of the PHS Act requires PCs to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant." When establishing service priorities and the	Strategy 6. Support community engagement and HIV planning (CDC-RFA-PSA24-047, page 10) 6A. Conduct strategic community engagement

	allocation of resources, PCs must consider relevant legislative funding requirements, such as the requirement that at least 75 percent of funds be spent on core medical services per Section 2604(c)(1) of the PHS Act.	6B. Establish and maintain an HIV planning group 6C. Conduct and facilitate the HIV planning process and the development of integrated HIV prevention and care plan (*locally known as the Comprehensive HIV Plan).*
HIV Prevention	**Ryan White – Part A**	**CDC-RFA-PS24-0047**
4. Planning Body – Planning-related Tasks and Activities		
Integrated Planning: Planning bodies have an important role in developing and using the Integrated HIV Prevention and Care Plan in their jurisdictions: • The Integrated HIV Prevention and Care Plan should include information on who is responsible for developing the Integrated HIV Prevention and Care Plan within the jurisdictions (i.e., RWHAP Part A planning councils, RWHAP Part B advisory groups, and CDC HIV planning bodies)." [Integrated Plan Guidance, p 8]		
Integrated Plan Guidance: "For the development of the Integrated Plan, jurisdictions should include and use their existing local prevention and care HIV planning bodies, as consistent with CDC and HRSA planning group requirements, and engage traditional stakeholders and community members (e.g., AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics and local education agencies (LEAs)) to get input." (page 6) "Jurisdictions must identify how they will provide regular updates to the planning bodies and stakeholders on the progress of plan implementation, solicit feedback, and use the feedback from stakeholders for plan improvements." (page 9) "The Integrated Plan is a "living document" and must be reviewed and updated at least annually or as needed. The process for annual review should include the identification of relevant data and data systems, analysis of data on performance measures, the inclusion of planning bodies in the ongoing evaluation of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process." (page 9) "To submit the Integrated Plan, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission." (page 7) The CDC 2012 Guidance indicates that: • The Health Department **is ultimately responsible** for	**Play the lead role in** development of the Integrated HIV Prevention and Care Plan for the organization and delivery of health and support services, which addresses unmet need, is coordinated with HIV prevention and substance abuse treatment programs, is consistent with the Statewide Coordinated Statement of Need (SCSN), and "includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds." [Section 2602(b)(4)(d)] A living document, with goals, objectives, and action plans reviewed either annually if significant changes occur in resources or in the external environment. Planning Council roles include the following: • **Develop** a planning process and assign responsibility to a committee • **Work with** the recipient on hiring a consultant • **Set** goals for the continuum of care and other areas of Planning Council responsibility **and help** develop goals and objectives in areas of shared responsibility • **Implement** components of the Plan that involve Planning Council responsibilities • **Monitor** progress in implementing the Plan	CDC-RFA-PS24-0047,page 29: Activity 6c: Conduct and facilitate an HIV planning process and the development of the Integrated HIV Prevention and Care Plan. • Conduct and facilitate an HIV planning process through which people from different walks of life and involvement in HIV come together as a group to inform and support the development and implementation of a jurisdictional or local HIV plan or roadmap. HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention needs and priorities, adhering to the basic tenets of HIV planning - parity, inclusion, and representation (PIR). • Ensure health departments work in partnership with the community and key partners to enhance prevention and care planning, improve the scientific basis of program decisions, enhance access to HIV prevention, care, and treatment services and focus resources to those communities and for populations disproportionately impacted by HIV. • Ensure that HIV planning is a participatory process, to include participating in the development and review of the Integrated HIV Prevention and Care Plan and submitting a letter to CDC signed by the HPG co-chairs on behalf of the HPG membership documenting the group's involvement in the process. • Develop, monitor, and update the jurisdiction's Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need. The Integrated HIV Prevention and Care Plan serves as a jurisdictional HIV strategy or roadmap for all HIV-related resources and activities and assists with identifying ways to measure progress toward goals and objectives to improve HIV prevention, care, and treatment efforts within the jurisdiction. The development of the jurisdictional prevention and care plan should be done in conjunction with the HIV Planning Group, Ryan White Care Planning Council, and other advisory bodies, such as EHE advisory bodies or Fast Track Cities, where appropriate. Recipients should leverage existing engagement groups and incorporate community engagement efforts with integrated HIV planning activities. • Support the implementation of a local planning process with the counties that

implementing the Jurisdictional HIV Prevention Plan • The planning body should **inform the development** or update of the **HIV Prevention Plan(s)** HPG roles include: • **Obtain** from the recipient and **use** the most current epidemiologic surveillance and evidence-based data • **Work with** the recipient to develop a process for reviewing a draft HIV Prevention Plan • **Review** the Plan annually • Annually, **submit** a letter of concurrence, concurrence with reservations, or non-concurrence with the Plan to CDC • **Promote and support**, as appropriate and feasible, the implementation of the HIV Prevention Plan in conjunction with the recipient		represent 30% or greater of the HIV epidemic within the jurisdiction [see table with the identified counties per state representing 30% or greater of the cumulative HIV diagnosis, 2021 data]. Each county should engage local partners, conduct a planning process resulting in the development of a locally developed jurisdictional plan that can be included in the overall Integrated Plan as an addendum or update or can be provided as a separate plan. Counties designated as EHE counties should have EHE plans in place that can be updated, if needed; however, continual HIV planning, and community engagement should occur in all the identified counties.
HIV Prevention	**Ryan White – Part A**	**CDC-RFA-PS24-0047**
Coordination that is directly related to needs assessment and comprehensive planning: "HRSA and CDC encourage RWHAP recipients and HIV prevention programs at the local and state levels to integrate existing planning activities, such as joint comprehensive needs assessment, information and data sharing, cross representation on prevention and care planning bodies, coordinated/combined projects, and integrated HIV prevention and care planning body meetings. Overall, planning groups are encouraged to streamline their approaches to HIV planning. HRSA and CDC recognize the necessity of developing an integrated plan, and therefore, allow jurisdictions to incorporate associated planning costs into their budgets. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States. We encourage you to incorporate your community engagement efforts with your integrated planning activities. Recipients may use, to the extent that it is helpful, existing planning bodies, such as integrated HIV prevention and care planning bodies or EHE planning bodies to conduct necessary community engagement events, and to identify new stakeholders who may need to participate." (HRSA/CDC Dear Colleagues Letter announcing the Integrated Plan Guidance, June 30, 2021)		
Work with the recipient to ensure that HPG composition contributes to collaborative planning, by including representatives of Ryan White planning groups, etc. Includes responsibility to proactively **engage** other planning bodies and other federal grant recipients during the planning process.	**Help ensure coordination** with other Ryan White programs and other HIV-related services. **Coordinate** with prevention planning bodies and programs in the areas of planning body membership, conducting planning activities (e.g., needs assessments), and service delivery coordination (e.g., early intervention services, outreach). [Section 2602(b)(4)(C) and (H)] **Collaborate** with other publicly funded programs on needs assessment, estimation and assessment of unmet need, and development of the Plan, including strategies to coordinate services with HIV prevention and substance abuse prevention and treatment, including outreach and early intervention services.	The engagement process involves the collaboration of key partners and broad-based communities who work together to identify strategies to increase awareness and coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. Health departments funded by CDC, through their federally funded state and local level HIV prevention programs, are required to have an HIV prevention planning process that includes the establishment of an HIV planning group (HPG) and the development of a jurisdictional HIV prevention and care plan. (Page 28)
Needs Assessment: A core component of an HIV prevention and care plan, as described in the Integrated Plan Guidance		

CDC 2012 HIV prevention planning guidance does not require HPG involvement in needs assessment. Integrated Plan Guidance encourages involvement of planning bodies including HPGs in needs assessment related to development of the integrated plan. "CDC Grantees are…strongly encouraged to utilize a wide variety of representatives to identify resources and gaps in HIV prevention and care services" [Integrated Plan Guidance, p 6], and HPGs can help to ensure such varied input.	Planning Council **takes primary responsibility** for needs assessment a partnership activity of the Planning Council, recipient, and community. • Section 2602(b)(4)(a) and (b) of the Ryan White legislation requires Part A Planning Councils to conduct needs assessments that: "determine the size and demographics of the population of individuals with HIV/AIDS"; "determine the needs of such populations, with particular attention to: (i) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services; (ii) disparities in access and services among affected subpopulations and historically underserved communities; and (iii) individuals with HIV/AIDS who do not know their HIV status." • Section 2602(b)(4)(G) requires the Part A Planning Council to "establish methods for obtaining input on community needs and priorities." • Section 2603(b)(1)(B) specifies that in seeking supplemental funding, the EMA or TGA is expected to provide information that "demonstrates the need in such area, on an objective and quantified basis, for supplemental financial assistance to combat the HIV epidemic." The Planning Council **is expected** to: • Directly or through a consultant, **design, plan and conduct** a needs assessment. • **Oversee** the needs assessment and **present results** to the Planning Council. • **Use results** in developing the Comprehensive Plan and **assure** that identified needs are demonstrated in PSRA. [Section 2602(b)(4)(A-B)] "HAB DMHAP recommends EMAs/TGAs align their needs assessment cycle with the Integrated HIV Prevention and Care Plan or with the three-year period of performance when possible. If using the Integrated Plan needs assessment cycle, the comprehensive needs assessment should inform the Integrated Plan with focused assessments in the subsequent years. If using the three-year needs assessment cycle, the comprehensive needs assessment should inform the competitive application or year one of the three-year cycle with focused assessments in subsequent years. This practice allows focus on high-impact populations and an update on the resource inventory that will support annual priority setting and resource allocation activities. Epidemiologic data should be obtained annually as part of that process in evaluating the progress of the Integrated HIV Prevention and Care Plan that supports decision-making for reallocation and Priority Setting and Resource Allocation (PSRA)." [Part A Manual, p 32]	
Statewide Coordinated Statement of Need (SCSN): A core component of an HIV prevention and care plan, as described in the Integrated Plan Guidance		

HPG members should participate in the Part B-led SCSN process in the state.	Ryan White legislation requires a Planning Council to: • "**Develop** a comprehensive plan for the organization and delivery of health and support services" that… (iii) is compatible with any State or local plan for the provision of services to individuals with HIV/AIDS [including the Statewide Coordinated Statement of Need]" [Section 2602(4)(D)]; and • [Section 2602(b)(4)(F)]: "**Participate in** the development of the statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under part B."	Not applicable.

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATING VALUES
(Revised - PP&A 8/27/2024)

PARADIGMS (Decision-Making)

- **Equity**[1]**:** Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically.
- **Compassion**[2]**:** Response to suffering of others that motivates a desire to help.
- **Retributive Justice:** Making up for past inequities.
    - **Restorative Justice**: Making up for past inequities.

OPERATING VALUES

- **Efficiency**: Accomplishing the desired operational outcomes with the least use of resources.
- **Quality**: The highest level of competence in the decision-making process.
- **Advocacy**: Addressing the asymmetrical power relationships of stakeholders in the process.
- **Representation**: Ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process.
- **Humility**[3]: Acknowledging that we do not know everything and willingness to listen carefully to others.
- **Access**: Assuring access to the process for all stakeholders and/or constituencies.

#7

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Monday, August 12, 2024 10:00:59 AM
Last Modified:	Tuesday, August 13, 2024 1:08:10 PM
Time Spent:	Over a day
IP Address:	216.70.188.22

Page 1: Introduction

Q1

Are you applying as a NEW or RETURNING Committee member?

NEW

Q2

Contact Information

Name and Pronoun (For example: "John Smith, he/him/his")	**Rob Lester, he/him**
Do you work for an agency/organization? If yes, please state agency/org name and if not, please indicate "N/A" for not applicable.	**Men's Health Foundation**
Address	**9201 W Sunset Blvd. #812**
City/Town	**West Hollywood**
State/Province	**CA**
ZIP/Postal Code	**90069**
Primary Email Address	**rob.lester@menshealthfound.org**
Primary Phone Number	**424-245-3466**

Q3

Were you recommended by an individual or organization? If so, please state the name of the recommending entity. **Not required; suggested for applicants representing agencies/organizations**

Yes,
Recommending individual/organization::
Men's Health Foundation

Q4

Are you affiliated with a Ryan White Program-funded agency? **Affiliated is defined as one who is either a board member, employee, or a consultant of an agency who receives Ryan White Program funding through the Los Angeles County Division of STD and HIV Programs (DHSP). Volunteers are considered unaffiliated. Click here for a list of Ryan White Program-funded agencies; subject to change**

Yes

Page 2: Committee Selection

Q5

Based on your expertise and the Committee description, role and responsibilities, please select below which Committee you would be interested in participating on.

Planning, Priorities & Allocations (PP&A) Committee

Page 3: Background & Experience

Q6

Why do you want to join the Committee selected?

My goal is to see the end of the HIV epidemic. We will achieve this by expanding access to biomedical preventions, such of PrEP and PEP, as well as by leveraging U=U/TasP to arrest the further spread of HIV. I have 30+ years of experience in the epidemic, as a volunteer, a community member, a professional in public health, [redacted] I believe that through my knowledge and experience I can contribute meaningfully to conversations and decisions about the prioritization and allocation of funding for HIV treatment and prevention. I want to use my voice to represent the needs of patients living with HIV both as a seasoned provider and as a patient. The end of the HIV epidemic is with in our grasp, and I want to increase my engagement in the fight against HIV through my participation in the planning process.

Q7

What skills, abilities, and/or experience do you have that can be helpful to the selected Committee?

I have extensive experience developing, implementing, and managing HIV treatment and prevention services for members of the LGBTQ-community living with or at risk of HIV in Los Angeles County. I currently manage a portfolio of seven DHSP-funded programs (BHPNS, SHEx-C, MCC, AOM, Transportation for PLWH, and Data 2 Care) as well as project funded by the City of West Hollywood, CDPH, Heluna Health, and private foundations. In the past, I've also managed programs providing Health Education/Risk Reduction services for MSM and transgender women engaged in sex work, street-based outreach for MSM and transgender women engaged in sex work, and a contingency-management-based treatment program for gay/bisexual men addicted to methamphetamines.
Further as a grant writer for one of the largest FQHC's in Los Angeles County, I have much experience with the funding mechanisms that underly our publicly-funded HIV services. I have written and assisted with the management of grants/contract funded by Ryan White Part A and C grants, Section 330 grants, SAMHSA grant, HRSA primary care and homeless services grants, and grants from private foundations.
Finally, as a former member of the LA County Commission on HIV (Alternate (Jun 2013 Jun 2015), I have firsthand experience about the structure and function of the Commission and its committee structure.

Q8

If you have a resume or other documents (i.e. certificates, awards, letters of recommendation, biosketch, curriculum vitae) that will support your membership application, please upload here. **This is optional and not required to be considered for membership**

Rob%20Lester%20Resume%20(JUL%202023)%20(3).pdf (84.7KB)

Q9

How can we support you so that you are able to fully participate and be effective on the selected Committee? Do you need special accommodations, i.e. translation or interpretation services, etc?

No support is needed at this time.

Page 4: Statement of Qualifications

Q10

Please save and upload your completed/signed SOQ here or email to Commission staff at hivcomm@lachiv.org. For additional information, please contact Commission staff.

1085 SOQForm General 04042023.pdf (313.2KB)

Page 5: Application Submission

Q11

Please be sure to check the appropriate box below affirming your committment and certifying all information is true and accurate.

Yes

Rob Lester

[redacted]

Demonstrated success in designing, funding, implementing, and managing programs for LGBTQ+ community members

WORK + PUBLIC SERVICE

Sr Director of Public Programs (Oct 2023 – current)
Director of Sexual Health (July 2021 – Oct 2023)
Director of Care Services (Oct 2018 – July 2021)
Men's Health Foundation, Los Angeles, California

- Lead program design and grant development which won initial $2.25m, 3-year award for Rapid Results, an express HIV testing and STI testing and treatment program.
- Grew Rapid Results from program founding in 2021 to having provided 8,076 sexual health encounters to 3,698 patients in CY2022 at two clinics serving West Hollywood and South LA.
- Developed policies, procedures, and workflows for Rapid Results that include on-line self-scheduling module allowing for same-day scheduling of testing, treatment, and PrEP appointments while keeping average testing cycle time under 30 minutes.
- Expanded PrEP/PEP program from July 2021 to current from 1,798 to 2,793 PrEP patients (CY2022), 38 to 128 PEP patients, and added $290k to program budget by writing proposal for CDPH PrEP Navigation program.
- Lead Medical Care Coordination team providing nursing, mental health, and case management services to 180 high-acuity patients living with HIV.

Sr. Grant Writer (Jan 2015 – Sept 2018)
Wesley Health Centers + JWCH Institute, Los Angeles, California

- Increased agency grant revenue by 79% from $12.1m in FY14/15 to $21.6m in FY 17/18 through the development, writing, submission, and monitoring of 53 grants worth $31.9m.
- Developed policies and procedures to expand scope of grant office to include grant management activities and to reduce overdue reports and missed performance goals.
- Provide project management support for private, county, and federal grants, including from HRSA, SAMHSA, City of Los Angeles, LA Care, HealthNet, Ahmanson Foundation, and Parsons Foundation.

Dir. of Programs, Friends Community Center (May 2014 – Jan 2015)
Friends Research Institute, Inc., Los Angeles, California

- Managed six DHSP programs with thirteen staff members providing health education, risk reduction, and HIV testing services to high-risk MSM and transgender Women.
- Developed and implemented new policies for program incentives to reduce waste and better track funding
- Reconstituted HIV testing and risk reduction programs after major staff changes

Commissioner, Alternate (Jun 2013 – Jun 2015)

Los Angeles County Commission on HIV, Los Angeles, California

- Represented the interests of AIDS service providers in formulating Los Angeles County's policy on the treatment and prevention of HIV and STIs
- Participated in establishing priorities and allocating funds for the $64 million HIV treatment and prevention budget for Los Angeles County
- Served as member of Public Policy committee and Operations committee

Consultant (Jun 2012 – May 2014)

Rob Lester Consulting, Los Angeles, California

- Wrote and delivered two-day seminar on the impact of the ACA in California on people living with HIV (Client: API Wellness Center)
- Developed and delivered webinar series on the impact of health care reform on CBOs (client: AIDS Project Los Angeles)
- Authored technical assistance documents to supplement webinars, on topics including FQHC certification, 340B drug program, mandated coverage under the ACA, and the future of the Ryan White program (client: AIDS Project Los Angeles)

EDUCATION

- Master of Public Policy (Sep 2010 – Jun 2012)
  Luskin School of Public Affairs at UCLA, Los Angeles, California
- Bachelor of Arts, Political Science; History (Jan 2008 – Jun 2010)
  University of Arkansas at Little Rock, Little Rock, Arkansas

WRITING + PUBLIC SPEAKING

- "Early Evidence from California on Transitions to a Reformed Health Insurance System for Persons Living With HIV/AIDS." JAIDS, Nov. 1, 2013 (with co-authors).
- "Resource Allocation Analysis of the HIV Testing Programs at the Los Angeles Gay & Lesbian Center," Los Angeles Policy Symposium. Los Angeles, California: May 2012.

Proposed Ryan White Program Year (PY) 35 Allocations Table

MOTION #4: Approve Ryan White Program Year 35 Allocations as presented or revised and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.

			FY 2024 (PY 34) [1]		FY 2025 (PY 35) [2]	
Service Type	**Service Ranking**	**Service Category**	**Part A %**	**MAI %**	**Part A %**	**MAI %**
Core	**6**	Medical Case Management (Medical Care Coordination)	27.15%	0.00%	**29.00%**	**0.00%**
Core	**8**	Oral Health	20.79%	0.00%	**21.30%**	**0.00%**
Core	**20**	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	17.11%	0.00%	**17.11%**	**0.00%**
Core	**11**	Early Intervention Services (Testing Services)	6.58%	0.00%	**0.00%**	**0.00%**
Core	**17**	Home and Community-Based Health Services	6.50%	0.00%	**6.50%**	**0.00%**
Support	**2**	Emergency Financial Assistance	6.32%	0.00%	**8.00%**	**0.00%**
Support	**7**	Nutrition Support (Food Bank/Home-delivered Meals)	5.79%	0.00%	**7.79%**	**0.00%**
Support	**5**	Non-Medical Case Management				
		Benefits Specialty Services	3.95%	0.00%	**3.95%**	**0.00%**
		Transitional Case Management - Jails	1.58%	0.00%	**1.58%**	**0.00%**
Support	**10**	Medical Transportation	1.84%	0.00%	**1.84%**	**0.00%**
Support	**23**	Legal Services	1.42%	0.00%	**2.00%**	**0.00%**
Support	**1**	Housing				
		Housing Services RCFCI/TRCF (Home-Based Case Management)	0.91%	0.00%	**0.91%**	**0.00%**
		Housing for Health	0.00%	100.00%	**0.00%**	**100.00%**
Core	**3**	Mental Health Services	0.29%	0.00%	**0.02%**	**0.00%**
Core	**9**	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	0.00%	0.00%
Core	**22**	Local AIDS Pharmaceutical Assistance Program (LPAP)	0.00%	0.00%	0.00%	0.00%
Core	**15**	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	0.00%	0.00%
Core	**16**	Home Health Care	0.00%	0.00%	0.00%	0.00%
Core	**28**	Hospice Services	0.00%	0.00%	0.00%	0.00%
Core	**26**	Medical Nutritional Therapy	0.00%	0.00%	0.00%	0.00%
Core	**12**	Substance Abuse Services Outpatient	0.00%	0.00%	0.00%	0.00%
Support	**18**	Child Care Services	0.00%	0.00%	0.00%	0.00%
Support	**13**	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%
Support	**27**	Linguistic Services (Language Services)	0.00%	0.00%	0.00%	0.00%
Support	**14**	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%
Support	**4**	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%
Support	**24**	Referral	0.00%	0.00%	0.00%	0.00%
Support	**25**	Rehabilitation	0.00%	0.00%	0.00%	0.00%
Support	**21**	Respite Care	0.00%	0.00%	0.00%	0.00%
Support	**19**	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%
		Overall Total	**100%**	**100.00%**	**100.00%**	**100.00%**

Footnotes:

(1) Approved by COH on 8/8/24

(2) Agreed by PP&A on 8/28/24

Green font indicates allocation increase from PY34

Red font indicates allocation decrease from PY34

Priority Setting and Resource Allocation Process: Developing Directives

Planning, Priorities and Allocations Committee
September 17, 2024

LOS ANGELES COUNTY
COMMISSION ON HIV

Objectives

- Understand the purpose of the directives
- Identify the four areas of focus of directives
- Understand the role of the Planning, Priorities and Allocations Committee in developing directives
- Identify sound practices and HRSA expectations for developing directives
- Learn how to draft directives

Content for this presentation was adapted from Ryan White Program Part A Manual and Planning CHATT Resource Developing Directives: Steps and Sound Practices.

Priority Setting and Resource Allocation Process

1. Review core medical and support service categories, including HRSA service definitions
2. Review data/information from DHSP & COH Caucuses
3. Agree on how decisions will be made; what values will be used to drive the decision-making process
4. Rank services by priority
   Ranking DOES NOT equal level of allocation by percentage
5. Allocate funding sources to service categories by percentage
   Ryan White Program Part A and Minority AIDS Initiative (MAI)
6. Draft Directives: Provide instructions to DHSP on how best to meet the priorities
   Informed by COH Committees, Caucuses, Task Forces, data, PLWH & provider input
7. Reallocation of funds across service categories, as needed throughout funding cycle

Directives

Development of directives is a legislative responsibility of a Ryan White HIV/AIDS Program (RWHAP) Part A Planning Council (PC).

Provides guidance to the recipient (DHSP) on how best to meet prevention and care priorities

- Involves instructions for the recipient to follow in developing requirements for providers for use in procurement and contracting
- Usually addresses populations to be served, geographic areas to be prioritized, and/or service models or strategies to be used

Directives are one way of strengthening the system of care. There are other ways, as well, such as adding requirements to universal or service category specific Service Standards.

Focus of Directives

Directives are indicated when your current system of care is not meeting identified service priorities, and you can identify actions that may enhance services and improve consumer engagement, retention, and outcomes such as linkage to care, retention in care, adherence to medications, and viral suppression, overall or for specific PLWH populations or geographic areas.

Most directives relate to one or more of the following:

- **Geographic focus** to ensure service availability throughout the EMA/TGA or in a particular county or area
- **Population focus** to ensure services that are appropriate for particular subpopulations of people with HIV (PWH)
- Improvements in **access to care**
- Testing of new **service models** or expansion of effective strategies

Timing of Directive Development

A planning council can develop a directive at any time. The needs for a directive may come from the review and discussion of data from the following sources:

- **Needs assessment** - service gaps, barriers to care, or issues identified by consumers, service providers, or PLWH who are out of care
- **Town hall meetings or public hearings** - identified service needs, gaps, services strengths or weaknesses
- **HIV care continuum** - disparities in linkage to care, retention, and/or viral suppression among specific PLWH populations
- **Service utilization** - disparities in use of particular service categories by different PLWH populations (i.e., race/ethnicity, age, gender/gender identity, sexual orientation, risk factor, or place of residence)
- **Clinical Quality Management (CQM)** - identified performance issues or changes in service models that improve patient care, health outcomes, and patient satisfaction

Sound Practices for Directive Development

There are many different ways to develop directives, and no single approach is best. The most effective processes have several sound practices in common:

- **Consumer and community input:** consumers often have the best understanding of what is and is not working
- **Clear responsibilities:** responsibility assigned to a committee with both appropriate expertise and sufficient time to fulfill this responsibility
- **Recipient involvement:** recipient is responsible for implementing directives and may also provide data and advice on implementation feasibility and timing. For example, if a directive involves a new service model, implementation may be feasible only when the recipient releases a new Request for Proposals (RFP) for the service category.
- The recipient can provide technical input and should be engaged in directives development, but the **planning council is the decision maker about the directives**.

HRSA Expectations

Planning councils have a great deal of flexibility in the development and use of directives. HRSA expects directives to be:

- **Based on an identified need** - determined through review of data
- **Explored and developed as needed throughout the year** - may include the involvement of committees/caucus and/or consumers
- **Presented in relation to the PSRA process**, since they often have financial implications and may require changes in how services are delivered
- **Approved by the full planning council**
- **Consistent with an open procurement process** - directives should not have the effect of limiting open procurement by making only 1-2 providers eligible. The planning council should not be involved in the selection of specific agencies to serve as subrecipients.

Tips for Preparing Directives

1. **Provide a limited number of carefully thought-out directives**. Too many directives may not receive the individual attention or resources needed for successful implementation.
2. **Review current directives**. Retire those that no longer apply and/or refine an existing directive rather than developing a new one.
3. **Base directives on data**. When proposing a new or revised directive, be prepared to justify the directive with data.
4. **Identify and research possible directives throughout the year** as part of ongoing efforts to improve the continuum of care. This provides time to explore service models used by other jurisdictions, determine costs, and have a well-considered directive to present as part of PSRA process.
5. **Refer to but don't duplicate requirements in existing Service Standards**.
6. **Use plain, direct language.** This makes the directive easy to understand and implement.

Drafting Directives

Directive format	Examples
A directive can call for a specific solution or several options, or it can be stated to define the required level of access rather than the specific solution.	Consumers will have access to AOM services within each of the Service Planning Areas (SPAs) at least two days a week, and transportation assistance will be provided for any consumer who lives more than 5 miles from an AOM location.
A directive can be flexible allowing the recipient to develop an approach or it can be specific and detailed-identifying desired outcomes or approaches to consider.	The recipient will develop and arrange for a two-year pilot implementation of a peer-based support program designed to ensure that young MSM of color who are newly diagnosed or out of care become fully engaged in care, adhere to treatment, and reach viral suppression.
A directive can also include instructions to include greater involvement of the planning council.	The recipient will work with the PC to develop a peer-based support program to be implemented as a 2-year pilot effort. The program will be developed in collaboration with the Consumer Caucus and the recipient and must be approved by both parties.

Directive Implementation

Some directives require changes in subrecipient (service provider) scopes of work or increased costs, and the recipient may not be able to implement them immediately.

For example, a directive for piloting a new peer Psychosocial Service may need to wait until the next program year. A directive requiring outpatient ambulatory health services (OAHS) to be available two evenings out of the week might require an increase in OAHS resource allocations.

Due to their financial and funding implications, discussions with the recipient about feasibility and implementation are needed.

Directive Implementation

Due to their financial and funding implications, discussions with the recipient about directive feasibility and implementation are needed.

The recipient must follow directives in procurement and contracting but cannot always guarantee full success. *

Some directives may require changes in subrecipient (service provider) scopes of work or increased costs, and the recipient may not be able to implement them immediately.

Directives are generally implemented by the recipient through:

- procurement and contracting, and/or
- program monitoring and clinical quality management (CQM) efforts

Once a directive has become a requirement for subrecipients, its implementation can be followed through program monitoring, reviewed as part of CQM, or assessed in terms of changes in performance measures or clinical outcomes for affected PLWH.

Assessment

Once a directive has become a requirement for subrecipients, its implementation can be followed through program monitoring, reviewed as part of CQM, or assessed in terms of changes in performance measures or clinical outcomes for affected PLWH.

The recipient should always be asked to **provide regular updates on implementation of directives**, ideally at least quarterly.

Sample Directives

1. At least one outpatient substance abuse treatment provider must offer services appropriate for and accessible to women, including women who are pregnant or have small children.
2. RWHAP-funded outpatient ambulatory health services must be available within each Service Planning Area (SPA), either through facilities located in the county or through other methods such as use of mobile vans or out-stationing of personnel.
3. Every funded outpatient ambulatory health services (OAHS) provider and every medical case management provider must offer services at least one evening a week and/or one weekend day a month.

Guidance on how best to meet prevention and care priorities.

Focus on:

- Geographic area
- Target population
- Access to care
- Service models

Sample Directives

4. At least two medical providers will receive funds to test the use of a Rapid Response linkage to care model, designed to ensure that newly diagnosed clients have their first medical visit within 72 hours after receiving a positive test result.
5. Core medical service providers must have bilingual Spanish-English staff in positions with direct client contact, including clinical staff.
6. PLWH with a history of unmet need must have access to peer navigator services or other targeted assistance for at least the first six months after they return to care.
7. Oral health care must be accessible to PLWH in the EMA regardless of where they live.

Guidance on how best to meet prevention and care priorities.

Focus on:

- Geographic area
- Target population
- Access to care
- Service models

Time to Draft Directives…

Consider the following questions as you prepare to draft your directives:

- What is the purpose of the directive? What should it try to accomplish?
- What service category(s) should be used or targeted?
- How should the directive be worded?
- Where is the data to justify the need for the directive?

#5. Approve proposed FY2024 Directives as presented:

FY2024 Directives

ADAP Pharmaceutical Formulary Stop Gap: Due to the inter-relationship between ADAP Pharmaceutical Formulary Stop Gap and OAHS medications, funds may be moved between categories.

Antiretroviral Therapy (ART): Increase the immediate administering of Antiretroviral Therapy (ART); monitor and track data to ensure all providers review patient plans for immediate, long term care, follow-up, and documentation of patient outcomes.

Atlanta Area Outreach Initiative: Continue to fund AAOI during Fiscal Year 2024 at the funding level of $50,000.

Continuum of Care: To the greatest extent possible, expand access to care to include areas outside of the urban core and within the Eligible Metropolitan Area (EMA).

Directive Status Reports: Recipient to formally report the status of all directives issued by the Planning Council at the end of 3rd quarter of the Fiscal Year.

Mental Health/Substance Abuse: Due to the inter-relationship between Mental Health and Substance Abuse, funds may be moved between categories, if all approved services have been funded at some level under the priority category. Example: If all initiatives under Mental Health have been at least partially funded, remaining Mental Health funds may be moved to fund SA initiatives.

Health Insurance Premium Support: Unawarded/unexpended funds in this category shall be moved to Outpatient Ambulatory Health Services or other Core Service category.

Telecare: To the greatest extent possible increase access to and retention in care through access via Telecare options for all in the EMA.

Minority AIDS Initiative (MAI): Increase care services to Minority AIDS Initiative priority populations (African American MSM, African American Males, African American Females, Hispanics, and Transgender persons) as expressed in the Integrated Plan and other reports.

Outpatient Ambulatory Health Services: To the greatest extent possible increase access to care through the implementation of co-locations of agencies and for expanded hours for areas as identified by the Assessment Committee.

Oral Health Care (Capacity): To the greatest extent possible expand oral health care options within the Eligible Metropolitan Area (EMA) by contracting with an oral health provider(s) who will provide comprehensive oral health care and accept referrals from all Ryan White Part A agencies.

Core Service Categories: Unexpended funds in any category shall be moved between support service categories during the Fiscal Year.

Support Service Categories: Unexpended funds in any category shall be moved between support service categories during the Fiscal Year.

Professional Services: Utilize "Other Professional Services" category, specifically for legal services as identified in HRSA's definition of legal services: provision of services to an HIV-positive individual to address legal matters directly necessitated by the individual's HIV status. This provision excludes criminal defense, class action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program.

Funding Decrease: The Priorities Committee shall reconvene should there be a decrease in funding from the current Fiscal Year more than $250,000. Should a reduction occur in the range of $1 to $250,000, reductions in expenditures should follow the percentages established in the PSRA process.

Funding Increase: The Priorities Committee shall reconvene should there be an increase in funding from the current Fiscal Year more than $500,000. Should an increase occur in the range of $1 to $500,000, expenditures should increase by the percentages established in the PSRA process.

Integrated Plan: The Priorities Committee shall meet with the Recipient and the Integrated Plan team by the end of the 3rd Quarter of FY2023 to synchronize funding allocations with the Priority Setting Process and the Integrated Plan.

2023 Directives to the Recipient from HIPC

New Jersey

1. Encourage outreach to aging populations to ensure they are informed about funded services.

   The recipient has and will communicate to Subrecipients that they must conduct outreach to aging populations to ensure they are aware of funded services in the EMA. Priority services to spread this message will primarily be done through medical case management and outpatient/ambulatory health services funded sites. The recipient will also research to determine whether this language can be integrated into contractual language.

2. Increase access to and awareness of telehealth options to medical and social service care; Request more information on telehealth services provided and the circumstance of its use.

   Telehealth options at multiple Ryan White outpatient/ambulatory sites have already been integrated into HIV primary care since the beginning of the COVID-19 pandemic. In August 2023, the Recipient completed an update on all Ryan White outpatient/ambulatory sites. Currently, all sites provide telehealth options, this includes platform specific telehealth (Doxy.Me, Doximity, EHR platforms, ZOOM, etc.) and telephonic services. Despite telehealth services quickly becoming the norm, further research is still needed to learn how these providers make their patients aware of telehealth services through multiple methodologies. The recipient recognizes that individuals receive messages in multiple ways. Ensuring communication is clear will result in increased access to telehealth services across services.

   There are some Subrecipients who are already implementing certain initiatives such as pager services, distributing free cell phones, and patient portals to name a few. However, these services are highly targeted to specific patients who have a history of falling out of care or have been identified to need extra support.

   Regarding social services, the bulk of Ryan White services must be conducted in-person. However, there are some exceptions for medical case management and substance abuse services. Telehealth services are provided to those clients on an as needed basis.

3. Ensure subrecipients are disseminating information on the availability and coverage of EFA funding so clients can access this service.

   The primary mechanism by which EFA services are shared is through medical case management services. All medical case managers must complete a vigorous training process with the Recipient's Medical Case Management Coordination Project. Through this training they are introduced to the EFA service category. More specifically, each medical case management program must designate an individual(s) who completes further training with PHMC to carry out the services properly. A client's needs are considered during their comprehensive assessment with their assigned medical case manager.

   Furthermore, the recipient will be adding a service search tool on the Philly Keep On Loving website (www.phillykeeponloving.com). This will describe services and People with HIV will be able to contact the recipient's Client Services Unit (CSU) staff via chat, email, or by phone to ask questions about services. Anyone in need of the service will be referred to MCM services and CSU will provide short term case management until the client has been assigned a MCM.

4. DHH is to report back to the Comprehensive Planning Committee with progress and updates on the currently implemented EFA-Housing Model.

   The intention of EFA-Housing is to Emergency Financial Assistance for limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

   Through FY22, $107,446 was allocated and the Subrecipient has exceeded program goals. In total 235 clients received 235 monthly payments for EFA-Housing. EFA-Housing has not encountered significant challenges. However, there are different situations that are not written in guidance or services provisions that must be handled uniquely on a case-by-case basis. The recipient is excited to report that the processing of applications continues to be completed in 1-2 business days.

5. In accordance with federal treatment guidelines, increase access to immediate ART initiation (within 96 hours) from diagnosis unless otherwise clinically indicated and recorded.

As previously reported, increasing access to iART has been part of the HRSA EHE initiative for Philadelphia. The Recipient has organized the following: an HIV Learning Collaborative as part of the EHE initiative, provided capacity building assistance to all EHE funded providers to develop and implement iART policies that included processes on access and expansion. In September 2023, the Recipient awarded all Status Neutral HIV testing providers to develop and implement iART policies to be completed by January 2024. Implementation of said iART policies across all EHE funded Subrecipient sites is now in force.

The major caveat is additional funds to implement are only available as part of EHE efforts and those funds can only be awarded to providers in Philadelphia. RW Part A providers in NJ are encouraged to implement iART with their current Part A funds.

6. Expand operating hours to include evening and weekend appointments for HIV medical care in community and hospital-based HIV treatment sites.

   As previously reported, expanded operating hours is also being implemented as part of EHE efforts. Additional funds to implement are only available to Philadelphia- based providers through HRSA EHE funding and those funds can only be awarded to providers in Philadelphia. RW Part A providers in NJ are encouraged to expand operating hours with their current Part A funds.

   The recipient will research internally the number of Subrecipients who have expanded their hours of operation (including nights and weekends) with comparisons from FY21 to FY22. Additionally, we will learn the proportion of patients and clients who utilize these services over a snapshot time in the same periods.

PA Counties

1. Increase access to and awareness of telehealth options to medical and social service care; Request more information on telehealth services provided and the circumstance of its use.

   Telehealth options at multiple Ryan White outpatient/ambulatory have been integrated into HIV primary care since the beginning of the COVID-19 pandemic. In August 2023, the Recipient completed an update on all Ryan White outpatient/ambulatory sites. Currently, all sites provide telehealth options, this includes platform specific telehealth (Doxy.Me, Doximity, EHR platforms, ZOOM, etc.) to telephonic services. Further research is needed

to learn how these providers make their patients aware of telehealth services.

Regarding social services, the bulk of Ryan White services must be conducted in-person. However, there are some exceptions for medical case management and substance abuse services. Telehealth services are provided to those clients on a as needed basis.

2. Encourage outreach to aging populations to ensure they are informed about funded services.

   The recipient will communicate to Subrecipients that they must conduct outreach to aging populations to ensure they are aware of funded services in the EMA. Priority services to spread this message will begin with medical case management and outpatient/ambulatory health services funded sites.

3. Ascertain the need for increased mental health services in the PA counties.

   The Recipient will reach out to all mental health funded Subrecipients identify gaps in services such as waiting list. However, there does not appear to be an increased need reported directly to the Recipient by way of additional funds requests or technical assistance.

Philadelphia County

1. Review which services are most utilized and needed by PLWH 50+ years old; encourage outreach to said population to ensure they are informed about funded services.

   Services most utilized by PWH 50+ years old will require further research via study of the Recipient's databases and direct inquiry with Subrecipients. This process will take time, but we are aiming to provide accurate information before the close of this fiscal year which ends 2/29/24.

   However, much work on this topic has already taken place. The Recipient convened a community-led symposium called Aging and Thriving which took place May 24, 2023. A day of discussion and resource-sharing for adults with HIV over 50 and their service providers. It was attended by 83 in-person attendees and about 20 online participants throughout the day.

   Goals for the day were: (1) to foster dialogue between community members and providers of health and social services about the resilience,

challenges, and wisdom of people aging with HIV and (2) to provide education to providers and community members about accessing services to meet the intersecting nature of health, economic and service needs of people aging with HIV; and (3) to provide insight to PDPH Division of HIV Health on how to design services that best serve the diverse local community of individuals aging with HIV, and align services for aging populations with the local EHE plan.

Many topics were discussed such as: resources available through the local Area Agency on Aging, Managing HIV in Older Adults: Understanding Your Labs & Common Co-Morbidities, Benefits and Employment Issues for Over 50, Death and Dying/End of Life Issues: Healing from Trauma as Long-Term Survivors, Needs and Experiences of Trans and Gender Non-Conforming Older Adults with HIV, Elder Housing Resources, and Criminalization of HIV Across the Lifespan to name a few. Co-leading the symposium with older adults with HIV who are long-standing members of local and national advocacy communities was a powerful learning experience for participants and for service providers.

Another symposium is tentatively planned for the third week of May 2024. We will reconvene the planning committee for the symposium starting in December 2023. University of Pennsylvania has been selected as focus group provider for adults with HIV and they are currently in the development and IRB phases of the project.

2. Increase access to and awareness of Food Bank services, especially those that are culturally relevant; request more information on Food Bank services provided and their utilization to determine improved health outcomes

There are five (5) Subrecipients in Philadelphia that receive Ryan White Part A funding for food bank services. The range of food bank services is diverse. Services include traditional food bank and food vouchers to various merchants. After reviewing these services, Subrecipients are implementing culturally relevant and appropriate food bank services.

<u>ACCESS</u>: Some examples include choice; this means giving clients the option to choose which food items they would like to take home. This may look like "supermarket" style food bank access or clients can submit a food bank shopping list while the worker packs their food bags. These same providers may source food items from Philabundance, Amazon and BJs to name a few. And, during the holiday season many Subrecipients will make available food baskets.

Clients are also given additional resources for food banks in and around the area, and agency brochures to make them aware of in-house services.

Moreover, clients are assessed to ensure access to entitlements such as SNAP benefits and WIC.

<u>CULTURAL RELEVANCE/ACCOMODATIONS</u>: Food voucher selection takes into consideration the cultural needs and access limitations among clients. This includes getting vouchers from local supermarkets and supermarket chains.

Alongside cultural relevance, other accommodations are made such as language access (all Subrecipients have language access policies in place), allergy considerations, food delivery, dietary considerations, supplements, and water filtration.

At least two (2) subrecipients have disclosed they have events or acknowledge cultural needs by having monthly Hispanic heritage pantry days. Additionally, one (1) subrecipient shared they have annual surveys specifically about their food bank services to ensure their needs are met. However, one (1) subrecipient reported they need additional support to competently offer and address diverse diets (such as religious considerations, vegan, and vegetarian diets).

3. Ensure subrecipients are disseminating information on the availability and coverage of EFA funding so clients can access this service.

The primary mechanism by which EFA services are shared is through medical case management services. All medical case managers must complete a vigorous training process with the Recipient's Medical Case Management Coordination Project. Through this training they are introduced to the EFA service category. More specifically, each medical case management program must designate an individual(s) who complete further training with PHMC to carry out the services properly. A client's needs are considered during their comprehensive assessment with their assigned medical case management.

Furthermore, the recipient will be adding a service search tool on the Philly Keep on Loving website (www.phillykeeponloving.com). This will describe services and People with HIV will be able to contact the recipient's Client Services Unit (CSU) staff via chat, email, or by phone to ask questions about services. Anyone in need of the service will be referred to MCM services and CSU will provide short term case management until the client has been assigned an MCM.

LOS ANGELES COUNTY COMMISSION ON HIV

APPROVED
COH Meeting 6-7-22

Approval Dates: Planning, Priorities, and Allocations Committee 5/17/22/; Executive Committee 5/26/22/; COH 6/9/22; DHSP Response 11/14/22

Program Directives for Maximizing Health Resources Services Administration (HRSA) Ryan White Part A and MAI Funds for Program Years (PY) 32, 33, 34 and Centers for Disease Control and Prevention (CDC) Funding

Purpose: These program directives approved by the Los Angeles County Commission on HIV (COH) on June 9, 2022 articulate instructions to the Division of HIV and STD Programs (DHSP) on how to meet the priorities established by the COH. The Ryan White PY Years 32, 33, and 34 service rankings and allocations table are found in Attachment A.

Considered complete and ongoing

1. Across all prevention programs and services, use a status-neutral approach in service delivery models and create a connected network of services that promote access to PrEP, ongoing preventive care, mental health, substance use, and housing services. A status-neutral approach considers the steps that can lead to an undetectable viral load and steps for effective HIV prevention (such as using condoms and PrEP). The status-neutral approach uses high-quality, culturally affirming care and empowers PLWH to get treatment and stay engaged in care. Similarly, high-quality preventive services for people who are at risk of HIV exposure help keep them HIV-negative.[1] A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated the same way, with dignity and respect, and with the same access to high-quality care and services.

DHSP Response:

- DHSP's EHE Outreach and Education team developed HIV Testing palm cards that are status-neutral. One side of the palm card has resources for persons diagnosed with HIV, and the other side of the card contains resources for persons who are HIV negative.
- DHSP recently released a new RFP (through Heluna Health) to fund mini-projects that will improve linkage to care, diagnoses, or engagement in care. The RFP recommends the use of a status-neutral approach and is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
- All DHSP prevention contracts are status-neutral
- Under vulnerable population contracts, at least four provide housing vouchers and three provide mental health services
- Persons at risk for HIV should have access to substance use prevention and treatment if they have any private health insurance or through MediCal
- Identification of a funding source for housing services for persons at risk of HIV has been a challenge. DHSP will advocate with CDC and HRSA to allow more flexibility with funding in order to support the status neutral approach

Rephrase to address issues with access and services in specific geographic areas.

2. Across all funding sources for prevention and care, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe. To determine populations and geographic areas most affected by HIV, request DHSP to provide data on the following:
   a. HIV and STD surveillance
   b. Continuum of care
   c. PrEP continuum
   d. Data on low service utilization in areas with high rates of HIV
   e. Viral suppression and retention rates by service sites
   f. and other relevant prevention and care data

Priority populations are those groups defined in the Los Angeles County Ending the HIV Epidemic plan. "Based on the epidemiologic profile, situational analysis, and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include Black/African American

[1] hiv-status-neutral-prevention-and-treatment-cycle (nyc.gov)

MSM, Latinx MSM, women of color, people who inject drugs, transgender persons, and youth under 30 years of age. Although priority populations have been selected for EHE, the LAC HIV portfolio will continue to support all populations affected by HIV and will not diminish efforts to prevent, diagnose, and treat HIV for populations who remain a critical concern, including people over age 50 who account for over 51% of PLWH in LAC and people experiencing unstable housing or homelessness, among others" (pg. 21).

The Health Districts with the highest disease burden represent five cluster areas that account for more than 80% of the disease burden (LACHAS, pg. 7)

1. Hollywood Wilshire (SPA 4)
2. Central (SPA 4)
3. Long Beach (SPA 8)
4. Southwest (SPA 6)
5. Northeast (SPA 4)

See health district (HD) maps for ranking by HIV disease burden (Attachment B).

DHSP Response:

- DHSP has developed HIV and STD dashboards which present current data and trends. Health district and SPA results are available. The dashboards can be accessed at http://publichealth.lacounty.gov/dhsp/Dashboard.htm
- DHSP Data Visualization team has developed Health District-level Epi Profiles and a Power BI tool to help track clusters and inform cluster detection and response initiatives more efficiently
- DHSP has and will continue to provide responses to COH data requests. HIV and STD surveillance, RWP Utilization, NHBS, HIV testing, and MMP data were presented during 2021 and 2022. Data were also provided and included in the Comprehensive Prevention Plan.

Considered completed and ongoing

3. Integrate telehealth across all prevention and care services, as appropriate.

DHSP Response:

- DHSP augmented some biomedical contracts to purchase telehealth software
- RWP AOM, MCC, MH, Transitional Case Management (TCM) and Home-Based Case Management (HBCM) services have had the capacity to deliver services via telehealth since March 2020, and will continue using telehealth (phone)
- Prevention programs used Zoom, Facebook and phone and will continue to use these telehealth modalities and a hybrid approach.
- DHSP will continue to monitor and evaluate telehealth usage in the RWP
- New services such as the Spanish language mental health services will require both on-site and telehealth options

4. Continue the implementation of the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and

inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

Considered complete; may be ongoing? Request update from DHSP

a. Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust, and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum, monitoring, and evaluation.

DHSP Response:

- DHSP developed a training that addresses issues of cultural humility and implicit bias last year. Three hundred people have been trained so far and this work is ongoing.

Black/AA Caucus currently conducting various listening sessions to identify needs.

b. In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women. Integrate needs assessment objectives and timelines in the 2022-2026 Comprehensive HIV Plan.

DHSP Response:

- DHSP has collaborated with Raniyah Copeland to obtain perspectives and feedback from the Black/African American community to develop a social marketing strategy
- Black/African American Taskforce will conduct key informant interviews with service providers including workforce development needs
- Conducting LACHNA is extremely labor intensive and time-consuming activity. The NHBS data can be used for prevention planning and the Medical Monitoring Project (MMP) can be used to understand HIV care needs.
- A more targeted needs assessments can be completed by COH and AJ as part of the CHP development

Provide more detail on "resources"; HIV specific? Rephrase to link to available resources.

c. Assess available resources by health districts by order of high prevalence areas.

DHSP Response:

- DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.
- See response to item #2

- DHSP will help improve the response of local HIV efforts to address epidemic among Blacks and African Americans by enlisting new providers and working with other county departments to help make the county contracting process easier to navigate and more inclusive.

d. Conduct a study to identify out-of-care individuals, and populations who do not access local services and why they do not.

DHSP Response:

- DHSP staff are currently analyzing data from the Linkage and Re-Engagement Program (LRP) as well as other Data-to-Care activities to identify out of care individuals and better understand their service needs.
- DHSP has developed a dedicated in-house Data to Action team

Mental Health assessment showed lack of overall providers; low mental health RWP utilization rates; mental health services primarily covered via Medi-Cal.

e. Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in person. Develop a network of Black mental health providers to promote equity and reduce stigma and medical mistrust.

DHSP Response:

- Under the HRSA EHE grant, DHSP has secured a contractor who has conducted a Mental Health Needs Assessment. This assessment includes three levels of inquiry: systems, providers, and clients/consumers. Fifteen keyholder interviews were conducted, and surveys were collected from 35 providers and 29 consumers.
- The consultant presented preliminary findings at the October COH meeting and the final report will be available before the end of 2022.
- Based on the results of the Needs Assessment, DHSP will determine next steps to increase availability of mental health services for Black/African American women.
- Three RFPs for Black/African American or Latino MSM, Black/African American cisgender women, and Black/African American transgender were recently released (October 2022)
- To fully accomplish this goal, reform in the educational and reimbursement systems are needed which is outside DHSP's scope.

5. Earmark funds for peer support and psychosocial services for Black gay and bisexual men. The Commission allocated 1% funding for Psychosocial Support Services in PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis. It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American

Revisit and refine directive to provide more detail.

community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community. For 2022, SBP is developing Best Practices for Special Populations with a specific document for Black/African community across multiple service categories.

DHSP Response:

- It would be helpful to obtain more specific information on the programmatic design of these psychosocial services from the COH
- One of the recently released priority population intervention RFPs (through Heluna Health) is for Black/African American MSM. This RFP requires both MH and psychosocial support services in the program model.
- DHSP currently supports one agency that has a robust peer support program and will obtain more information from them on their program model to inform the development of a RFP. A solicitation is scheduled for release in 2023.

Considered complete and ongoing

6. Provide Non-Medical Case Management (NMCM) services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 years). The COH's approved allocations for NMCM for PYs 32, 33, and 34 are as follows: 2.44% Part A and 12.61% MAI. The COH requests a solicitations schedule and updates from DHSP on an annual basis.

DHSP Response:

- DHSP recently released a new RFP (through Heluna Health) to fund mini-projects that will improve linkage to care, diagnoses, or engagement in care. Traditional and non-traditional service sites can be proposed. The RFP also encourages non-traditional HIV providers to apply, and the RFP is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
- Two additional RFPs (through Heluna Health) were released. There is one RFP for ciswomen and another for TG persons. A peer-to-peer model to assist with referrals, access to care, and support services is a component of these new RFPs
- One possible way to improve referral and care coordination is electronically through a new data system. DHSP plans to use EHE funds to procure a new data system in 2023.
- DHSP is also exploring the possibility of developing a program that combines psychosocial and NMCM services
- It would be helpful to obtain more specific information on the programmatic design of the requested NMCM services from the COH

7. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high-quality nutrient-rich fruits, vegetables, and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to

provide grocery, gas, and transportation support (e.g., Metro Tap cards, rideshare services) to clients to facilitate expanded access to food.

Review and revisit. Service Standards were updated 8/10/23. EHE pilot grocery store gift card program implemented 9/24.

DHSP Response:

- The majority of HRSA CARES funds were allocated to nutritional support services for new equipment, food, and PPE
- DHSP has augmented and is currently in the processes of augmenting nutritional support contracts
- Essential non-food items are currently available at DHSP contracted nutritional support providers
- Further enhancement of contracts has been a part of DHSP's investment strategy for RWP funds in 2022

8. Food insecurity affects all people regardless of their HIV status. Support agencies that provide prevention services to have access to and the ability to provide or link clients to foodbanks, food delivery services, and nutritious meals to maintain overall health and wellness. The PrEP navigation system offers a model for linking clients regardless of their status to benefits counseling and leveraging prevention funds to link individuals to wrap- around services and social supports such as housing, transportation, job referrals, legal services, and foodbanks.

Revisit; consider adding training/ capacity building for prevention providers to linkage to services.

DHSP Response:

- DHSP highly recommends that all prevention contractors provide referrals to foodbanks and food delivery services
- DHSP will advocate with CDC and other prevention funders to be more flexible in allowable services/costs

9. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase the target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

Considered complete and ongoing

DHSP Response:

- Intensive Case Management services are available to clients participating in the Housing for Health (MAI Housing) program. Initially, Housing for Health notified DHSP that they had other funding to cover the Intensive Case Management services so it was not part of their DHSP contract.
- DHSP is working with Housing for Health to now cover the costs of Intensive Case Management Services and to expand the number of clients served under this contract. DHSP is waiting for a budget proposal from Housing for Health.

10. Continue to support the expansion of medical transportation services for all individuals regardless of their HIV status.

Considered complete and ongoing; transportation services also covered under Medi-Cal.

DHSP Response:

- Some HTS providers have transportation under their incentive line items. It is up to each provider to request a transportation line item.
- Transportation services are available and an integral part of Linkage and

Reengagement and Rapid and Ready program.
- DHSP RWP transportation contracts allow family members to utilize ride share
- DHSP will ask CDC if transportation is an allowable cost

Considered complete and ongoing; RWP fact sheets and I am positive website creation and dissemination

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

DHSP Response:
- RWP Fact Sheets for each service category are currently available on online in both English and Spanish language. These documents will be included in the welcome packet.
- Under the HRSA EHE grant, DHSP has contracted with Heluna Health and the client eligibility cards are one of the scope of work items. The Heluna Health contract was approved within the past 45 days.
- Additionally, the proposed data system will also contain eligibility information to further reduce the paperwork burden on clients

Childcare RFP released and announced twice; no applications received. Revisit; consider DHSP to explore alternative methods to provide childcare

12. Augment contracts to permit agencies to have an operational line-item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Explore funding informal childcare for Medical Care Coordination (MCC) programs for maximum flexibility. The County's Department of Public and Social Services administers a program under CalWORKs that provides childcare allowances to foster care parents. This model may provide insights on a possible contractual or administrative mechanism to expand childcare options using Ryan White or Net County Cost funding.

DHSP Response:
- RWP transportation contracts currently exist
- The Childcare RFP is in development with new services starting in 2023

Implemented and ongoing; EFA allocation increased for PY34. EHE pilot of grocery store gift cards program.

13. Continue to expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM, and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

DHSP Response:
- All eligible PLWDH can obtain EFA regardless of which RWP service they utilize. Thus, all MCC clients can apply for EFA and a line item is not necessary
- All MCC providers (subrecipients) will be eligible to apply for a Childcare Services contract

- Note: Although not considered EFA, a contingency management program (iCARE) was launched in August 2022. This program provides financial incentives in the form of store gift cards for successfully reaching milestones in HIV care including appointment attendance, lab draws, linkage to supportive services, achieving and sustaining viral suppression for youth (age 30 or younger) and women of child bearing age that are enrolled in the Linkage and Reengagement Program (LRP).

14. Fund mobile care teams or clinics that provide holistic care for women living with HIV. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged. Mobile clinics should aim to be all-inclusive and include bilingual services, STI services, linkages to clinics for ongoing care, STI/HIV testing, PrEP, mammograms, health education, and made availability to women of all ages. Mobile clinics should have the capacity to provide community referrals to food, childcare, housing, recreation and wellness resources, and other support services. Explore partnering with existing street medicine programs to enhance mobile care teams specifically designed for women.

Street medicine teams currently being established; revise to explore how specific population needs can be addressed.

DHSP Response:

- DHSP is assessing the current mobile unit inventory and discussing the type and quantity of mobile units needed
- Beginning in 2019 DHSP staff developed and implemented the POWER project. The goal of the POWER Project is the identification and treatment of women with undiagnosed and/or untreated HIV or syphilis infection who may not otherwise be tested in routine healthcare settings through partnership with County agencies and community-based organizations across Los Angeles County serving women with substance use disorder (SUD), experiencing mental health challenges or experiencing homelessness to provided HIV and STI testing and treatment to these women and their partners. DPH identified three Partner Models for expanding testing and treatment in this population: CBO with DPH staff, street based medicine provider model, and hybrid model (still in development). This project is still ongoing.
- DHSP is collaborating with the USC Street Medicine Group to provide street medicine based services to PLWDH. The program will be called the HIV Transition of Care Project and the contract is currently under review.

15. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support to build a stronger sense of community, empowerment, and resilience among women living with HIV. Maximize access to psychosocial and support group services by offering services remotely and in person. The Commission allocated 1% funding for Psychosocial Support Services for PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis.

Review and revisit psychosocial support services; refine to provide more detail, if needed.

DHSP Response:

- Two recently released RFPs recommend peer models for cisgender and transgender women

- A DHSP consultant is training DHSP staff and providing psychosocial and mental health services for women enrolled in the LRP program
- It would be helpful to obtain more specific information on the programmatic design of these psychosocial services from the COH

Review and revisit

16. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program and integrate the HIV and Aging care framework developed by the Aging Task Force. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, who experience aging-related issues earlier in life (before age 50). See Attachment C for the HIV and Aging Framework.

DHSP Response:

- A DHSP workgroup will be developed to review this directive. A progress update will be provided to the Aging Caucus in January 2023.

Review and revisit

17. Integrate a geriatrician in medical home teams and establish a coordination process for specialty care services for older adults living with HIV.

DHSP Response:

- DHSP is currently reviewing Homebased Case Management Services with the intent of developing a new RFP.

by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

ons (PY 32) (1)				FY 2023 RW Allocations (PY 33)(2)			FY 2024 RW Allocation (PY 34)(2)		
	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI % (3)	Part A %	MAI %	Total Part A/ MAI % (3)
ies	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
ed	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
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	0.65%	0.00%	0.60%	0.65%	0.00%		0.65%	0.00%	
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	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
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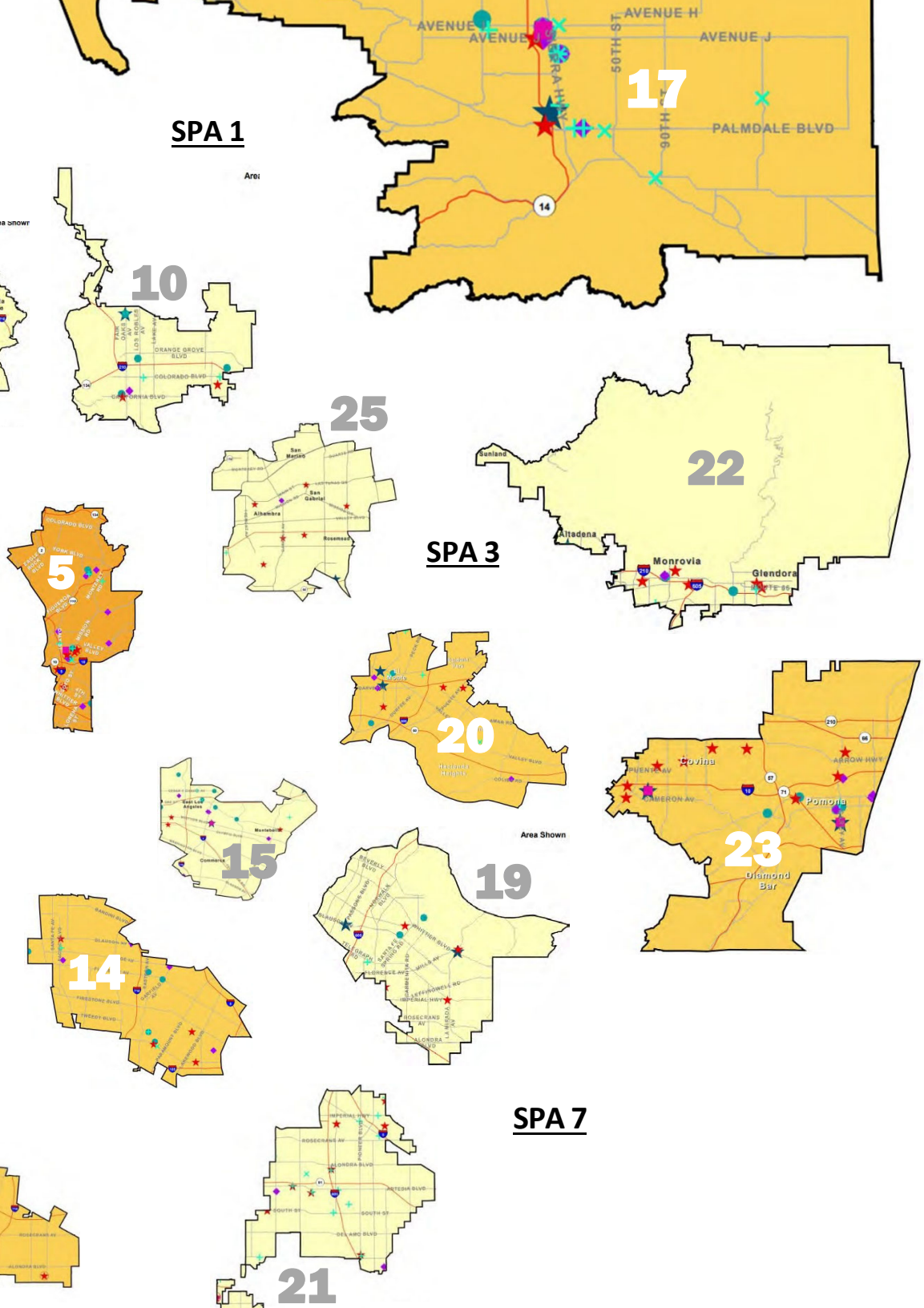
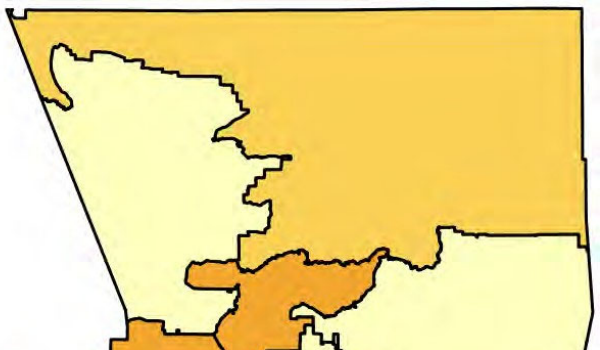


Los Angeles County HIV/AIDS Strategy Goals

By 2022:

1. Reduce annual HIV infections by 500
2. Increase diagnoses to at least 90%
3. Increase viral suppression to 90%



Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21; COH approved on 11/18/21)

STRATEGIES:

1. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for ALL older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, experience aging-related issues earlier in life (before age 50) .

2. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program.

3. Integrate a geriatrician in medical home teams.

4. Establish coordination process for specialty care.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21)

Assessments and Screenings			
Mental Health	Hearing	HIV-specific Routine Tests	Immunizations
Neurocognitive Disorders/Cognitive Function	Osteoporosis/Bone Density	Cardiovascular Disease	Advance Care Planning
Functional Status	Cancers	Smoking-related Complications	
Frailty/Falls and Gait	Muscle Loss & Atrophy	Renal Disease	
Social Support & Levels of Interactions	Nutritional	Coinfections	
Vision	Housing Status	Hormone Deficiency	
Dental	Polypharmacy/Drug Interactions	Peripheral Neuropathologies	

From Golden Compass Program

From Aging Task Force/Commission on HIV

Screenings & Assessment Definitions

- HIV-specific Routine Tests
  - HIV RNA (Viral Load)
  - CD4 T-cell count
- Screening for Frailty
  - Unintentional weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, weak grip strength
- Screening for Cardiovascular Disease
  - Lipid Panel (Dyslipidemia)
  - Hemoglobin A1c (Diabetes Mellitus)
  - Blood Pressure (Hypertension)
  - Weight (Obesity)
- Screening for Smoking-related Complications
  - Lung Cancer - Low-Dose CT Chest
  - Pulmonary Function Testing, Spirometry (COPD)

Screening for Renal Disease

  - Complete Metabolic Panel
  - Urinalysis
  - Urine Microalbumin-Creatinine Ratio (Microalbuminuria)
  - Urine Protein-Creatinine Ratio (HIVAN)
- Screening for Coinfections
  - Injection Drug Use
  - Hepatitis Panel (Hepatitis A, B, C)
  - STI - Gonorrhea, Chlamydia, Syphilis

Screenings & Assessment Definitions (continued)

- Screening for Osteoporosis
  - Vitamin D Level
  - DXA Scan (dual-energy X-ray absorptiometry)
  - FRAX score (fracture risk assessment tool)
- Screening for Male and Female Hormone Deficiency
  - Menopause, decreased libido, erectile dysfunction, reduced bone mass (or low-trauma fractures), hot flashes, or sweats; testing should also be considered in persons with less specific symptoms, such as fatigue and depression.
- Screening for Mental Health Comorbidities
  - Depression – Patient Health Questionnaire (PHQ)
  - Anxiety – Generalized anxiety disorder (GAD), Panic Disorder, PTSD
  - Substance Use Disorder - Opioids, Alcohol, Stimulants (cocaine & methamphetamine), benzodiazepines
  - Referral to LCSW or MFT
  - Referral to Psychiatry
- Screening for Peripheral Neuropathologies
  - Vitamin B12
  - Referral to Neurology
  - Electrodiagnostic testing
- Screening for Sexual Health

Other Suggestions from ATF/COH Discussions

- Screen patients for comprehensive benefits analysis and financial security
- Assess patients if they need and have access to caregiving support and related services
- Assess service needs for occupational and physical therapy (OT/PT) and palliative care
- Review home-based case management service standards for alignment with OT and PT assessments
- Establish a coordinated referral process among DHSP-contracted and partner agencies
- Collaborate with the AIDS Education Training Centers to develop training for HIV specialist and geriatricians.