LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, January 18, 2022
1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

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https://tinyurl.com/bd4bpjrh

**Link is for non-Committee members only*

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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 hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, JANUARY 18, 2022|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/bd4bpjrh
**Link is for non-committee members only*
To Join by Phone: 1-415-655-0001
Access code: 2594 268 6045

Planning, Priorities and Allocations Committee Members:			
Frankie Darling Palacios, Co-Chair	Kevin Donnelly, Co-Chair	Al Ballesteros, MBA	Felipe Gonzalez
Joseph Green	Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray	Jesus "Chuy" Orozco	LaShonda Spencer, MD
Damone Thomas	Guadalupe Velasquez, (LOA)	DHSP Staff	
QUORUM:	8		

AGENDA POSTED: January 13, 2022

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

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 hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. 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 Commission on HIV 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 Comisión en HIV al (213) 738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 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, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

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

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

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

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

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

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

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

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:20 P.M. – 1:30 P.M.

6. CO-CHAIR REPORT 1:30 P.M. – 1:45 P.M.

a. Co-Chair Nominations/Elections

b. 2022 Workplan **MOTION #3**

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:45 P.M. – 2:00 P.M.

a. Minority AIDS Initiative (MAI)

i. Three years of MAI Expenditures and Demographics by Service Category

b. Emergency Financial Assistance (EFA) Expenditure and Client Demographics

ii. EFA Expenditures and Demographics

V. DISCUSSION 2:00 P.M. – 2:30 P.M.

8. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. Ryan White Part A, MAI, and Prevention Programs

9. COMPREHENSIVE HIV PLAN (CHP) 2:30 P.M. – 2:50 P.M.

a. Address Integrated Plan Questions, Activities for Completing the Plan, Ways to Reduce Duplication of Effort and Steps for Plan Alignment

VI. NEXT STEPS 2:50 P.M. – 2:55 P.M.

10. Task/Assignments Recap

11. Agenda Development for the Next Meeting

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

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

VIII. ADJOURNMENT 3:00 P.M.

13. Adjournment for the Meeting of January 18, 2022.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve Meeting Minutes as presented or revised.
MOTION #3:	Approve the Planning, Priorities and Allocation Committee 2022 Workplan, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 12/06/21

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

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

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

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

November 16, 2021

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

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

Meeting agenda and materials can be found on the Commission's website at https://tinyurl.com/y7sakk9a

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Kevin Donnelly and Frankie Darling Palacios, Committee Co-Chairs, called the meeting to order at approximately 1:06 PM. Members introduced themselves and stated their conflicts of interest.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

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

2. APPROVAL OF MEETING MINUTES

MOTION #2: The Committee approved the October 19, 2021 meeting minutes. Minutes can be amended up to 1 year after approval. **(Passed by Consensus)**

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

There were no new business items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Operational Updates

The Committee was reminded of the Annual Meeting scheduled for Thursday, November 18, 2021. Members were encouraged to share meeting information with the community consumers. The meeting will include an update on Ending the HIV Epidemic activities, the Arming Minorities Against Addiction & Disease (AMAAD) Community Engagement project, HIV cluster detection, street medicine and HIV and aging.

The Committee was reminded the December Commission meeting is cancelled. The Operations and Executive Committees have elected to meet on December 9, 2021. Staff will send meeting notifications.

The Board of Supervisors (BOS) votes monthly on continuing virtual meetings. It is anticipated BOS will approve virtual meetings through December 2021. Staff will notify members of any changes in BOS policy.

6. CO-CHAIR REPORT

a. Co-Chair Nominations/Elections

Nominations for Committee Co-Chairs were opened. The term is one year. Committee members can nominate themselves. Committee members are encouraged to submit nominations through Tuesday, January 18, 2022 at which time elections will take place.

Miguel Martinez nominated Dr. William King. Dr. King requested time before accepting the nomination. M. Martinez and Dr. King nominated Kevin Donnelly. K. Donnelly accepted the nomination.

b. Holiday Meeting Schedule (December 21, 2021)

K. Donnelly proposed cancelation of the December 21, 2021 Committee meeting. Dr. Spencer seconded the motion. The motion passed by consensus. The December 21, 2021 meeting is canceled. The next scheduled meeting is Tuesday, January 18, 2022.

c. "So, You Want to Talk about Race" by I. Oluo Reading Activity – Excerpts only from Chapters 16 or 17

K. Donnelly provided the reading from Chapter 16 entitled "I Just Got Called Racist, What Do I Do Now?"

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Minority AIDS Initiative (MAI) Expenditure and Client Demographics

i. Three Years of MAI Expenditures and Demographics by Service Category

Dr. Green announced the Department of Public Health (DPH) has a change in policy. All documents going outside of DPH must be approved to ensure information produced by the Department is consistent. That includes all documents presented to the Commission. K. Donnelly inquired about delays due to the policy change. Dr. Green anticipates no delays.

- DHSP plans to share an in-depth review/analysis of MAI funds to include analysis of expenditures and client statistical data.

b. Emergency Financial Assistance (EFA) Expenditure and Client Demographics

ii. EFA Expenditures and Demographics

An EFA presentation will be provided by DHSP at the annual meeting on Thursday, November 18th as part of the EHE presentation. It will include in aggerate the number of people served as well as the number of applicants and referrals received by providers.

- DHSP will provide a report on EFA to the PP&A Committee at the January 2022 meeting. The report will be provided to the Committee in December 2021 in preparation for January presentation.

Dr. King requested the MAI demographics be extrapolated to identify ethnicities and corresponding funding received by service planning area (SPA) to provide additional data for analysis.

DHSP will review data to determine if information can be extrapolated at a client level. DHSP can provide subcontracted agencies receiving funding and show the geographic distribution of the expenditures. It was noted this information assumes clients are receiving services near where they live.

- DHSP will work with W. Garland to gather data from CaseWatch.

D. Thomas requested clarification on DHSP EFA and MAI presentations. Will the information include those interested in services? Dr. Green clarified the information provided will include those who have begun the application process but not those who have shown an interest but have not started the application process.

V. DISCUSSION

8. PLANNING TASKS

a. Proposed Ryan White Part A and MAI Program Year PY 33 and 34 Service Category Rankings – MOTION #3

K. Donnelly reviewed the Ryan White Program Year 25 Minority AIDS initiative (MAI) Plan provided to DHSP. It was noted, recent Committee discussions regarding MAI funding touched on strategies included in this plan.

K. Donnelly noted the only part of Ryan White funds eligible for rollover is the MAI grant. Part A funds must be spent during the program year. It was noted, this means all funds were not expended. It was recommended, DHSP directives include language to maximize the MAI grant within the allocation program year.

M. Martinez noted the reason for multiyear planning was to develop standards and establish programs with funds that are manageable within the County's contracting restraints.

M. Martinez posed the questions can the Commission allocate within a service category with a target population and service area. The example given was a housing program for Black/African Americans in Willowbrook? Is it possible for the Committee to be intentional in its allocation process? It was noted SPA 1 was specifically targeted for a special program by the Commission in the past.

DHSP confirmed the Committee can make specific allocations that target specific communities. DHSP would be charged with finding agencies that can serve communities identified.

C. Barrit reviewed the planning process. Clarifying allocation percentages and services rankings precedes the creation/refinement of directives.

K. Donnelly clarified the Committee had questions about what could be done with directives prior to determining allocations percentages and service rankings. Additionally, there was some concern as to whether the Committee had enough information to determine allocation percentages and service rankings.

D. Murray recommended the Committee follow the agenda and focus on the Service Category Rankings for PY 33 and 34 rankings. The Committee began ranking PY 33 services based on PY 32 approved rankings. Housing was identified as the number one issue in determining positive health outcomes.

The Committee requested clarification on Consumer Caucus input in determining service category rankings. C. Barrit stated Consumers were consulted and reviewed the PY 32 rankings. It was recommended Consumer Caucus allocations and service rankings prioritize consumer needs.

A. Burton, Consumer Caucus Co-Chair, noted there are no consumer changes to the recommendations. Further, if the Caucus does determine future recommendations require adjustments to address consumer needs, the Caucus is committed to emphasizing those needs.

D. Thomas noted that although there were no current changes housing should be assessed due to increases in unhoused individuals. It was noted the unhoused are increasing. Concern was noted about agencies that are receiving increased funding for housing services, yet homelessness is not decreasing.

F. Gonzalez noted that funding should not be given to providers that are not effective in providing housing. Additionally, providers should be required to provide "proof" that they are housing persons or preventing individuals from being unhoused.

D. Murray noted that the concerns voiced is why housing was ranked #1. Additionally, it was noted the

service category rankings and funding allocations have no correlation. The ranking of the service does send a message that the Commission recognizes housing as a significant need among those living with HIV.

F. Darling Palacios put the following link https://www.lahsa.org/news?article=514-groundbreaking-report-on-black-people-and-homelessness-released in the chat regarding a homelessness study that links to institutional racism to homelessness. The study provides policy recommendations. An example was given regarding an EFA applicant that applied for services in March for a housing deposit but did not receive the funding until October. F. Darling Palacios cited such incidents as indicating the Commission/DHSP need to review the policies for administering housing services.

Dr. Spencer noted, directives could address some of the issues identified around housing and provide an opportunity to make program corrections.

Additionally, it was noted some housing issues related to systems should be directed to Public Policy for systemic policy changes.

Dr. King made a motion to adopt approved PY 32 service category rankings for PYs 33 and 34 with the understanding the Committee can revisit and make modifications to the recommendations as more information is obtained on service performance. D. Murray seconded the motion. Dr. Michael Green and Karl Halfman abstained. Dr. Spencer, Derek Murray, Dr. King, Joe Green, F. Gonzalez, E. Alvarado, F. Darling Palacios, K. Donnelly voted in the affirmative. **Motion #3 was passed.**

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

Motion #4 was introduced by Co-Chair F. Darling Palacios. C.Barrit reviewed the motion and the allocation worksheet the Committee used to determine percentages.

It was suggested the percentages approved for PY 32 be approved for PY 33 and PY34 with the understanding the percentages can and will be modified going forward as more information is obtained on expenditures and performance.

K. Donnelly noted PY 32 allocation percentages will be revisited once the PY 32 awarded is received in 2022. The PY 33 allocation will be reviewed in August 2022 when the application for PY 33 is prepared for submission. It was noted the Committee can revisit allocations not only when the award is received, but also if the needs of the community are being met with approved allocation based on data provided by DHSP.

D. King inquired as to why there was no percentage allocated to Substance Abuse Outpatient and residential services. It was noted this is due to Drug Medi-Cal funding these services. Dr. King further noted a greater need for these services is anticipated due to COVID 19. It is important to have the expenditure information for these services presented to the Committee to enhance future decision-making regarding these services.

Dr. Green noted DHSP had not increased funding in Substance Abuse Residential for the past couple of program years because it was anticipated Drug Medi-Cal would fund the services. DHSP is meeting with

Substance Abuse Prevention and Control (SAPC) on November 29, 2021 to identify gaps in services and to request service data. SAPC has a larger budget than DHSP for Substance Abuse services and may be able to fund any service gaps identified. It was noted, DHSP does receive approximately $3 million per year from SAPC for substance abuse services for those living with HIV.

D. Murray posed the question why the Committee has no allocation for Psychosocial Support Services. It was noted providers in North Hollywood cited a lack of Psychosocial Support Services for the newly diagnosed. The lack of those services reduces the effectiveness of linking individuals to care at time of diagnosis. Thus, the newly diagnosed individuals needing Psychosocial Support Services may not be linked to care for several months or years after their diagnosis.

D. Murray recommended allocating a percentage to Psychosocial Support services. It was noted some of the funding would be for the newly diagnosed. Once the percentage is allocated then directives for the service would include in DHSP directives. It was noted directives can provide a continuity of care and address the racial inequities tied to linkage to care.

It was noted some service categories have funding sources that are not allocated by the Commission. So, services categories with no allocations may be funded through other funding sources.

Dr. Green noted changing PY 33 allocations would not impact service delivery due to the time necessary to contract for services. Thus, the services would be available in PY 34. However, the allocation must be made to have DHSP initiate contracts for the service. The Committee would set the precedence for the service to be provided in future program years.

D. Murray recommended allocating percentage now and review once additional program data is received.

The Committee made a motion to extend the time of the meeting by 15 minutes because additional time was may be needed beyond the meetings scheduled end time. The Committee agreed by consensus.

The recommendations for PY 33 and 34 allocation are to maintain the same allocation for PY 33 and revise PY 34 allocation to include a reduction in to MCC 28% and Oral Health to 17.48% and increase Psychosocial Support Services allocation to 1%. The motion vote was as follows. D. Murray, F. Darling Palacios, Joe Green, K. Donnelly, Dr. Spencer, and Dr. King all voted in the affirmative. **The motion was passed.**

9. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. Ryan White Part A, MAI and Prevention Programs

- K. Donnelly moved that the program directives discussion be agendized on the January 18, 2022 PP&A meeting. F. Darling Palacios seconded the motion.

10. COMPREHENSIVE HIV PLAN (CHP)

a. Address Integrated Plan Questions, Activities for Completing the Plan, Ways to Reduce Duplication of Effort and Steps for Plan Alignment

C. Barrit informed the committee that all committees, taskforces, caucuses, and workgroups are now aware of the CHP and its priority for the Commission. Additionally, based on Committee discussions, no

separate CHP workgroup will be formed. Therefore, CHP will remain a standing item on the agenda for all committees, taskforces, caucuses, and workgroups to keep the work moving forward in the development of the plan. The information gathered will be presented to the PP&A Committee on an ongoing basis.

Additionally, the recommendations from the Black/African American Community (BAAC) Taskforce (TF), Aging TF and Women's Caucus will be reviewed by the CHP consultant to ensure those ideas are integrated into the plan. In addition, ongoing feedback provided by the Consumer and Transgender Caucuses will be incorporated in the CHP.

The COH is coordinating with city partners to align efforts. A meeting is scheduled for Friday, November 19th to meet with Long Beach, Pasadena, Los Angeles, and West Hollywood. All cities have plans addressing HIV which may have elements that can be incorporated and/or aligned with the CHP.

C. Barrit is working with AJ King, CHP consultant, to inform the full Commission and community about the CHP. This is to take place at the full COH meeting in January or February of 2022.

VI. NEXT STEPS

a. Task/Assignment Recap

K. Donnelly noted there are two nominees for Co-Chairs. They are K. Donnelly and Dr. King who will consider the nomination before fully committing.

b. Agenda Development for the Next Meeting

- The Comprehensive Program Directive will be agendized
- The CHP will beagendized

VII. ANNOUNCEMENTS

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

D. Murray announced the City of West Hollywood World AIDS day event. "Warrior Awards" will be awarded to care and prevention frontlines workers. Seven individuals will be honored. The program will be broadcasted on WEHO TV on YTube December 1, 2021 beginning at 6:30PM.

Additionally, "AIDS Watch" will be broadcasted on the WEHO cable station and AIDS watch.org. It will list names of those lost to HIV/AIDS. It will run for 24 hours. Anyone can submit names for display.

VIII. ADJOURNMENT

a. Adjournment:

The meeting ended at 3:10 PM approximately.

LOS ANGELES COUNTY COMMISSION ON HIV

DRAFT - 2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly
Committee Approval Date:	Revision Dates:
Purpose of Work Plan: To focus and prioritize key activities for COH 2022	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Develop the Comprehensive HIV Plan 2022-2026	The Committee will gather, discuss, develop and provide planning priorities for inclusion in the plan.	10/2022	PP&A will continue to agendize the CHP. The Committee is the conduit for information obtained from all Commission Committees and subgroups.
2	Address Areas of Improvement from the HealthHIV Planning Council Effectiveness Assessment	The Committee will engage the broader community in developing and shaping the CHP. in	Ongoing	PP&A is discussing activities to enhance community representation/engagement of underserved populations impacted by HIV in LAC.
3	Strengthen Core Planning Council Responsibilities	The Committee will continue to improve the Commission's prevention and care multi-year planning process and decision-making	Ongoing	PP&A has increased the scope and frequency of data reviewed in the decision-making process to optimize services offered.
4	Develop Strategies for Maximizing Part A and MAI Funding	Monitor, assess and create directives for DHSP to effectively expend Part A and MAI funds to meet the needs of the underserved with specific focus on minority communities.	03/2022 - Ongoing	The Committee has used data provided by DHSP, Ending the HIV Epidemic (EHE) Plan, Transgender, Women and Consumer Caucuses; Black African American Community (BAAC) and Aging Taskforces (TF) recommendations in multi-year planning efforts. PP&A will create specific DHSP Directives for the use of MAI funding to fully expend funds within the allocation program year.

LOS ANGELES COUNTY COMMISSION ON HIV

DRAFT - 2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

	TASK/ACTIVITY	**DESCRIPTION**	**TARGET COMPLETION DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
5	Review, discuss and understand financial information from DHSP	Review and monitor fiscal reports on all HIV funds supporting LAC HIV Care and Prevention services.	Ongoing	The Committee has requested DHSP provide this information on a monthly basis.
6	Annual Progress Report (APR)	Review progress report prepared for Health Resources and Services Administration (HRSA) by DHSP	08/2022	
7	Rank Service Categories for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Rank (HRSA) Ryan White services numerically and obtain Commission approval to provide service rankings to DHSP for program implementation.	08-2022	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before ranking services.
8	Allocations for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Determine financial resource allocation percentages for HRSA ranked services and obtain Commission approval to provide to DHSP for program implementation.	08/2022	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before determining funding allocations.
9	Prevention Planning	Develop integrated prevention and care planning strategies. Participate in the CDC prevention application process by recommending strategies for inclusion in the CDC prevention plan.	Ongoing	The committee established a Prevention Planning Workgroup to prepare short- and long-term prevention activities for recommendation to DHSP; DHSP to provide prevention data

Utilization of Selected Ryan White Services by Minority AIDS Initiative Subpopulations of Focus and Other Subpopulations of Importance

BACKGROUND

As a Ryan White Program (RWP) Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives supplemental Minority AIDS Initiative (MAI) resources from the federal Health Resources and Services Administration (HRSA) to increase access to core medical and related support services and reduce disparities in health outcomes among persons of color living with HIV. The amount of the award is based on the number of people of color living with diagnosed HIV residing within a jurisdiction. MAI funds represent approximately 8.3% of the $43.9 million combined MAI ($3.6 million) and Part A ($40.3 million) award for FY 2021.

HRSA requires that each eligible metropolitan area and transitional grant area (EMA/TGA) identify MAI subpopulations of focus based on local epidemiologic and programmatic data. For LAC, there are three MAI subpopulations:

1. Cisgender men of color aged 30 or older who have sex with men (MSM of color ≥ age 30)
2. Cisgender men of color aged 18- 29 years who have sex with men (YMSM of color), and
3. Transgender persons (Trans clients)

Additional important minority subpopulations impacted by HIV (but who are not included in the defined MAI subpopulations include) cisgender women of color, heterosexual cisgender men of color, and people who use injection drugs (PWID).

This report is a follow-up to a presentation on RWP service utilization by MAI subpopulations at the October 19, 2021 meeting of the Planning, Priorities and Allocation (PP&A) Committee of the Los Angeles County Commission on HIV (COH). That presentation described who was being served through LAC RWP overall and among the three MAI subpopulations. This report expands on that presentation by:

1. Including cisgender women of color, heterosexual cisgender men of color and PWID as subpopulations of importance (in addition to the three MAI subpopulations).
2. Providing service utilization data that includes total service units used and service units per client for selected RWP service categories to determine whether there are differences in how services are used among MAI subpopulations compared to all RWP clients and other subpopulations.
3. Estimating expenditures per client and subpopulation for the selected service categories to determine the amount spent to provide services to MAI and other minority subpopulations and all RWP clients.

The service categories for initial evaluation will include:

Top Funded Services (all funding sources)	Services Supported with MAI Funds	Service Used by Largest Percent of MAI Subpopulations
Ambulatory Outpatient Medical	**Non-Medical Case Management:** Transitional Case Management – Jails	Mental Health
Medical Care Coordination		
Benefit Specialty	**Housing:** Permanent Supportive Housing [Housing for Health]	
Oral Health		

INDICATORS

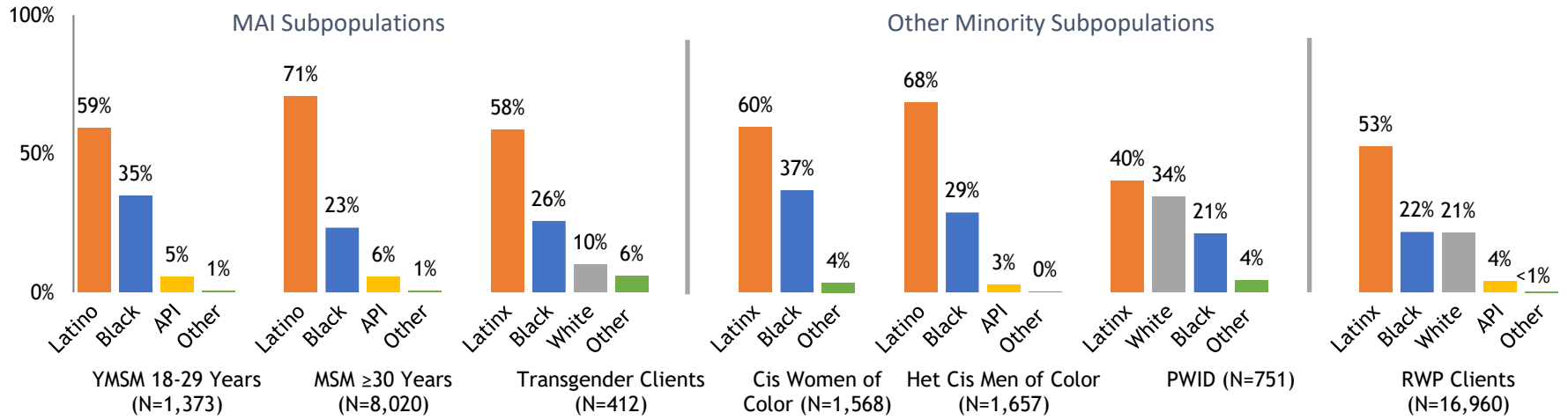
The following indicators will be used to describe service utilization and estimate expenditures. Service units vary by service category and may include visits, hours, procedures, days, or sessions and are indicated in each table below.

- Total service units=Number of service units paid for by DHSP in the reporting period (Year 30)
- Percent of service units=Total service units/number of service units per subpopulation
- Service units per client=Total service units/Number of clients
- Expenditure per service unit=Total expenditures/Total service units
- Expenditures per Client=Service units per client * Expenditure per service unit
- Expenditures per Subpopulation=Total service units*Expenditure per service unit

SUBPOPULATIONS

As shown below, the largest subpopulation in Year 30 was MSM of color ≥30 years who represent nearly half of all RWP clients. Latinx and Black clients make up most of each subpopulation, except PWID, where the majority was Latinx and White. Latinx and White clients also represented the majority of the total RWP client population.

Figure 1. Minority AIDS Initiative Subpopulations by Race/Ethnicity compared to Other Minority Subpopulations and Ryan White Clients aged ≥ 13 years, LAC, Year 30 (March 1, 2020-February 28, 2021)[1,2]



[1]Other race/ethnicity may include American Indian, Alaskan Natives, Asian/Pacific Islander (API) and persons of multiple race/ethnicities; [2]Total percentage may exceed 100% due to rounding

MEDICAL CARE COORDINATION (MCC)

Year 30 Funding Sources: RWP Part A (99%), **MAI (<1%)**
Percentage of RWP Clients Accessing MCC in Year 30: 49%
Unit of Service: Hours

Table 1 Highlights

- *Population Served:* Over half of clients using MCC services in Year 30 were MSM of color (55%) - 45% were MSM of color ≥ age 30 and 11% were YMSM of color.
- *Service Utilization:*
  - Over half of the total MCC hours were used by MSM of color ≥ age 30 (56%).
  - Hours per client were highest among PWID (21.3 hours per client) and heterosexual women of color (21.3 hours per client) compared to total MCC clients and other subpopulations.
  - Despite representing the largest percentage of MCC clients, MSM of color ≥ age 30 used the lowest number of MCC hours per client.
- *Expenditures:* While estimated expenditures per client were highest among PWID, the largest estimated expenditure by subpopulation was among MSM of color ≥ age 30.

Table 1: MCC Hours per Ryan White Program Client, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	Clients, N	*Clients, %[a]*	*Total Hours*	*% of Hours*	*Hours Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total MCC Clients	**8,350**	**100%**	**118,793**	**100%**	**14.2**	**$1,550.93**	**$12,950,275.00**
Cisgender MSM of Color age 18-29 (YMSM)	893	11%	12,891	11%	14.4	$1,573.65	$1,405,271.58
Cisgender MSM of Color ≥ age 30	3,720	45%	49,782	42%	13.4	$1,458.87	$5,427,002.79
Transgender Clients[b]	263	3%	5,364	5%	20.4	$2,223.38	$584,748.09
Cisgender Women of Color	569	7%	12,040	10%	21.2	$2,306.71	$1,312,515.76
Heterosexual Cisgender Men of Color[b]	628	8%	10,705	9%	17.0	$1,858.31	$1,167,016.08
People Who Inject Drugs (PWID)	397	5%	8,475	7%	21.3	$2,327.21	$923,902.86

[a]Describes percent among total clients in service category.
[b]Includes clients who identify as transgender women (n=258) or transgender men (n=5).
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting.
[d]Based on cost per hour estimated at $109 (total hours divided by total estimated expenditures).

AMBULATORY OUTPATIENT MEDICAL (AOM)

Year 30 Funding Source: RWP Part A (100%), **MAI (0%)**
Percentage of RWP Clients Accessing AOM in Year 30: 33%
Service Unit: Visits

Table 2 Highlights

- *Population Served:* Approximately half of clients accessing AOM services were MSM of color ≥ age 30 (54%).
- *Service Utilization:*
  - Over half of the total AOM visits were attended by MSM of color ≥ age 30 (56%).
  - Visits per client were highest among PWID (3.4 visits per client) and lowest among YMSM of color (2.7 visits per client) compared to total AOM clients and other subpopulations.
- *Expenditures:* While estimated expenditures per client were highest among PWID compared to total AOM clients and other subpopulations, the largest estimated expenditure by subpopulation was among MSM of color ≥ age 30.

Table 2: AOM Visits per Ryan White Program Client, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	N	*%[a]*	*Total Visits*	*% of Total Visits*	*Visits Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total AOM Clients	**5,653**	**100%**	**16,973**	**100%**	**3.0**	**$1,635.00**	**$9,252,137**
Cisgender MSM of Color age 18-29 (YMSM)	422	8%	1,157	7%	2.7	$1,471.50	$630,565
Cisgender MSM of Color ≥ age 30	3,044	54%	9,578	56%	3.1	$1,689.50	$5,220,010
Transgender Clients[b]	96	2%	302	2%	3.1	$1,689.50	$164,590
Cisgender Women of Color	625	11%	1,884	11%	3.0	$1,635.00	$1,026,780
Heterosexual Cisgender Men of Color[b]	773	14%	2,219	13%	2.9	$1,580.50	$1,209,355
People Who Inject Drugs (PWID)	110	2%	377	2%	3.4	$1,853.00	$183,665

[a]Describes percent among total clients in service category.
[b]Includes clients who identify as transgender women (n=94), transgender men (n<5).
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting.
[d]Based on cost per visit estimated at $545 (total visits divided by total estimated expenditures).

BENEFITS SPECIALTY SERVICES (BSS)

Year 30 Funding Sources: RWP Part A (100%), **MAI (0%)**
Percentage of RWP Clients Accessing BSS in Year 30: 27%
Unit of Service: Hours

Table 3 Highlights

- *Population Served:* Half of BSS clients in Year 30 were MSM of color ≥ age 30 (50%) followed by heterosexual cisgender men of color (9%).
- *Service Utilization:*
  - Nearly half of the total BSS hours were used by MSM of color ≥ age 30 (45%).
  - Hours per client were highest among PWID (7.4 hours per client) and transgender clients (6.5 hours per client) compared to total BSS clients and other subpopulations.
  - Despite representing the largest percentage of BSS clients, utilization by hours per client was lowest among MSM of color ≥ age 30.
  - PWID represented 4% of BSS clients however they accounted for 8% of total service hours.
- *Expenditures:* While estimated expenditures per client were highest among PWID, the largest estimated expenditure by subpopulation was among MSM of color ≥ age 30.

Table 3: BSS Hours per Ryan White Program, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	N	*%[a]*	*Total Hours*	*% of Hours*	*Hours Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total BSS Clients	**4,542**	**100%**	**16,353**	100%	**3.6**	**$296**	**$1,345,389**
Cisgender MSM of Color age 18-29 (YMSM)	333	7%	1,135	7%	3.4	$280	$93,371
Cisgender MSM of Color ≥ age 30	2,287	50%	7,392	45%	3.2	$266	$608,135
Transgender Clients[b]	73	2%	472	3%	6.5	$532	$38,846
Cisgender Women of Color	384	8%	1,910	12%	5.0	$409	$157,159
Heterosexual Cisgender Men of Color[b]	426	9%	2,021	12%	4.7	$390	$166,243
People Who Inject Drugs (PWID)	186	4%	1,369	8%	7.4	$606	$112,629

[a]Describes percent among total clients in service category
[b]Includes clients who identify as transgender women (n=73), transgender men (n=0).
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting
[d]Based on cost per hour estimated at $82.27 (total hours divided by total estimated expenditures).

ORAL HEALTH

Year 30 Funding Sources: RWP Part A (100%), **MAI (0%)**
Percentage of RWP Clients Accessing Oral Health in Year 30: 20%
Unit of Service: Procedures

Table 4 Highlights

- *Population Served:* Half of clients accessing Oral Health services in Year 30 were MSM of color ≥ age 30.
- *Service Utilization:*
  - Nearly half of total Oral Health procedures were used by MSM of color ≥ age 30 (45%).
  - Transgender clients had the highest number of procedures per client (9.5) compared to all Oral Health clients and other subpopulations.
- *Expenditures:* While estimated expenditures per client were highest among Transgender clients, the largest estimated expenditure by subpopulation was among MSM of color ≥ age 30.

Table 4: Oral Health Procedures per Ryan White Program, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	N	*%[a]*	*Total Procedures*	*% of Procedures*	*Procedures Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total Oral Health Clients	**3,377**	**100%**	**29,424**	**100%**	**8.7**	**$1,951**	**$6,587,521**
Cisgender MSM of Color age 18-29 (YMSM)	107	3%	889	3%	8.3	$1,860	$199,032
Cisgender MSM of Color ≥ age 30	1,736	51%	15,436	52%	8.9	$1,991	$3,455,851
Transgender Clients[b]	67	2%	638	2%	9.5	$2,132	$142,837
Cisgender Women of Color	352	10%	2,975	10%	8.5	$1,892	$666,051
Heterosexual Cisgender Men of Color[b]	303	9%	2,693	9%	8.9	$1,990	$602,916
People Who Inject Drugs (PWID)	135	4%	1,143	4%	8.5	$1,896	$255,898

[a]Describes percent among total clients in service category.
[b]Includes clients who identify as transgender women (n=66), transgender men (n<5).
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting.
[d]Based on cost per procedure estimated at $223.88 (total procedures divided by total estimated expenditures).

PERMANENT SUPPORTIVE HOUSING (Housing)

Year 30 Funding Sources: RWP Part A (0%), **MAI (100%)**
Percentage of RWP Clients Accessing Housing in Year 30: <1%
Unit of Service: Days

Table 5 Highlights

- *Population Served:* The largest percentages of RWP clients accessing Housing Services in Year 30 were MSM of color ≥ age 30 (20%) and PWID (17%).
- *Service Utilization:*
  - Over half of the total Housing days were used by MSM of color ≥ age 30 (56%).
  - Days per client were higher among Heterosexual Cisgender Men of Color (298 days per client) and MSM of color ≥ age 30 (294 days per client) compared to total Housing clients and other subpopulations.
- *Expenditures:* While estimated expenditures per client were highest among PWID, the largest estimate expenditure by subpopulation was among MSM of color ≥ age 30.

Table 5: Permanent Supportive Housing Days per Ryan White Program, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	N	*%[a]*	*Total Days*	*% of Days*	*Days Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total Housing Clients	**147**	**100%**	**39,839**	**100%**	**271**	**$19,818**	**$2,913,290**
Cisgender MSM of Color age 18-29 (YMSM)	3	2%	745	2%	248	$18,160	$54,479
Cisgender MSM of Color ≥ age 30	29	20%	8,515	21%	294	$21,471	$622,673
Transgender Clients[b]	17	12%	4,343	11%	255	$18,682	$317,589
Cisgender Women of Color	18	12%	4,382	11%	243	$17,802	$320,441
Heterosexual Cisgender Men of Color[b]	19	13%	5,658	14%	298	$21,776	$413,750
People Who Inject Drugs (PWID)	25	17%	4,487	11%	179	$13,125	$328,119

[a]Describes percent among total clients in service category
[b]Includes clients who identify as transgender women (n=15) or transgender men (n<5)
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting
[d]Based on expenditure per day estimated at $73.13 (total procedures divided by total estimated expenditures).

TRANSITIONAL CASE MANAGEMENT – JAILS (TCM-JAILS)

Year 30 Funding Sources: RWP Part A (0%), **MAI (100%)**
Percentage of RWP Clients Accessing TCM-Jails in Year 30: 3%
Unit of Service: Days

Table 6 Highlights

- *Population Served:*
  - The largest percentages of RWP clients accessing TCM Jails in Year 30 were MSM of color ≥ age 30 (25%) and Heterosexual Cisgender Men of Color (17%).
  - The low percentage of Cisgender Women of Color using TCM-Jails may a reflect limited access to TCM-Jails services in the Women's jails given lower service need compared to men. Historically, Transitional Case Managers have been based at the men's jails versus the women's jail (Century Regional Detention Facility (CRDF)) given the low number of women living with HIV identified at CRDF. This service arrangement merits additional review.
- *Service Utilization:*
  - Approximately a quarter of the total TCM-Jails hours were used by MSM of color ≥ age 30 (26%).
  - Hours per client were highest among Transgender clients (4.7 hours per client) and lowest among Cisgender Women of Color (2.8 hours per client) compared to total TCM-Jails clients and other subpopulations.
- *Expenditures:* While estimated expenditures per client were highest among Transgender clients, the largest estimated expenditure by subpopulation was among MSM of color ≥ age 30.

Table 6: Transitional Case Management-Jails Hours per Ryan White Program, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	N	*%[a]*	*Total Hours*	*% of Hours*	*Hours Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total TCM Jails Clients	**476**	**100%**	**1,648**	**100%**	**3.5**	**$1,377**	**$655,294**
Cisgender MSM of Color age 18-29 (YMSM)	42	9%	154	9%	3.7	$1,455	$61,092
Cisgender MSM of Color ≥ age 30	120	25%	436	26%	3.6	$1,444	$173,301
Transgender Clients[b]	18	4%	84	5%	4.7	$1,850	$33,295
Cisgender Women of Color	22	5%	61	4%	2.8	$1,106	$24,322
Heterosexual Cisgender Men of Color[b]	82	17%	281	17%	3.4	$1,364	$111,879
People Who Inject Drugs (PWID)	56	12%	205	12%	3.7	$1,456	$81,538

[a]Describes percent among total clients in service category.
[b]Includes clients who identify as transgender women (n=18), transgender men (n=0).
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting
[d]Based on expenditure per hour estimated at $397.55 (total procedures divided by total estimated expenditures).

MENTAL HEALTH SERVICES (MH)

Year 30 Funding Sources: RWP Part A (99%), other (<1%), **MAI (0%)**
Percentage of RWP Clients Accessing MH in Year 30: 2%
Unit of Service: Sessions

Table 7 Highlights

- *Population Served:* Over half of RWP clients accessing MH Services in Year 30 were MSM of color ≥ age 30 (56%)
- *Service Utilization:*
  - Over half of the total MH sessions were used by MSM of color ≥ age 30 (56%).
  - Cisgender women of color represented 9% of the clients accessing MH services however they received 16% of total sessions
  - Sessions per client were highest among cisgender women of color (17.1 sessions per client) compared to total Housing clients and other subpopulations.
  - Despite representing the largest percentage of MCC clients, utilization by hours per client was lowest among MSM of color ≥ age 30.
- *Expenditures:* While estimated expenditures per client were highest among cisgender women of color, the largest estimate expenditure by subpopulation was among MSM of color ≥ age 30.

Table 7: MH Sessions per Ryan White Program, RWP Year 30 (March 1, 2020-February 28, 2021), Los Angeles County

	N	*%[a]*	*Total Sessions*	*% of Sessions*	*Sessions Per Client*	*Estimated Expenditures per Client[d]*	*Estimated Expenditures by Subpopulation[d]*
Total Mental Health Clients	**312**	**100%**	**3,168**	**100%**	**10.2**	**$1,317**	**$410,978**
Cisgender MSM of Color age 18-29 (YMSM)	27	9%	112	4%	4.1	$538	$14,530
Cisgender MSM of Color ≥ age 30	174	56%	1,762	56%	10.1	$1,314	$228,581
Transgender Clients[b]	12	4%	105	3%	8.8	$1,135	$13,621
Cisgender Women of Color	29	9%	495	16%	17.1	$2,214	$64,215
Heterosexual Cisgender Men of Color[b]	24	8%	230	7%	9.6	$1,243	$29,837
People Who Inject Drugs (PWID)	17	5%	260	8%	15.3	$1,984	$33,729

[a]Describes percent among total clients in service category.
[b]Includes clients who identify as transgender women (n=12) or transgender men (n=0).
[c]Heterosexual orientation estimated from HIV risk category and may be subject to incomplete reporting.
[d]Based on cost per session estimated at $129.73 (total sessions divided by total estimated expenditures).

KEY FINDINGS

Service use and expenditures vary by subpopulation within each service category. This variation may be influenced by the subpopulation size, underlying characteristics within each subpopulation such as health status, income, housing status or neighborhood of residence, service need or service access. While unmet service need is not reported directly by clients, it can be indirectly estimated as demonstrated need by looking at higher use relative to population size (percentage of subpopulation using the service compared to percentage of total service hours received by that subpopulation) and service units used per client. Key findings for each subpopulation are highlighted below.

- YMSM of color
  - YMSM of color represent 8% of total RWP clients
  - MCC, AOM and BSS were used by the largest numbers of YMSM color however they had some of the lowest per client service utilization of these services compared to other subpopulations or all RWP clients.
  - Service utilization was low among YMSM of color for OH and Housing services.
  - While 9% of MH clients were YMSM of color, they only accounted for 4% of MH services provided and had the lowest per client service units and expenditures.
  - Reasons for low service utilization are unclear but may reflect poor service engagement, low service access, effective service provision, low acuity, stigma or other client, provider or system-level determinants.

- MSM of color ≥ age 30
  - The highest number of clients served in each service category and total estimated expenditures by subpopulation was among MSM of color ≥ age 30. This is consistent with them being the largest subpopulation representing 42% of all RWP clients.
  - Despite their population size, MSM of color ≥ age 30 generally represented lower expenditures per client compared to other subpopulations or all RWP clients suggesting lower utilization of services.

- Transgender clients
  - Despite making up a small percentage (2%) of the total RWP client population, transgender clients had some of the highest per client utilization of MCC, BSS and TCM. This utilization is consistent with data presented in the previous MAI presentation that higher percentages of transgender clients experienced poverty and recent incarceration in Year 30 compared to other MAI subpopulations.
  - The previous MAI presentation reported that 25% of transgender clients experienced homelessness in Year 30 compared to 11% for all RWP clients. Approximately 12% of Housing clients were transgender suggesting increased need for these services. Despite the demonstrated need, transgender clients received fewer housing days per client compared to all RWP clients.

- Cisgender women of color
  - Cisgender women of color were high utilizers of MCC and BSS as demonstrated by the percentage of total service hours they received and the number of service hours per client.
  - They were the highest utilizers of MH services – while 9% of MH clients were cisgender women of color, they used 16% of total service hours provided and they had the highest per client utilization of and expenditures for MH services compared with other subpopulations and all RWP clients.
  - Low use of TCM-jails services may be due to low numbers of cisgender women of color living with HIV in these facilities rather than low service need.

- Heterosexual cisgender men of color
  - Heterosexual cisgender men of color were the highest utilizers of Housing services using the highest number of days per client. As a result, they also reflected the highest per client expenditures even though they only represented 13% of Housing clients.
  - The second largest subpopulation using TCM-jails was heterosexual cisgender men of color, however they received the lowest per client service hours after cisgender women of color.

- PWID
  - Despite accounting for 4% of total RWP clients, PWID were the highest utilizers of MCC and BSS compared to other subpopulations or total RWP clients. They also had the highest expenditures per client and total expenditure per subpopulation for these services.
  - For AOM services, PWID accounted for 2% of total AOM clients but had the highest per client utilization and expenditures.
  - PWID were lower utilizers of OH services compared to all RWP clients.
  - While a large percentage of Housing services clients were PWID in Year 30 (17%), service utilization was low. They accounted for only 11% of total housing days and had the lowest per client utilization of all subpopulations. The reason for lower utilization despite demonstrated service need is not clear but may be eligibility criteria related to substance use in the program or housing facilities or clients dropping out of services due to substance use.

Quick Reference Handout 5.2: Directives

RWHAP Legislative Requirements

One of the duties of a Ryan White HIV/AIDS program (RWHAP) Part A planning council (PC)* is to

> *"...establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a recipient should consider in allocating funds" [Legislation, Section 2602(b)(4)(C)]*

Directives address *how best to meet* the priorities established by the planning council.

**Planning bodies provide recommendations rather than serving as decision makers, but sound practice is for both PCs and PBs to develop directives.*

Purpose and Focus of Directives

Directives help strengthen the system of care. They provide written guidance to the recipient from the PC/PB regarding how best to meet specific service priorities established as part of the priority setting and resource allocation (PSRA) process, and other factors the recipient should consider in arranging for services. Often, directives address identified barriers to care or disappointing health care system performance on measures and clinical outcomes such as linkage to care, retention in care, adherence to medications, and viral suppression, overall or for particular PLWH populations or geographic areas.

Most directives focus on one or more of the following:

1. **Geographic targeting:** ensuring availability of services in all parts of the EMA/TGA or in a particular county or area

   Examples of directives:
   - *RWHAP-funded outpatient ambulatory health services (HIV-related medical care) must be available within each county in the EMA/TGA, either through facilities located in the county or through other methods such as use of mobile vans or out-stationing of personnel.*
   - *Oral health care must be accessible to PLWH in the EMA/TGA regardless of where they live.*
   - *Mental health and outpatient substance abuse treatment services must be available to PLWH within County X at least 2 days a week.*

2. **Population targeting:** ensuring services appropriate for specific target PLWH populations

   Examples of directives:
   - *Core medical service providers must have bilingual Spanish-English staff in positions with direct client contact, including clinical staff.*
   - *Each of the three counties in the EMA/TGA must have at least one service provider qualified to provide culturally appropriate services to young MSM of color.*
   - *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.*

3. **Access to care:** overcoming barriers that reduce access to care

   Examples of directives:
   - *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.*
   - *Transportation must be made available to PLWH who are unwilling to seek care in their own communities due to fear of exposure and stigma, and who require such assistance so they can access care in another location within the EMA or TGA.*
   - *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.*

4. **Service models:** requiring the testing or broader use of a particular service model

   Examples of directives:
   - *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.*
   - *All medical case management providers will ensure that at least one case manager completes recipient-approved geriatric training on a refined case management model for older PLWH.*
   - *The EMA/TGA will pilot test an Early Intervention Services (EIS) model designed to reach young MSM of color who are newly diagnosed or out of care, link them to care, and help ensure that they become fully connected to medical care.*

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. Sometimes a directive will call for testing a new service model or approach. If it proves successful in addressing the identified need, it may be added to Service Standards and implemented throughout the system of care.

Identifying the Need for a Directive

The PC/PB may identify needs and issues leading to directives at any time of the year through many sources, among them 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, or through a review of epidemiologic data trends
- **Town hall meetings or public hearings** that are part of the PSRA process—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 based on such characteristics as 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

Often, review of such information will help to identify issues such as the following:

- ***Poor service access,*** limited use of services, poor retention, or low rates of viral suppression for PLWH populations, especially those who are traditionally marginalized and/or have co-morbidities
- ***Lack of culturally and linguistically appropriate services*** overall or in particular locations or specific service categories
- ***Too few providers in outlying areas*** of the EMA or TGA
- ***A need for new models or strategies*** to better address the changing local epidemic

HRSA/HAB Expectations

PC/PBs have a great deal of flexibility in the development and use of directives. Directives can be developed whenever available data indicate the need for action to provide parity in access to high quality care for all PLWH, regardless of who they are or where they live within the service area.

HRSA/HAB expects directives to be:

- **Based on an identified need,** determined through review of data from needs assessment, town hall or other community meetings, service utilization data, CQM activities, or other sources
- **Explored and developed as needed throughout the year**—often with the involvement of several committees, such as the following (Committee structures and names vary by jurisdiction):
  - *Needs Assessment and Planning*
  - *Care Strategy/System of Care*
  - *Consumer/Community Access*
  - *Priority Setting and Resource Allocation*
- **Presented in relation to the PSRA process,** since they often have financial implications and may require changes in how services are delivered—and are best addressed through discussion with the recipient before allocations have been made
- **Approved by the full PC/PB,** along with or separate from resource allocation
- **Consistent with an open procurement process.** Directives should not have the effect of limiting open procurement by making only 1-2 providers eligible, since the PC/PB should have no involvement in the selection of specific entities to serve as subrecipients.

  For example, consider the following possible directives:

  > *Mental health services must be provided by clinicians that can demonstrate expertise in serving people living with HIV*
  >
  > *Mental health services must be provided by organizations with prior RWHAP experience*

  The first is an acceptable directive, requiring that mental health clinicians have appropriate expertise to serve PLWH—which can be obtained through training and/or prior experience, regardless of funding source. The second suggested directive is not acceptable, because it limits possible subrecipients to those that have received RWHAP funding in the past. There might be only one or two entities that meet that requirement, which would prevent an open procurement process.

Tips for Preparing Sound Directives

The following approaches support the development of sound directives:

1. **Provide a limited number of carefully thought-out directives.** If the PC/PB proposes too many directives, they may not receive the individual attention or resources needed for successful implementation.
2. **Review current directives,** to retire those that no longer apply and to avoid duplication where appropriate by refining an existing directive rather than developing a new one. Directives only rarely need to be maintained over many years. If the approach in the directive proves effective, it can be made permanent through other means, such as inclusion in Service Standards.
3. **Base directives on data and be prepared to present the underlying data** when proposing a new or revised directive to the PC/PB.
4. **Identify and research possible directives throughout the year,** as part of your 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 —and ensure allocation of resources needed for implementation.
5. **Refer to but don't duplicate requirements in existing Service Standards.** If aggregate monitoring or CQM data show that Service Standards are not being met, the PC/PB should explore with the recipient why this is happening—and may want to consider a directive that offers a refined approach.
6. **Use plain, direct language** so that the directive is easy to understand and implement.

Role of the Recipient

The recipient is *responsible for implementing* directives. Beyond that, the PC/PB should collaborate with the recipient as it formulates directives, particularly with regard to assessing the costs, feasibility, and timing of implementing a potential directive.

COSTS

Suppose the PC/PB has developed the following proposed directive to improve retention in care for employed PLWH:

> *All RWHAP Part A-funded OAHS and medical case management providers must provide services at least one evening a week or one weekend day a month .*

Adding evening or weekend hours may improve care, access and retention, but it also adds costs for staff and for keeping the facility open longer. Before time for resource allocation, the PC/PB needs to ask the recipient to estimate the added costs per year for evening hours and for weekend hours. That will allow the PC/PB to refine the directive if necessary. For example, if it would be much less expensive to use evening rather than weekend hours, it might remove the weekend option. That will also give the PC/PB the information needed to add dollars to the OAHS and medical case management allocation to permit implementation of this directive—unless it is willing to serve fewer PLWH in these service categories.

FEASIBILITY

The PC/PB should consult with the recipient regarding such issues as whether a similar strategy or service model has been tried before, and if so, with what results; and whether the directive can be implemented or perhaps needs to be revised or restated. For example, a directive that calls for use of telemedicine in providing mental health services is feasible only if state law allows such use of telemedicine. Strategies must be

consistent with RWHAP service definitions and other HHS guidance. Incentives for keeping medical appointments must meet federal guidelines or be funded out of non-federal funds.

TIMING

It is not always possible for a directive to be implemented quickly. While some jurisdictions may be able to modify the scope of work for a multi-year subrecipient contract, others will not be able to change requirements or specify a new service model until the service category goes out for competitive bid, which may happen only every 2-4 years. It is sometimes possible to state a directive so that parts can be implemented immediately. For example, the directive below will probably be implemented only after these service categories go out for bid, since it is likely to require hiring of staff with specific skills and experience:

> *All OAHS and medical case management providers must ensure transgender PLWH and African immigrants receive services only from clinicians and case managers with both training and experience in serving these populations.*

As an interim measure, the following directive could be implemented quickly, with assistance from the recipient, or the PC/PB could instead decide to add it as a requirement in its Service Standards:

> *All OAHS and medical case management staff serving transgender PLWH and African immigrants must first complete in-depth, recipient-approved cultural competence training to prepare them to serve these populations.*

Discussion with the recipient can help in addressing these cost, feasibility and timing challenges.

Assessing Implementation and Results

Directives are generally implemented by the recipient through procurement and contracting, and/or program monitoring and clinical quality management (CQM) efforts, including quality improvement projects. The recipient must follow directives in procurement and contracting but cannot always guarantee full success. For example, the recipient might put out a request for proposals (RFP) to implement a new service model but receive no qualified responses. The recipient may want to suggest revisions in the directive to make responses more likely.

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 updates on implementation of directives, ideally at least quarterly. The PC/PB and recipient should work together to assess the results of directives and to decide when a pilot project should be expanded, refined, or ended.

Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32
Status Updates from the Division of HIV and STD Programs (DHSP)

DIRECTIVE	DHSP RESPONSE/STATUS UPDATE
1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.	Solicitations are composed using the latest data, which reflect the geography and other demographics of target populations
2. Implement 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:	
• Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.	In progress. Some training resources still need to be identified and tested.
• In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/AfricanAmerican population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.	This should be included in the needs assessments conducted as part of the formative work for the development of the comprehensive plan.
• Assess available resources by health districts by order of high prevalence areas.	
• Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.	
• Fund mental health services for Black/African American women that are responsive to their needs and strengths.	Is there a different standard of care for these services for this population?

• Earmark funds for peer support and psychosocial services for Black gay and bisexual men. • It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.	Must be allocated by PP&A. DHSP relies on SBP for guidance.
3. Provide Non-Medical Case Management services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 yrs).	Commission must allocate funds for these programs.
4. 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, ride share services) to clients to facilitate expanded access to food.	DHSP has used EHE and HRSA CARES funds to improve capacity to store perishable, nutritious foods, and increase variety and quality of food available consistently.
5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase 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.	The entire housing portfolio needs to be examined in order to determine where DHSP's limited housing resources can have the most impact.
6. Continue to support the expansion of medical transportation services.	In progress
7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to	In progress

reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distributionof eligibility cards as stated by DHSP representatives.	
8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM andtransgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.	Childcare solicitation is nearly complete. EFA program is in place.
9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.	Need more information on what this would look like.
10. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.	Commission should allocate funds accordingly.

LOS ANGELES COUNTY
COMMISSION ON HIV

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October 9, 2020

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

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

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

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

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

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)
This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure

alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

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

The 2019 HIV Surveillance Report notes following areas of disparities:

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

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

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

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

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income

and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

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

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

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

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (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:

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

3. Provide Non-Medical Case Management services in non-traditional and traditional

locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. 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, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase 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.

6. Continue to support the expansion of medical transportation services.

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

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

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

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

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

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

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

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

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

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

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

(REVISED) Black/African American Community (BAAC) Task Force Recommendations

October 10, 2019

Introduction

The BAAC Task Force was formed in response to the Commission on HIV's (COH) February 14, 2019 National Black HIV/AIDS Awareness Day (NBHAAD) Panel discussion in an effort to address the disproportionate impact of HIV/AIDS in the Black/African American (AA) communities of Los Angeles County.

The BAAC Task Force convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the COH on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs in all subsets of the Black/AA community utilizing a community-wide mobilization effort.

Healthcare Disparities in the Black/AA Community

The United States Census Bureau estimates Black/AA living in Los Angeles County (LAC) at 9% or approximately 909,500 as of 2018.(1) In 2017, there were 51,438 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) were Black/AA.**(2)

In 2016, **the highest overall rate of HIV diagnoses was among African Americans (56 per 100,000)**, followed by Latinos (19 per 100,000), whites (12 per 100,000), and Asians (6 per 100,000). These differences in rates were also observed by sex, most notably among **African American females (17 per 100,000) where the rate of HIV diagnoses** was 8 times higher than that of white females (2 per 100,000) and 5 times higher than the rate for Latinas (3 per 100,000). Among **males**, the rate of HIV diagnoses among **African Americans (101 per 100,000)** was 5 times higher than among whites (22 per 100,000) and 3 times higher than the rate for Latinos (34 per 100,000).(2)

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).(2)

Black/AA Care Continuum as of 2016[3]

Demographic Characteristics	Diagnosed/Living with HIV	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
Race/Ethnicity						
African American	**9,962**	**54.2%**	**65.9%**	**49.7%**	**50.3%**	**53.0%**
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.10%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%

The Ryan White (RW) program in LAC served 15,747 individuals between March 1, 2018 and February 28, 2019. Three-thousand three-hundred sixty (3,360) were Black/AA during the same period.[4]

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

General/Overall Recommendations:

1. Provide on-site cultural sensitivity and education training – to include addressing implicit bias and medical mistrust within the Black/AA community – for all County-contracted providers and adopt cultural humility into the local HIV provider framework. *Decision makers must realize their own power, privilege and prejudices and be willing to accept that acquired education and credentials alone are insufficient to address the HIV epidemic in the Black/AA community.*

2. Revise messaging County-wide around HIV to be more inclusive, i.e., "If you engage in sexual activity . . . you're at risk of HIV" in an effort to reduce stigma.

3. Incorporate universal marketing strategies for HIV prevention that appeal to all subsets of the Black/AA community in an effort to reduce stigma and increase awareness.

4. Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant.

5. Support young people's right to the provision of confidential sexual health care services.

6. Increase Pre-exposure Prophylaxis (PrEP) advertising within the Black/AA community to increase awareness. Marketing materials must depict the very community it is attempting to reach - specifically, Black/AA youth, women, transgender individuals, and gender nonconforming populations.

7. Initiate or partner in culturally informed research that aims to address the needs of the Black/AA communities. Researchers, whenever possible, must mirror the affected community it purports to study. Community reflectiveness in academic and CBO partnerships should include training in instrument development, data interpretation, presentations and publications.

8. Increase use of local statistics regarding new infections and disparities to educate and plan for the community; request Department of Public Health data be organized by Health Districts and zip codes to better target and identify communities in need.

9. Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive services.

10. Proactively reach out to engage CBOs that are connected to the local Black/AA community.

11. End the practice of releasing Request for Proposals (RFPs) that have narrowly defined "Proposer's Minimum Mandatory Requirements." *This discriminatory practice purposely disqualifies existing relevant CBOs and other agencies that provide intersection health and human services.* When issuing RFAs, RFPs, or RFSQs, establish a demonstration/data pilot by creating a 15% funding carve-out for CBO's/ASO's, whose qualifications are below the "Minimum Mandatory Requirements", but at an agreed upon standard, to identify the proven and effective grassroots/community empowerment efforts that reach specified Black/AA audiences. This will allow DHSP in collaboration with the Commission to determine the efficacy of methodologies for outreach, linkages to care, retention in care, and other sensitive treatment and prevention interventions that are effective in reducing new HIV cases.

12. Continue to evaluate for effectiveness and increase the investment in Vulnerable Populations Grants that target subset populations of the Black/AA community (i.e. Trans men/women, women & girls, MSM) to address barriers and social determinates of health.

13. Engage agencies already funded as well as those not currently funded to focus on a Countywide PrEP Education and Outreach mini-grant process that will target all various subset populations of the Black/AA community, i.e. Trans community, women & girls, MSM.

14. Increase mobilization of community efforts to include:
    a. Increase community awareness fairs and social media campaigns intended to promote health and wellness in the Black/AA community, with concentration in high incidence areas;
    b. Condom distribution in spaces where adults congregate;
    c. HIV education and access to prevention tools in schools, spiritual communities, social clubs, neighborhood associations, etc.;
    d. Fund one social marketing campaign that addresses stigma and internalized homophobia as it relates to health and wellness around HIV;
    e. Support efforts that will ensure additional research and evaluation support be made available to agencies that provide services to the Black/AA community and to increase their capacity to link and collaborate with research institutions; and
    f. Provide training and incentives for CBOs within high incidence areas to prescribe PreP and nPep.

Population-Specific Recommendations:

Black/African American Trans Men:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.
2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.
3. Include Trans men in program decision making.
4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.
5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

6. Create a pilot/demonstration project using the information obtained from the various data sources listed above.

Black/African American Trans Women:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans women community to address barriers and social determinants of health to better provide more targeted programming.
2. Increase efforts in collecting epidemiological data through surveillance on Trans women for purposes of planning more targeted programming.
3. Use William's Institutes' research/data using SOGI (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans women-specific programming.
4. Include and prioritize Trans women in program decision making.
5. Address stigma and the increasing violence against Trans women.

Black/African American Women and Girls: *(DHSP defined Black/AA women and girls as either childbearing women between the ages of 15-44 and those 50 Years and Older)*

The Ryan White (RW) program in LAC served 501 Black/AA women during the period of March 1, 2018 to February 28, 2019. This is approximately 31.82% of those receiving RW services.(4)

1. Evaluate existing PrEP and prevention access and messaging for impact on intervention groups and community health; assess dissemination methodologies and refine outreach and engagement strategies.
2. Allocate resources to create a PrEP Center for Excellence targeting women and their families, sexual and social networks.
3. Conduct an inventory of County-wide HIV/STD interventions and initiatives that target African American women at risk of and living with HIV that focus on education, employment services, empowerment, co-infections, treatment as prevention (TAsP), sexual reproductive health, intimate partner violence, and mental health.
4. Obtain data for all populations of women, especially those who are pregnant or such age groups affected by the high rates of STIs; include women-specific data in summits, reports, and community forums.

5. Reorganize and adopt educational approaches to care and prevention that incorporate information and knowledge on how preventative methods can benefit the woman within the context of her life. Such approaches include but should not be limited to:
   a. Integrate train-the-trainer models for community health outreach workers and testing staff that use motivational and empowerment strategies as a tool for risk reduction. Generating collective approaches and solutions that promote honesty and integrity within self and relationships with others is paramount. Hold agencies accountable to host honest adult conversations and have the courage to meet people where they are and build on what they know.
   b. Generate collective approaches and solutions that promote honesty and integrity of self and relationships with others is paramount; and
   c. Train community health outreach workers in all HIV Testing Sites to have conversations that validate the experience and power dynamics women confront within their relationships. Most often partners are missing from engagement, enrollment, and retention strategies. Include sexual and social networks in education, outreach, testing and other interventions that support family sustainability as a method of retention.

6. Allocate money to partner with institutions to support three demonstration projects at $250,000 each led and facilitated by and for Black women:
   a. Ensure agencies have tools available to demonstrate accountability and cultural competence. Staff should be linguistically and culturally representatives of the community and any intervention include a navigation component to address barriers to recruitment, uptake and retention of prevention and care based programming.
   b. All protocols should explicitly embrace the experience of women who have sex with men of known or unknown status as well as those diagnosed with HIV/AIDS. Further, qualitative interviews or Audio Computer-Assisted Self-Interview (ACASI) instruments should include an assessment of historical care and prevention participation as well as barriers to continuous engagement and participation.

7. Strategically reflect the needs of women in the jurisdictional stigma reduction efforts by funding projects that reduce stigma and increase access to female controlled HIV preventive tools such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), and the Female Condom 2 (FC2). Support agencies to integrate comprehensive opportunities for education, research and a complement to other strategies that give women the power to take control of their lives and situations in which have historically had little to no influence.

8. Expand the availability of community-based mental health services as a part of a continuous effort to treat women holistically: HIV and mental health education and awareness should accompany a range of holistic services that recognize that a woman may have multiple traumas that inform her choices. Increased collaborations between community and the private sector which is necessary to build awareness and reduce cultural and social based stigmas associated with mental health care. Increased education and training of non-HIV/AIDS service providers in hopes of offering a full circle of multidisciplinary services to those in need.

9. Develop a standard requiring all contracted organizations offer living wages as an incentive to hiring persons with lived experience. Initiating programming for Black women enables organizations to invest in their peers. Further, increased access to professional development opportunities and resources (ex. Income) enables them to self-sustain and decrease the impact that social correlates of health such as poverty have on informed sexual decision making.

<u>Black/African American Men Who Have Sex with Men (MSM):</u>

The Ryan White (RW) program in LAC served 2,093 Black/AA MSM during the period of March 1, 2018 to February 28, 2019. This was approximately 13.3% of those receiving RW services. (4)

1. Continue to increase the investment in innovative layered interventions that target young MSM and address barriers and social determinates of health like the Vulnerable Populations Grant.

2. Develop and release of Request for Application/Request for Proposal (RFA/RFP) that focuses on HIV positive MSM of all ages who are sexually active and at risk of co-infections.

3. Increase funding and resources in treatment as prevention, social support efforts, housing and mental health services.

4. Address Chemsex within the Black/AA MSM community through CBO led group sessions, evidence-based medicine directed intervention and medication assisted treatment.

Conclusion

Only by genuinely addressing the recommendations as provided above can the Los Angeles County HIV/AID Strategy (LACHAS) goals be met. Many of the recommendations provided are in alignment with the LACHAS and the County's Comprehensive HIV Plan (CHP), however, there must be very intentional and targeted efforts made to address social determinants, primarily stigma and racism, in the Black/AA communities. It is not enough to implore the same strategies of old; we must modernize methodologies in our marketing strategies to reach subpopulations within the Black/AA communities who do not identify according to current messaging. Messaging must be *truly* inclusive – "if you are sexually active, you are at risk".

The adage is true – "to reach them, you have to meet them where they are" - HIV and sexual health education along with HIV prevention interventions must be accessible in schools, jails, churches, barber/beauty shops, and social venues where Black/AA communities gather; while providers must be trained and educated to understand the various cultural nuances that can either stigmatize and subsequently discourage or create a culturally welcoming environment for Black/AA communities to access HIV prevention, care and treatment services.

On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter (COH), Dr. William King (COH), Cynthia Davis (AHF), Luckie Fuller (COH), Jeffrey King (ITMT), Louis Smith III, Stevie Cole, Ivan Daniel III, Carl Highshaw (AMAAD Institute), Charles McWells (LACADA), Dr. Derrick Butler (THE Clinic), David Lee (CDU), Rev Russell Thornhill (MAPP), Terry Smith (APLA), Doris Reed (COH), Carolyn Echols-Watson (COH) and Dawn Mc Clendon (COH).

Endnotes

1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19) Los Angeles County; Utilization by Service Category among Ryan White Priority Populations in Year 28

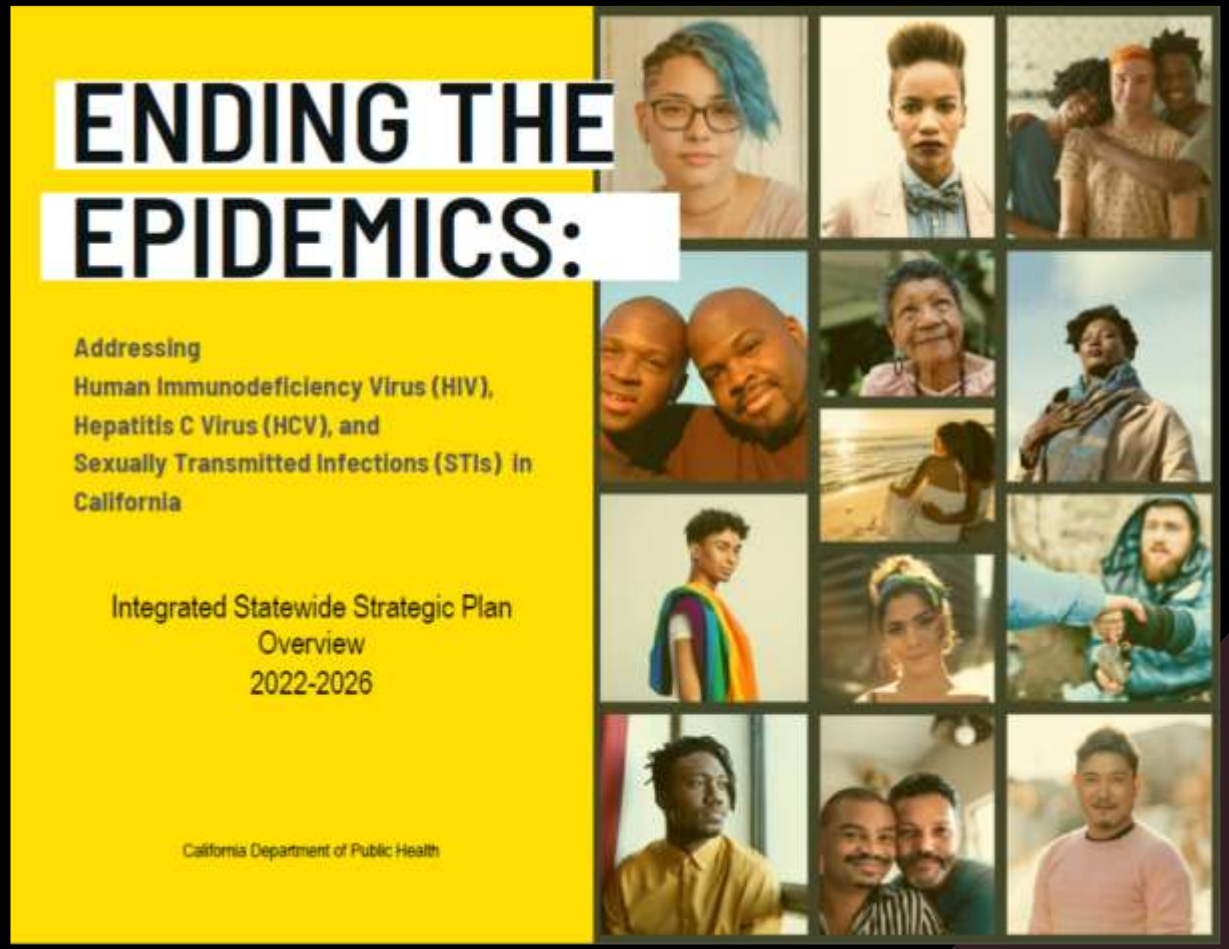
CDPH STRATEGIC PLAN PLANNING PROCESS

CDPH and Facente Consulting

Lazara Paz-Gonzalez, MPH

What is it?

- Acknowledges root causes in addressing the HIV, HCV, and STI syndemics
- Approaches the work from a social determinants of health lens
- Supports reframing the work to transform the system and meet the needs of the people
- Highlights existing public health efforts and activities that have contributed to successful outcomes



Who developed it and how?

- Core workgroup of 23 individuals, plus 27 invited guests from state agencies
- Key stakeholders and partners from CDPH OA & STD Control Branch, various state agencies, local health jurisdictions, community-based organizations, and people with lived experience
- Conducted 13 weekly workgroup sessions (June and October 2021)
  - *Key content speakers*
  - *Strategy brainstorm sessions via Mural*
  - *Consensus building*
  - *Identification of core strategies (5 per SDH Topic)*
- Developed and disseminated virtual survey (English/Spanish); reached over 640 people
  - *Addressed respondent-identified, most important and relevant activities for preventing, treating, and otherwise addressing HIV, HCV, and/or STDs in California*
  - *50 respondents shared their information for further involvement and follow-up in Phase 2*

What it contains…

20-page visual document (*to be made available electronically*)

- Contextual Opening Statement
- Vision, Mission, Purpose
- Guiding Values
- Focus on Intended Priority Populations
- Data Overview (HCV, STD, HIV)
- Public health strategies acknowledgement
- Social Determinants of Health Topics: *Racial Equity, Housing First, Health Access for All, Mental Health and Substance Use, Economic Justice, Stigma Free*
- Future Roadmap
- A Proclamation
- Key Terms
- Thank You/Contact Us

What's Next?

- More broad approach to addressing CY 2022 – 2026 Goals and Objectives, per the HRSA/CDC Integrated HIV Prevention and Care Plan Guidance, including Statewide Coordinated Statement of Need

  In-depth collection of qualitative and quantitative data

- Continued community engagement throughout the state through a variety of virtual and in-person sessions (first half of the year)
- Determining the logistics and resources necessary to successfully implement prioritized strategies
- Drafting a comprehensive statewide blueprint to guide our activities at the state, regional, and local levels
- Circulating the proposed plan for community review and final input
- Final review and dissemination; submission to HRSA/CDC

Proposed Plan

Scope of Work

- Collaborative initiative to develop a blueprint with activities supporting the implementation of the Strategic Plan with input from health department and community partners throughout the state

Advisory Committee

- CDPH OA & STD staff
- Part A Grantees
- IHS
- Individuals from Priority Populations
- Key community partners and stakeholders

Community Engagement Efforts

- Addressed through townhalls and focus groups held throughout 5 California regions (in-person and virtual)
- Survey assessment
- Virtual public comment

Our Commitment

- Work closely with LA County Commission on HIV
- Collaborative community engagement process
- Ensure alignment and synergy in strategic priority areas
- Sharing data and information as appropriate
- Ongoing communication throughout the development of the plans