LOS ANGELES COUNTY
COMMISSION ON HIV

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EXECUTIVE COMMITTEE
Meeting

Thursday, October 26, 2023
1:00pm-3:00pm (PST)
510 S. Vermont Ave
9th Floor, Terrace Conference Room A
Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

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COMMISSION ON HIV

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

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

EXECUTIVE COMMITTEE

THURSDAY, OCTOBER 26, 2023 | 1:00PM - 3:00PM

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

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Password: EXECUTIVE Access Code: 2532 093 9662

EXECUTIVE COMMITTEE MEMBERS			
Luckie Fuller, Co-Chair (LOA)	*Bridget Gordon, Co-Chair*	*Joseph Green, Co-Chair Pro Tem*	Miguel Alvarez (Executive At-Large)
Al Ballesteros, MBA	Danielle Campbell, MPH (Executive At-Large)	Erika Davies	Kevin Donnelly
Lee Kochems, MA	Katja Nelson, MPP	Mario J. Peréz, MPH	Kevin Stalter
Justin Valero, MPA			
QUORUM: 7			

AGENDA POSTED: October 20, 2023

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

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT 1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS 1:15 PM – 1:20 PM

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

IV. REPORTS

7. Executive Director/Staff Report 1:20 PM – 1:30 PM

A. Commission (COH)/County Operational Updates

(1) November 9, 2023 COH Annual Conference

(2) Upcoming COH-Sponsored Activities & Events

(3) Facilities and Technology Update

8. Co-Chair Report 1:30 PM – 1:45 PM

A. October 12, 2023 COH Meeting | FOLLOW UP & FEEDBACK

B. Conferences, Meetings & Trainings | OPEN FEEDBACK

C. Member Vacancies & Recruitment

D. 2023 Holiday COH & Committee Meeting Schedule for November & December

E. 2024 Committee Co-Chairs Open Nomination & Elections Preparation

9. Division of HIV and STD Programs (DHSP) Report 1:45 PM – 1:55 PM

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI

(2) Fiscal

(3) Ending the HIV Epidemic (EHE) Initiative | UPDATES

(4) Mpox | UPDATES

10. Standing Committee Report 1:55 PM – 2:35 PM

A. Operations Committee

(1) Membership Management

a. Standards & Best Practices (SBP) Committee-Only Membership Renewal Application | Dr. Mark Mintline **MOTION #3**

b. New Membership Application | Daryl Russell**,** Unaffiliated Consumer, At-Large #3 **MOTION #4**

c. Mentorship Volunteer Opportunities

d. Parity, Inclusivity & Reflectiveness (PIR) | UPDATES

(2) PY 32 Assessment of the Administrative Mechanism (AAM) | UPDATE

(3) Policies & Procedures

a. COH 2 Person/Per Agency Policy | REVIEW

(4) (REVISED) 2023 Training Schedule | REMINDER

(5) Recruitment, Retention and Engagement

B. Standards and Best Practices (SBP) Committee

(1) Universal Service Standards & Patient Bill of Rights | UPDATES

(2) Medical Care Coordination (MCC) Service Standards | **MOTION #5**

(3) Prevention Service Standards Review | UPDATE

C. Planning, Priorities and Allocations (PP&A) Committee

(1) PY 33 RWP/MAI Expenditures and Utilization Report Updates

(2) Prevention Integration & Status Neutral Planning

(3) 2024 Workplan Development

11. Standing Committee Report (cont'd) 1:55 PM – 2:35 PM

D. Public Policy Committee (PPC)

(1) County, State and Federal Policy, Legislation, and Budget

a. 2023-2024 Legislative Docket | UPDATES

b. House Appropriations FY24 Labor-HHS Spending Proposal

c. Coordinated STD Response | UPDATES

d. Act Now Against Meth (ANAM) | UPDATES

(2) Ryan White Care Act (RWCA) Modernization: Determine Strategy and Outline Presentation Schedule

12. Caucus, Task Force, and Work Group Reports: 2:35 PM – 2:45 PM

A. Aging Caucus

B. Black/AA Caucus

(1) SAVE THE DATE: World AIDS Day Collaborative w/ SD2: December 6, 2023 (Details Forthcoming)

C. Consumer Caucus

(1) SAVE THE DATE: 2023 Consumer Caucus Retreat: December 14 @ 11AM-2PM (Vermont Corridor)

D. Transgender Caucus

(1) REGISTER NOW: TGI Health Summit: November 2 @ 8AM-4PM (Village at Ed Gould Plaza)

E. Women's Caucus

F. Bylaws Review Taskforce

H. Prevention Planning Workgroup

V. NEXT STEPS 2:45 PM – 2:55 PM

13. Task/Assignments Recap

14. Agenda development for the next meeting

VI. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

Adjournment for the meeting of October 26, 2023.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve Renewal SBP Committee-Only Member Application for Dr. Mark Mintline, as presented or revised.
MOTION #4	Approve New Membership Application for Daryl Russell to occupy Unaffiliated Consumer, At-Large #3 seat (#34), as presented or revised.
MOTION #5	Approve Medical Care Coordination (MCC) Service Standards, as presented or revised.

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DRAFT

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

EXECUTIVE COMMITTEE MEETING MINUTES

September 28, 2023

COMMITTEE MEMBERS **P = Present | A = Absent | EA=Excused Absence | AB2449=Virtual**			
Luckie Fuller, Co-Chair (LOA)	EA	Erika Davies	P (AB2449)
Joseph Green, Co-Chair, Pro Tem	P	Kevin Donnelly	P
Bridget Gordon, Co-Chair	P	Lee Kochems, MA	P
Miguel Alvarez (EXEC At-Large)	P	Katja Nelson, MPP	P (AB2449)
Everardo Alvizo, LCSW	P	Mario J. Peréz, MPH	P
Al Ballesteros, MBA	A	Kevin Stalter	P
Danielle Campbell, MPH (EXEC At-Large)	P	Justin Valero	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Lizette Martinez, MPH; Jose Rangel-Garibay, MPH; Sonja Wright,			
DHSP STAFF			
No other DHSP staff in attendance			

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER & MEETING GUIDELINES/REMINDERS

Bridget Gordon, Commission on HIV (COH), commenced the meeting at around 1:00PM and provided an overview of the meeting guidelines.

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

B. Gordon led introductions and requested that Committee members their state conflicts of interest.

ROLL CALL (PRESENT): M. Alvarez, E. Alvizo, D. Campbell, K. Donnelly, L Kochems, M. Peréz, K. Stalter, J. Green (COH Co-Chair Pro Tem), and B. Gordon (COH Co-Chair)

2. APPROVAL OF AGENDA

MOTION #2: Approve the Agenda Order, as presented or revised. ***✓Passed by consensus***

3. APPROVAL OF MEETING MINUTES

MOTION #3: Approve the Executive Committee minutes, as presented or revised. ***✓Passed by consensus***

II. PUBLIC COMMENT

4. OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.

No public comments.

III. COMMITTEE NEW BUSINESS ITEMS

5. OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.

No committee new business items.

IV. REPORTS

6. EXECUTIVE DIRECTOR/STAFF REPORT

A. Commission (COH)/County Operational Updates

(1) Updated HRSA Planning Council Requirements and Expectations Letter

Chery Barrit, MPIA, Executive Director, reported that HRSA provided updated guidance and clarification regarding their requirements and expectations. Key points discussed:

- Term limits: COH is collaborating with BRT and County Counsel to address this. Currently, term limits are waived by BOS but HRSA mandates term limits and member rotations.
- Separation of planning council and grantee (DHSP): BRT is revising language to include DHSP as a non-voting member.
- Concerns were expressed about member term limits.
    - Mario J. Peréz, DHSP, Director, emphasized the need to align planning council needs with the current epidemic and suggested reevaluating the structure to be more responsive to LA County's evolving challenges.

  - B. Gordon proposed drafting a response letter to HRSA.
  - Lee Kochems highlighted the importance of adapting to the changing HIV landscape while retaining historical context.
- C. Barrit shared that a meeting between County Counsel and COH and DHSP leadership is currently being scheduled to discuss updated guidance.

(2) November 9, 2023 COH Annual Conference

C. Barrit provided updates on the Annual Conference:

- M. Peréz will not be in attendance due to a prior commitment, but a DHSP representative will provide programmatic updates.
- Confirmed presenters include Dr. Sid Puri, Dr. Ardis Moe, and Dr. Curley Bonds. Although invited, Supervisors Horvath and Barger are not available.
- Va Lecia Adams Kellum, Chief Executive Officer of the Los Angeles Homeless Services Authority (LAHSA) has been invited to provide a lunch plenary, pending confirmation.
- AJ King was suggested to facilitate the intergenerational panel.
- The Mental Health Commission, Commission on Alcohol & Other Drugs, and the Youth Commission, have been invited to attend as non-traditional stakeholders and partners.

(3) Upcoming COH-Sponsored Activities & Events

C. Barrit reported on the COH's upcoming activities & events:

- COH will host a table at the Taste of Soul, adjacent to Dr. King, promoting cross collaboration and HIV testing.
- The Transgender Caucus is hosting a TGI health and empowerment summit on November 2nd at The Village at Ed Gould Plaza.
- The Annual Conference is scheduled for November 9th.
- Two World AIDS Day events will be hosted: one by the Black Caucus in collaboration with Supervisor Mitchell on December 6th at CDU, and another led by Commissioner Jonathan Weedman for a leadership breakfast in District 5 on December 1st. Coordination with all BOS for WAD events is encouraged, including inviting the mayor to the WAD leadership breakfast.

7. Co-Chair Report

A. Evaluating Hybrid Meeting Format Effectiveness

B. Gordon solicited ideas on how to evaluate the effectiveness of our hybrid meetings. There was a consensus to keep the hybrid meeting format.

C. Barrit reminded the group that AB 2449 is a state legislation and is not open to negotiation, and further reminded the group that AB 2449 will sunset in 2026 and can be invoked only twice per year.

A. Burton stressed the need for a well-executed hybrid option, particularly for immunocompromised individuals and community members who prefer virtual participation.

Suggestions include surveying membership for feedback, enhancing public awareness of the virtual option, and potential IT taskforce development led by A. Burton to improve IT infrastructure.

B. September 14, 2023 COH Meeting | FOLLOW UP & FEEDBACK
(1) DHS HIV Data Cascade Presentation.
As a follow up, C. Barrit suggested that a letter be sent to Drs. Ghaly, Corado and Belani, memorializing a summary of the key recommended action steps and comments that emerged during the Q&A part of the presentation and emphasize support for collecting necessary data to better serve clients.

(2) City Representatives Harm Reduction/Substance Use Presentations.
Presentations were well-received, revealing new funding streams. The Prevention Planning Workgroup (PPW) will further examine them for incorporation into planning. Suggestion to request quarterly reports from city representatives on their programs and services.

C. October 12, 2023 COH Meeting Agenda Development
(1) RWP Part C Presentation (pending)
(2) UCLA LAFAN Presentation Re: Latina Women & HIV Podcast Series (pending)
(3) DHSP Presentation: HIV Surveillance Update & Data Challenges for LA County Native American Communities (Part 2: Programmatic Overview)
(4) New/Renewing Member Applications
(5) National HIV Awareness Days
a. National Latinx AIDS Awareness Day #NLAAD2023
As a continuing effort to highlight the Latinx experience around HIV in commemoration of NLAAD, a request was made to invite Latinx community members to provide testimony.

D. Conferences, Meetings & Trainings | OPEN FEEDBACK
(1) Collaboration in Care Conference: Improving HIV and Aging Services | September 17-19
It was reported that Arlene Frames attended the conference and suggested that Dr. Paul Nash present at an upcoming COH meeting.

(2) "Let's Talk About Sex" | September 22
Kevin Donnelly attended the training and provided a brief evaluation of its successes and improvements and noted an overall success and opportunity to conduct a similar training for other key populations.

E. Member Vacancies & Recruitment
F. 2023 Holiday COH & Committee Meeting Schedule for November & December
B. Gordon requested that committees, caucuses, and taskforces poll their members to determine whether to cancel their December meetings and report back on decision.

G. 2024 Committee Co-Chairs Open Nomination & Elections Preparation
B. Gordon reminded the committee co-chairs to agendize 2024 Co-Chair open nominations for December, with elections held in January, contingent upon holiday meeting schedule.

9. Division of HIV and STD Programs (DHSP) Report
A. Fiscal, Programmatic and Procurement Updates
(1) Ryan White Program (RWP) Part A & MAI
Mario J. Peréz, MPH, Director (DHSP) reported that DHSP received one response to the childcare Request for Proposal (RFP), but this response did not meet the minimum requirements. He emphasized that several community partners, who had indicated their intent to submit RFPs, did not submit any responses. DHSP is facing an impasse and needs to resolve appeals related to childcare, which have resulted in a lack of responses to RFPs. M. Peréz expressed frustration that advocates are not ensuring that childcare providers submit RFPs for this service, which is essential to meet community needs.

M. Peréz noted that he has been working directly with a Commission member to address their specific healthcare needs and stressed that Commission meetings are for planning and should not serve as forums for individual case management; alternative methods should be identified to assist members with their healthcare needs. M. Peréz directed all service-related requests and concerns to its Customer Support Program. Ryan White Program (RWP) facts sheets are available for all RWP services which provide access points for services. A RWP promotional campaign is in development and will provide a centralized repository for RWP service information. M. Peréz acknowledged that its website is due for a refresh to create a more consumer friendly format.

- Members raised concerns that the Customer Support Program is not adequately promoted at UCLA Dental Services. M. Peréz committed to an annual review to ensure that UCLA actively promotes the Customer Support Program in a location visible to clients.
- Additionally, M. Peréz pledged to provide an annual summary of calls to the Customer Support Program. He also highlighted that DHSP conducts various quality assurance activities, such as secret shopper evaluations, to ensure services comply with quality standards and are delivered effectively.
- The Commission will ensure that the Customer Support Program contact information is promoted and made available in all meetings. M. Peréz committed to have a DHSP representative available to assist individuals with concerns regarding services.

(2) Policy & Fiscal
M. Peréz reported that given the potential government shutdown in October, it is not clear what impact it will have on DHSP's day-to-day operations and other functions, especially considering the recent $400 million cuts to CDC Federal Infrastructure Grant and recent $74 million proposed cuts to the HIV portfolio.

M. Peréz reported that AB 1645 is currently on the Governor's desk and thanked the County and community advocates for their efforts in supporting AB 1645.

More recently, M. Peréz reported that the County has increased allocations in response to the growing STD crisis. DHSP is actively working to refine the spending plans submitted and will soon provide recommendations for final review. M. Peréz noted that capacity concerns within organizations may hinder their ability to hire staff, leading to challenges in healthcare delivery, even when investments are made.

Furthermore, DHSP is working closely with community partners to gain a comprehensive understanding of the various challenges and issues associated with the STD crisis. This collaborative approach includes LA Care and HealthNet to ensure they are fully aware of the available opportunities to bolster funding for Federally Qualified Health Centers (FQHCs). These increased resources will enable FQHCs to respond more robustly and efficiently to the STD crisis.

(3) Ending the HIV Epidemic (EHE) Initiative | UPDATES
No reports provided.

(4) Mpox | UPDATES
M. Peréz reported that there were no new cases of mpox reported last week. Two cases were reported from the previous Friday. M. Peréz indicated that the morbidity remains low and noted that DHSP is managing a handful of mpox cases involving those living with HIV which require additional care and attention. M. Peréz noted the challenge in PLWH getting their mpox vaccines as the percentage of PLWH who are vaccinated remains at 24%.

M. Peréz further reported that COVID is on the uptick and that boosters are making their way to pharmacies and health systems. DHSP is working to make sure healthcare workers are vaccinated with the latest COVID booster; refer to DPH's COVID-19 website for updates HERE.

10. Standing Committee Report
A. Operations Committee
(1) Membership Management

a. Renewal Application – Derek Murray | City of West Hollywood Rep MOTION #3 (√Approved by Roll Call Vote: M. Alvarez, E. Alvizo, D. Campbell, E. Davies, K. Donnelly, L. Kochems, K. Nelson, K. Stalter, M. Peréz (Abstain), J. Green & B. Gordon)

b. Renewal Application – Dr. Mikhaela Cielo | Part D Rep MOTION #4 (√Approved by Roll Call Vote: M. Alvarez, E. Alvizo, D. Campbell, E. Davies, K. Donnelly, L. Kochems, K. Nelson, K. Stalter, M. Peréz (Abstain), J. Green & B. Gordon)

c. Mentorship Volunteer Opportunities
Everardo Alvizo, Co-Chair, reminded members to volunteer as a mentor for new members.

d. Parity, Inclusivity & Reflectiveness (PIR) | UPDATES
E. Alvizo acknowledged that the COH is overall reflective of the epidemic. However, he emphasized the need for more targeted recruitment efforts to engage young adults and the youth community. Furthermore, E. Alvizo noted that due to the mixed-race demographic

category, the Black and Latino demographics have experienced fluctuations. As the membership continues to grow, the PIR will be updated to accurately represent the evolving demographics.

(2) PY 32 Assessment of the Administrative Mechanism (AAM) | UPDATE
The Committee supports a proposal, as recommended by Dr. Michael Green (DHSP), to conduct an assessment with senior-level County managers to evaluate the efficiency of the County's contracting processes. This proposal aligns with a concurrent effort by the Quality & Productivity Commission, which is engaged in a similar assessment. By leveraging resources and collaborating with the Quality & Productivity Commission, the Committee aims to optimize the evaluation of County contracting processes and ensure a more efficient and effective approach.

(3) Policies & Procedures
a. COH 2 Person/Per Agency Policy
The Committee is addressing a potential conflict regarding the 2 person/per agency policy and has requested staff to seek guidance from County Counsel to provide a clear definition of the term "employee" within the context of affiliation and in relation to the referenced policy. The Committee will continue its deliberations at its next meeting.

(4) (REVISED) 2023 Training Schedule | REMINDER
Refer to updated training schedule in meeting packet.

(5) Recruitment, Retention and Engagement
No reports/updates.

B. Standards and Best Practices (SBP) Committee
No reports/updates.

C. Planning, Priorities and Allocations (PP&A) Committee
Kevin Donnelly, Co-Chair, reported that the Committee met on September 19th and had a full house.

(1) Los Angeles Housing Service Authority (LAHSA) Data Request Update
LAHSA provided raw data to which the COH team are working to analyze and will present at an upcoming meeting once completed.

(2) Fiscal Year 2022 RWP/MAI Expenditures and Utilization Report Updates
Dr. Sona Oksusyan (DHSP) provided a presentation on Mental Health and Substance Abuse (Residential) Services utilization.

(3) Community Listening Sessions Questionnaire Feedback
The Committee approved the Community Listening Session questionnaire as presented.

Furthermore, K. Donnelly reported that Dr. William King and Miguel Martinez presented on the Prevention Planning Workgroup's (PPW) status neutral recommendations to include a revised

proposed continuum of HIV prevention and care. It was noted that most individuals would visit their primary care physician for general medical needs and would seek a community-based provider for their sexual healthcare needs thus necessitating the addition of a community engagement element to the continuum.

M. Peréz noted that providers must build capacity and reconcile funding for a status neutral model to effectively work.

The next PP&A Committee meeting will be October 19, 2023 @ 1-4PM; an extended meeting which will include the next installment of the DHSP utilization report.

D. Public Policy Committee (PPC)
(1) County, State and Federal Policy, Legislation, and Budget
a. 2023-2024 Legislative Docket | UPDATES
Katja Nelson, Co-Chair, indicated there was nothing new to report and that the Governor Newsome has until October 14, 2023, to sign bills on his desk. To date, no key bills have been signed.

b. House Appropriations FY24 Labor-HHS Spending Proposal
K. Nelson referred to the earlier report by M. Peréz and pointed out that Congress is expected to pass a continuing resolution. She further shared that HRSA has sufficient resources to fund clinics, which means that there should not be a service gap while Congress is in the process of working towards a fiscal resolution.

c. Coordinated STD Response | UPDATES
K. Nelson referred to M. Peréz' earlier report and reminded members to attend upcoming BOS and Health Deputy meetings to make public comments in support of items that improve the health and wellness of people living with and at risk for HIV and STDs.

K. Nelson further reported that the state's Ending the HIV coalition is in the process of scheduling its annual meeting at which time they will determine budgetary asks for the next fiscal year.

d. Act Now Against Meth (ANAM) | UPDATES
No updates.

(2) Ryan White Care Act (RWCA) Modernization: Determine Strategy and Outline Presentation Schedule
K. Nelson requested that members review the materials in the committee meeting packet posted online and provide feedback.

The next Public Policy Committee meeting will be Monday, October 2 @ 1-3PM.

11. Caucus, Task Force, and Work Group Reports

A. Aging Caucus
K. Donnelly reported that the Caucus recently held its Let's Talk About Sex educational event and has scheduled a call w/ Women's Caucus representatives for a future collaboration.

B. Black/AA Caucus
Danielle Campbell, Co-Chair, reported that the Caucus is currently planning for its Taste of Soul debut and for those interested in volunteering, to contact Dawn Mc Clendon. Additionally, the Caucus continues to plan for its December 6th Worlds AIDS Day collaborative event w/ Supervisor Holly Mitchell's office and continues planning for its community listening sessions.

C. Consumer Caucus
A. Burton reported that, at its last meeting, the Caucus reviewed and provided feedback on the Medical Care Coordination (MCC) services, postponing remaining agenda items to its next meeting. A. Burton encouraged consumers to attend the Caucus meetings and promote widely in their communities.

D. Transgender Caucus
Jose Rangel-Garibay, COH staff, reported that the Caucus continues to plan for its TGI Health and Empowerment Summit on November 2nd at The Village at Ed Gould Plaza.

E. Women's Caucus
C. Barrit provided information regarding the Caucus's upcoming activities. The next Caucus meeting is scheduled as a hybrid meeting on October 16th. In addition, Caucus representatives, in collaboration with Black Caucus representatives, will participate in a dinner and conversation event with Dr. Opara. This event is part of a community engagement initiative by Dr. Opara and UCLA Luskin School of Public Affairs and CHIPTS.

F. Bylaws Review Taskforce (BRT)
E. Alvizo, Co-Chair, reported that the BRT continues to review the bylaws and agreed to prioritize updates corresponding to HRSA's findings.

H. Prevention Planning Workgroup (PPW)é
K. Donnelly reported that PPW is scheduled to sunset at the end of the year. To ensure continued engagement, the group is actively developing a mechanism to incorporate its work into the PP&A Committee. K. Donnelly recognized the significant progress achieved during the year. To maintain a balanced focus on both prevention and care, there is consideration of restructuring the PP&A Committee.

V. NEXT STEPS

12. Task/Assignments Recap

- Preparation for October 12th COH meeting
- Work with DHSP to widely promote the Customer Support Program
- Continue planning for the November 9th Annual Conference

13. Agenda development for the next meeting

Refer to minutes.

VI. ANNOUNCEMENTS

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

None.

VII. ADJOURNMENT

Adjournment for the meeting of September 28, 2023, at 2:59PM.

Annual Conference

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

LOS ANGELES COUNTY COMMISSION ON HIV

KEY TOPICS:

- Division of HIV and STD Programs Highlights
- The County's Response to the Intersection of HIV and Substance Use | Harm Reduction
- PrEP, Long-acting PrEP, Doxy PEP | Increasing Access and Utilization among Priority Populations
- Housing and People Living with HIV (PLWH)
- Community Discussion on Intergenerational Perspectives on Community Building and Resilience
- Enhancing Access to Mental Health Services for PLWH
- Raffles, prizes, post-event reception

Vermont Corridor @ 510 S. Vermont Ave,
Los Angeles, CA 90020

NOV | 9th | 2023

Free Validated Parking | 523 Shatto Pl
Details will be posted at
https://hiv.lacounty.gov/

Save The Date

November 2, 2023

8 AM - 4 PM

TGI HEALTH SUMMIT

Increasing awareness of the health disparities and strategies surrounding Transgender, Gender-Nonconforming, and Intersex (TGI) communities. This Summit will support to mobilize information about community resources available, improving knowledge and awareness of HIV care and prevention services in LA, and offer community building initiatives centering healing for TGI Populations.

Village At Ed Gould Plaza

1125 N McCadden Pl, Los Angeles, CA 90038

REGISTRATION COMING SOON

REACH LA · LOS ANGELES LGBT CENTER · LOS ANGELES COUNTY COMMISSION ON HIV · trans* lounge · Keck School of Medicine of USC

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

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

Will I be denied services for reporting a problem?

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

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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

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

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

2023 MEMBERSHIP ROSTER| UPDATED 9.25.23

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2022	June 30, 2024	
3	City of Long Beach representative			***Vacant***	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2022	June 30, 2024	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2022	June 30, 2024	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2022	June 30, 2024	
8	Part C representative	1	PP	Leon Maultsby, MHA	Charles R. Drew University	July 1, 2022	June 30, 2024	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2023	June 30, 2025	
10	Part F representative	1	PP	Sandra Cuevas	Pacific AIDS Education and Training - Los Angeles Area	July 1, 2022	June 30, 2024	
11	Provider representative #1	1	OPS	Jose Magana	The Wall Las Memorias	July 1, 2023	June 30, 2025	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2022	June 30, 2024	
13	Provider representative #3	1	PP&A	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2023	June 30, 2025	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2022	June 30, 2024	
15	Provider representative #5	1	SBP	Byron Patel, RN, ACRN	Los Angeles LGBT Center	July 1, 2023	June 30, 2025	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2022	June 30, 2024	
17	Provider representative #7	1	EXC	Alexander Luckie Fuller ***(LOA)***	Invisible Men	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2022	June 30, 2024	
19	Unaffiliated consumer, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	
20	Unaffiliated consumer, SPA 2	1	SBP	Russell Ybarra	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
21	Unaffiliated consumer, SPA 3	1	PP&A	Ish Herrera	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2022	June 30, 2024	Lambert Talley (PP&A)
23	Unaffiliated consumer, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
24	Unaffiliated consumer, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2023	June 30, 2025	Ronnie Osorio (PP)
26	Unaffiliated consumer, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2023	June 30, 2025	Dechelle Richardson (PP&A)
28	Unaffiliated consumer, Supervisorial District 2	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2022	June 30, 2024	Juan Solis (SBP)
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
32	Unaffiliated consumer, at-large #1	1	PP&A	Lilieth Conolly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
33	Unaffiliated consumer, at-large #2	1	OPS	Shonte Daniels ***(LOA)***	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	Erica Robinson (OPS)
34	Unaffiliated consumer, at-large #3			***Vacant***		July 1, 2022	June 30, 2024	David Hardy (SBP)
35	Unaffiliated consumer, at-large #4	1	EXEC	Joseph Green	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2022	June 30, 2024	
37	Representative, Board Office 2	1	EXC|OPS	Danielle Campbell, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2022	June 30, 2024	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2022	June 30, 2024	
41	Representative, HOPWA	1	PP&A	Jesus Orozco	City of Los Angeles, HOPWA	July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	PP	Alasdair Burton	No affiliation	July 1, 2022	June 30, 2024	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3	1	PP	Pearl Doan	No affiliation	July 1, 2022	June 30, 2024	
47	HIV stakeholder representative #4	1	PP&A	Redeem Robinson ***(LOA)***	No affiliation	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2022	June 30, 2024	
49	HIV stakeholder representative #6	1	PP	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2022	June 30, 2024	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2022	June 30, 2024	
	TOTAL:	**42**						

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

LOA: Leave of Absence

Overall total: 48

Planning Council/Planning Body Reflectiveness Table

(Use most recent HIV Prevalence data)

HIV Prevalence data source and year of data: 2022

Race/Ethnicity	HIV Prevalence in EMA/TGA		Total Members of the PC/PB		Unaffiliated RWHAP Part A Clients on PC/PB	
	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
White, not Hispanic	13,320	24.86%	11	22.45%	4	33.33%
Black, not Hispanic	10,758	20.08%	14	28.57%	5	41.67%
Hispanic	24,961	46.59%	13	26.53%	2	16.67%
Asian/Pacific Islander	2,127	3.97%	4	8.16%	0	0.00%
American Indian/Alaska Native	316	0.59%	0	0.00%	0	0.00%
Multi-Race	1,980	3.70%	7	14.29%	1	8.33%
Other/Not Specified	115	0.21%	0	0.00%	0	0.00%
Total	53,577	100%	49	100%	12	100%

Gender	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
Male	46,509	86.81%	31	63.27%	6	50.00%
Female	5,947	11.10%	15	30.61%	5	41.67%
Transgender: male-to-female	1,079	2.01%	0	0.00%	0	0.00%
Transgender: female-to-male	42	0.08%	1	2.04%	0	0.00%
Other gender identity	-	0.00%	2	4.08%	1	8.33%
Total	53,577	100%	49	100%	12	100%

Age	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
13-19 years	94	0.18%	0	0.00%	0	0.00%
20-29 years	3,465	6.47%	3	6.12%	1	8.33%
30-39 years	10,648	19.87%	13	26.53%	0	0.00%
40-49 years	11,038	20.60%	11	22.45%	2	16.67%
50-59 years	14,905	27.82%	13	26.53%	6	50.00%
60+ years	13,427	25.06%	9	18.37%	3	25.00%
Total	53,577	100%	49	100%	12	100%

Percentages may not equal 100% due to rounding.
(Includes alternates)

Non-Aligned Consumers = 24.5% of total PC/PB

*Multi-Race: 5 commissioners indicated multi-race but did not specify their exact races/ethnicities, (1) White and American Indian, and (1) Hispanic/Latin-X and White.
Gender: (1) Non-Binary/Gender Non-Conforming and (1) Androgyne

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

Daryl Russell

Application on file at Commission office

Interview Panel: Everardo Alvizo, Jayda Arrington, and Joe Green
SEAT #34| MOTION #3

LOS ANGELES COUNTY
COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

Mark Mintline

Application on file at Commission office

1.

LOS ANGELES COUNTY COMMISSION ON HIV (COH)
FY 2022-2023 ASSESMENT OF MECHANISM (AAM)
APPROACH AND FOCUS PROPOSAL
DRAFT 8.8.23; 9.21.23

FOR DISCUSSION PURPOSES ONLY

BACKGROUND

The federal Health Resources and Services Administration (HRSA) requires all Part A planning councils (the Commission on HIV is Los Angeles County's Ryan White Part A planning council) to conduct annual "Assessments of the Administrative Mechanism" (AAMs). The AAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in LA County.

The most commonly cited key systemic weakness in the County's administrative mechanism is the protracted contracting period to executive a contract. It generally takes 12-18 months from solicitation development to contract execution.

It is recommended that the FY 2022-2023 AAM focus on identifying challenges to and identifying strategies to shorten and fast-track the contracting process. Furthermore, the Division of HIV and STD Programs (DHSP) suggested the following:

- Consider a very specific service category assessment.
- Tailor questions on how the County is responding to homelessness among PLWH and those at risk.
- The County demonstrated during the COVID response that a fast-track contracting process is possible, however the willingness by DPH and the CEO to allow expedited contracting for HIV and STD services remains very elusive for DHSP. This continues to be a problem with new grants.

METHODOLOGY

Key informant interviews and focus groups facilitated by a consultant.

Conduct key informant interviews with staff from the following County Departments and units:

Division of HIV and STD Programs (DHSP)

1. Senior management staff
2. Contracts and procurement staff
3. Finance staff
4. Contract monitoring/audit staff

Department of Public Health

1. Office of the Director
2. Contracts and Grants

Board of Supervisors

1. Health Deputies
2. Administrative Deputies

3. Chiefs of Staff

Chief Executive Office

- Administrative Services Division, Contracts and Procurement team

Contracted Agency Perspectives

- Interview a representative sample from DHSP-funded agencies.

Consumer Focus Group

- Consumers of HIV prevention and care services

Opportunity to Leverage the Board of Supervisor's Motion on Procurement Modernization and Transformation

On June 14, 2022 the Board approved a motion authored by Supervisor Kathryn Barger and co-authored by Supervisor Janice Hahn to modernize and transform the County's approach to purchasing and contracting. This motion supports past appeals made by the COH to the Board to remedy the outdated and protracted contracting and procurement process across the County. Some of the key goals of the motion is to streamline cycle times, move to paperless system, and implement a strategic, equitable, accessible, and transparent online procurement process.

The County Chief Executive Office (CEO), Internal Services Division (ISD), Quality and Productivity Commission (QPC) and other Departments are in the process of hiring an independent consultant to test and validate initial analyses and recommendations made by ISD and QPC and develop key recommendations to the Board for implementation across the County.

It is recommended that the COH's AAM for FY 2022-2023 leverage the activities underway as a result of the Board motion and develop assessment questions that would enhance the results of the study.

OVERVIEW OF THE CONTRACTING AND SOLICITATIONS PROCESS AT DPH/DHSP (EXCERPTS FROM FY 2014, 2015, 2016 AAM)

In November of 2016 Dr. Michael Green, Chief of the Planning Section of DHSP made a presentation to the PP&A Committee describing the contracting and solicitations process currently in place at DPH/DHSP. In order to place the process in context, we summarize his presentation here (based on approved minutes):

The process is designed to ensure County programs do not enter into contractual agreements without a full, unbiased review and that community-based organizations (CBOs) receiving contracts meet requirements and are fully accountable to the County.

- The Commission and DHSP coordinate on planning services. DHSP then plans and releases solicitations. Requests for Proposals (RFPs) are the most common while Requests for Statements of Qualifications (RFSQs) are used occasionally. Invitations for Bid (IFBs) are price-based solicitations generally insufficient to reflect the complexity [that] services require.

- It generally takes 12-18 months from solicitation development to contract execution. That does not include time at the Commission and DHSP to develop the service concept and Standards of Care which add at least six months.
- Proposal evaluation is in phases: first, to ensure they meet minimum requirements; second, an external review panel convened by Contracts and Grants (C&G), DPH; third, final funding recommendations; fourth, departmental reviews; fifth, contracts go to the Board for approval. Once approved, contract negotiations occur with the CBOs, then a Board Letter is submitted for contract approval. Once approved, the CBOs sign the contracts and then they can be executed.
- C&G is charged with managing the contracting process and solicitations for DPH overall but, for DHSP, C&G manages solicitation while DHSP manages programmatic content and contracting. In 2015, C&G staff was assigned to DHSP. That increased solicitations from zero in the prior three years with up to six in the last 12-14 months and more in progress.
- C&G's role includes responding to questions on a solicitation and releases an addendum that may clarify or change some solicitation language and answer specific questions. C&G will host a proposer's conference if the solicitation warrants one. Such conferences are not required by the County, but are helpful for complex solicitations.
- Proposers must meet minimum contract requirements as well as appear to be able to sustain services for 90 days without County funds to demonstrate financial stability. Proposers passing those tests go on to further evaluation.

  DHSP is responsible for identifying unbiased, non-conflicted evaluators for review panels. That is difficult, e.g., there were 36 proposals for one RFP. Serving requires significant time for no pay and evaluators must sign a statement of no conflict of interest so local providers are often ineligible. Evaluators have been recruited, e.g., from Las Vegas, San Diego and San Francisco, but often nonlocal people are not invested in participating. DHSP has recommended DPH leadership identify a list similar to a jury pool for a 12-month period. DPH showed interest, but has not acted.
- Contractors are selected and funding recommendations are developed based on evaluation scores as well as funding requirements, geographic distribution of services and targeted populations defined in the solicitation. Proposers may request a debriefing after the recommendations to review their proposals. They may appeal decisions.
- Services are solicited for a variety of reasons, e.g., to meet emerging need, redefine services, replace expiring contracts, [or] utilize new grant funding. DHSP tends not to apply for short-term grants, e.g., 24-36 months, because the time is too short to contract services within the grant term. For longer term grants, DHSP typically begins solicitation at the same time it applies for the grant to facilitate service implementation. Delegated authority allows DHSP to increase or decrease funds for a service by a certain percentage or time, but eventually services will need to be resolicited.
- Prior to applying for funding, DHSP must receive DPH approval by showing: purpose of funding, why it is needed, specifically how it will be used and how services will be implemented in the community.
- Concurrently, DHSP begins work on a Board Letter for approval to receive grant funds which includes: the amount of funds to be received in response to an application submitted on a certain date requesting a certain amount; how funds will be used and a proposed list of contractors. The Board Letter is required even for the annual Ryan White grant. DHSP cannot technically contract any services if the Health Resources Services Administration (HRSA) or

another grantor delays its Notice of Grant Award. HRSA often has delayed its Notice of Grant Award from one to six months.

- A sole source solicitation allows DHSP to identify an agency or agencies that it knows can do the work in the way it needs to be performed without putting the contract out to bid. DHSP has to prove to the Board that no other contractors can provide the needed service or that sole source is needed to expedite the work and the identified provider(s) are well-qualified to do the work.
- Generally, the Board does not approve sole source contracting. It did approve DHSP to use sole source for Medical Care Coordination (MCC) expansion after the Commission advocated for it and data supported the beneficial impact of MCC.
- Other solicitation forms theoretically save time, but rarely do so in practice. The RFP process takes the most time, but offers more clarity about what is wanted and proposer submittal requirements are more stringent so results are better.
- Dr. Green said the County's process is determined by the Board, Chief Executive Office and Auditor-Controller. Multiple attempts to persuade the Board to streamline the process were met with opposition but, as noted with MCC, the Board allows adjustments if need is demonstrated.

PROPOSED TENTATIVE TIMELINE

Secure feedback and approval from Operations, Executive and full Commission on AAM focus and approach for FY 2022-2023	August-September 2023 No feedback received from Ops as of 9.
Secure project consultant	September-November 2023
Selected project consultant to review interview questions and study approach with Operations, Executive, and COH.	December 2023-January 2024
Conduct assessment	February-April 2024
Develop report	April-May 2024
Present draft, findings, to Operations and Executive Committees	May- June 2024
Present final report to full Commission for adoption	July 2024

POLICY/PROCEDURE #09.4205	Commission Membership Evaluation, Nomination and Approval Process	Page 1 of 8

SUBJECT: **The submission, evaluation, scoring, selection, and nomination of applications/ candidates for seats on the Los Angeles County Commission on HIV.**

PURPOSE: **To outline consistent method for evaluating, scoring and selecting candidates to fill Commission seats, and for appropriate communication with those applicants before and after evaluation of the application.**

PROCEDURE(S):

1. **Membership Applications**: There are two Commission membership application forms:
   a) **New/Renewal Member Application**: for first-time applicants for Commission membership and renewing members, refer to electronic Membership Application found at https://www.surveymonkey.com/r/2023CommissiononHIVMemberApplication .
   b) **Non-Commission Committee Member Application(s)**: for applicants who are applying for membership on one of the Commission's standing committees, but not for the Commission, see Policy/Procedure #09.1007 (Non-Commission Committee Membership) for details regarding the process for evaluating and nominating non-Commission Committee member candidates.

2. **Application Submission**: All candidates for Commission or Committee membership must complete and submit a Commission or Committee-only membership application. Once the application is submitted and received by staff:
   a) Staff will review the application for member eligibility, completeness, and accuracy, and will verify with the candidate, via telephone and email, to ensure all eligibility requirements are met and/or to seek clarification on incomplete sections or confirm information not understandable/ accurate. Additionally, staff will review with the applicant the Commission's requirements, commitment expectations, and onboarding process for membership.
   b) Once the application has been completed and verified by staff, staff will coordinate interview and/or next steps with the Operations Co Chairs.

3. **Application Evaluation Timeline**: Provided all conditions for a Commission membership application are met, the Operations Committee, via a designated interview panel, will evaluate and score the application within 60 days of its receipt. Necessary conditions include, but are not limited to:
   a) Candidate meets or will meet by time of appointment, the Board of Supervisor's COVID-19 vaccination requirement.
   b) All sections of the application are complete,
   c) Original or electronic signatures have been provided,
   d) The applicant is willing and available to sit for an interview when appropriate.
   e) Current Commissioners or Alternates who are seeking to continue their membership on the Commission are required to complete an application prior to the expiration of their membership terms. The renewal application focuses on the member's past performance, strengths and weaknesses, and methods for improving any gaps in service and/or participation.
   f) Candidates for institutional seats will not be required to sit for an interview but may be assessed for strengths and skill sets for training opportunities and placement in the appropriate committee, task force, caucus, or workgroup.
   g) Candidates who are employed by organizations who receive Ryan White Program Part A funding through the Division of HIV and STD Programs (DHSP) must provide a written letter of support from their employer and provide to staff prior to interview. This requirement ensures that the employer is not only aware of their staff's participation on the Commission but confirms their support given the nature of the Commission's work and member expectation.

4. **Candidate Interviews**: All new member candidates must sit for an interview with a panel composed of at least two Commission members or alternates in good standing with at least one member assigned to the Operations Committee. To maintain transparency and integrity of the nomination process, should an interview panelist be assigned to an interview of an applicant with which the panelist has a personal relationship, working relationship while employed by same employer, used as reference by the applicant, and/or other conflict of interest as identified by the Operations Co-Chairs and Executive Director, the panelist will be removed from the interview panel and a qualified Commission member will be selected in their stead.

   The Operations Committee, in consultation with the Commission Co-Chairs, may request an interview with a member seeking to renew his/her Commission membership. Likewise, a renewal membership candidate may request an interview with the Operations Committee. .

5. **Interview/Scoring Sequence**: Applications are always evaluated and scored following the interview. At its discretion, the interview panel may request a second interview after it has scored an application, and re-score the application following the interview to incorporate any new information learned at subsequently and/or at the interview. Point scores may or may not change when an application is re-scored following an interview.

6. **Score(ing)**: The interview panel evaluates the applicant according to the appropriate "Los Angeles County Commission on HIV New Member Application Evaluation & Scoring."
   a) Each member of the interview panel participating in the evaluation assigns a point value to each factor of criteria.
   b) All interview panel members' scores are totaled and averaged. The final point value is the applicant's final score.

7. **Scoring Forms**: The Commission's Operations Committee is responsible for the development and revision of the Membership Candidate Evaluation/Scoring Forms. The Committee develops separate scoring forms for new member candidates and renewal candidates:
   a) Scoring criteria is based on essential skills and abilities, qualities and characteristics, experience, and past performance (for renewal candidates) that the Committee determines is necessary for effective Commission member participation.
   b) The Operations Committee determines those factors and their relative importance through annual membership assessments.
   c) The Operations Committee is authorized to revise the scoring form as needed. To the degree that revisions are substantial, or criteria are altered, the revised scoring form must be approved by the Commission.

8. **Qualification Status**: By virtue of their application scores, candidates' application will be determined to be "Qualified" or "Not Qualified" for nomination to a Commission membership seat. A minimum of 60 points qualifies the candidate for nomination consideration ("Qualified"); a score of less than 60 indicates that a candidate is "Not Qualified".
   a) If the applicant earns a "Not Qualified" score, the Operations Co-Chairs will inform the applicant accordingly and suggest opportunities of other HIV/AIDS planning or volunteer involvement as further preparation for future Commission service.

9. **New Member Candidate Eligibility**: New member candidates must also be "eligible" for Commission membership nomination. New member candidates are considered eligible if they meet the following conditions:
   a) The application score qualifies ("Qualified") the candidate for Commission membership.
   b) There is not purposefully misleading, untruthful, or inaccurate information on the application.
   c) The applicant has fully participated in the evaluation/scoring process, as appropriate.
   d) The applicant does not violate the Commission's "two persons per agency" rule. *To avoid potential influence and to preserve the integrity of the Commission's decision-making and planning process, the Commission's membership cannot consist of more than two agency representatives from the same agency*.

10. **Renewal Candidate Eligibility**: Current Commissioners seeking re-appointment to the Commission must be "eligible" for continued Commission membership. Renewal candidates are considered eligible if they meet the following conditions:
    a) There is not purposefully misleading, untruthful or inaccurate information on the application.
    d) The applicant does not violate the Commission's "two persons per agency" rule.
    e) The candidate has fulfilled Commission member requirements in his/her prior term of service, including, but not limited to:
        - ***Commission Meeting Attendance***: unless the reason for the absence falls within Policy #08.3204 Excused Absences, members cannot miss three sequential, regularly scheduled Commission or primary assignment committee meetings in a year, or six of either type of meeting in a single year. Policy 08.3204 dictate that excused absences can be claimed for the following reasons:
            - personal sickness, personal emergency and/or family emergency;
            - vacation; and/or
            - out-of-town travel
        - ***Primary Committee Assignment***: members have actively participated in the committee to which they have been assigned, including compliance with meeting attendance requirements.
        - ***Training Requirements***: members are required to participate in designated trainings as a condition of their memberships.
        - ***Plan of Corrective Action (PCA)***: the member must fulfill the terms of any PCA required of him/her by the Operations and/or Executive Committee(s).

11. **Nominations Matrix**: If the applicant is eligible for Commission membership, the Operations Committee will place the candidate among those that can be nominated for available and appropriate seats on the Commission on its upcoming agenda for Committee approval. The candidate's name is entered on the "Nominations Matrix" which lists candidates in order of scores, alongside available Commission seats and vacancies.

12. **Seat Determination**: At the recommendation of the interview panel, the Committee will then determine the individual seats, if any, that are most appropriate for the available qualified candidates—based on the seats the candidates indicated in their applications, and any other seat(s) identified by Committee members that the candidate(s) are qualified to fill.
    a) Duty Statements for each seat dictate requirements for each membership seat on the Commission.

13. **Multiple Application Requirement**: In accordance with HRSA guidance, there should be multiple candidates for membership seats when possible. All consumer and provider representative seats, along with other seats designated by the Operations Committee, require two or more applications. The Operations Committee may exempt a seat previously designated to require multiple applications from that requirement under the following circumstances:

a) There has been a vacancy in the seat for six or more months,
b) The pool of available, possible candidates is limited, and
c) The Committee is convinced that every effort has been made and exhausted by the appropriate stakeholders to identify additional membership candidates.

14. **"Representation" Requirement**: Ryan White legislation and HRSA guidance require the Part A planning council membership to include specific categories of representation. The Commission's membership seats have been structured to fulfill that requirement. As specified in the COH Bylaws (Policy/Procedure #06.1000), Commission membership shall include individuals from areas with high HIV and STD incidence and prevalence. The Commission endeavors to ensure those categories are always represented by planning council membership.

15. **"Unaffiliated Consumer" Requirement**: Ryan White legislation and HRSA guidance require one-third or 33% of the voting membership of the Ryan White Part A planning council to be "unaffiliated" or "non-aligned" consumers. "Unaffiliated" consumers are patients/clients who use Ryan White Part A-funded services **and** who are not employees or contractors of a Ryan White Part A-funded agency **and** do not have a decision-making role at any Ryan White Part A-funded agency. (Policy/Procedure #08.3107 contains information on Consumer Definitions and Related Rules and Requirements). In addition, the Commission defines "Unaffiliated Consumer" as someone using Ryan White Part A-funded services within the last year and who is "unaffiliated" or "non-aligned," consistent with Ryan White legislative and HRSA definitions.

    Following the updated ordinance of the Commission as an integrated HIV prevention and care planning body, a "Consumer" is defined as an HIV-positive and/or AIDS-diagnosed individual who uses Ryan White-funded services or is the caretaker of a minor with HIV/AIDS who receives those services, or an HIV-negative prevention services client.

16. **"Reflectiveness" Requirement**: Ryan White legislation and HRSA guidance require both the entire Commission membership and the subset of unaffiliated consumer members to "reflect" the gender and ethnic/racial distribution of the local HIV epidemic. The Commission endeavors to always reflect the gender and ethnic/racial demographic distribution of Los Angeles County's HIV epidemic among its membership and consumer members. Furthermore, the CDC HIV Planning Guidance notes that planning bodies place special emphasis on identifying representatives of at-risk, affected, HIV-positive, and socioeconomically marginalized populations.

17. **Committee Nominations**: All factors being equal among two or more applications that meet the requirements of a particular open seat, the Committee will forward the candidate with the highest application score to the Commission for nomination to the Board of Supervisors for appointment to the Commission.

18. **Special Considerations**: There are several "special considerations" that may preclude the Committee from nominating the candidate with the highest score, resulting in the nomination of a candidate with a lower score to a seat. Those factors may include, but are not limited to:
    a) the necessity of maintaining "reflectiveness",
    b) an adequate proportion of consumer members,
    c) the need to fill certain "representative" categories,
    d) Board of Supervisors interest or feedback,
    e) over-representation of a particular stakeholder/constituency, otherwise known as the "two persons per agency" rule.
    f) potential appointment challenges.
    g) candidate would violate the COH's two person/per agency rule

19. **Conditional Nomination(s)**: The Operations Committee may nominate candidates "conditionally." Conditional nominations require candidates to fulfill certain obligations from the Executive and/or Operations Committee prior to or following the nomination. Conditions are detailed in a "Plan of Corrective Action (PCA)" imposed to correct past Commission performance issues or to enhance certain skills and abilities of the candidate/ member.
    a) The PCA is written with expected timelines and objectives, and must be agreed to and signed by the candidate, the Executive Director and an Executive or Operations Committee co-chair, as appropriate.
    b) The candidate must agree to the PCA by the subsequent regularly scheduled committee meeting following the development of the PCA. A candidate's refusal to accept a PCA may render his/her application ineligible.
    c) If the PCA obligates the candidate to certain conditions prior to nomination, the nomination will not proceed until the candidate has fulfilled those obligations.
    d) If the candidate/member has not fulfilled the conditions of the PCA, he/she will not be eligible for future re-nomination to the Commission.
    e) Terms of the PCA may be modified at any time upon agreement from all three parties (candidate/member, Executive Director, committee).
    f) The Operations Committee is responsible for monitoring a candidate's progress and fulfillment of any PCA obligations and requirements.

20. **Candidate Communication**: At the conclusion of a candidate's evaluation (interview, scoring, qualification and eligibility designation, seat determination, nomination), the Committee shall notify the candidate in written communication of the results of the evaluation and scoring process. The notification will detail one of the three possible results:
    a) The Committee has nominated the candidate for a particular Commission seat;
    b) The Committee has judged that there are no specific seats available concurrent with the candidate's qualifications, but the Committee will keep the candidate's application and evaluation scores for ongoing consideration for up to a year from the date of application submission; or
    c) The candidate's application and/or evaluation has been placed on hold temporarily.

21. Temporary Hold: A candidate's application may be held temporarily for up to a year under certain conditions that preclude an otherwise eligible nomination to proceed, including but not limited to:

a) Multiple candidates have not applied for a seat that requires multiple applications,
b) Appointment of the candidate to a seat would interfere with the Commission's capacity to meet representation, consumer and/or reflectiveness requirements, and/or
c) The Committee intends to nominate the candidate to a seat that is expected to be vacated soon.

The Operations Committee will provide the reason(s) for a temporary hold when it notifies the candidate of his/her application status. Once a candidate's application has been released from the hold, the candidate must agree to the nomination before it proceeds. If the hold is not released within the year, the candidate must submit a new application for Commission membership.

22. Withdrawal/Declination: At any time after a candidate has submitted an application up until the appointment is approved by the Board of Supervisors, a candidate is entitled to withdraw his/her application and/or decline a proposed nomination.

23. Training Requirements: Commissioners and Alternates are required to fulfill all training requirements, as indicated in the Commission's approved comprehensive training plan, including, but not limited to, the New Member Orientation(s), and Los Angeles County Ethics and Sexual Harassment trainings. Failure to fulfill training requirements as a Commission member may render the member's subsequent renewal applications ineligible.

24. Nomination and Approval: Once the Operations Committee has nominated a candidate for Commission membership, the Committee forwards the nomination(s) to the Commission for approval at its next scheduled meeting. When a candidate's nomination has been approved by the Commission, the candidate's Statement of Qualifications shall be forwarded within two weeks to the Executive Office of the Board of Supervisors.

a) Candidates are advised to attend the Commission meeting at which their nomination will be considered.
b) Upon Commission approval, the candidate is encouraged to attend all committees to learn how they operate and assess the best fit for a committee assignment.
c) Upon Commission approval, the candidate is asked to select its preferred primary Committee assignment. In most instances, the candidate will be asked to review the Committee Description and select their preferred committee in advance of approval to allow staff to review committee membership assignments to ensure parity, inclusion and reflectiveness.

25. Appointment: The Executive Office of the Board of Supervisors places the nomination on a subsequent Board of Supervisors agenda for appointment. Upon Board of Supervisors approval, the candidate is appointed to the Commission.

a) Candidates are not required to appear before the Board of Supervisors, although they may attend the designated meeting if so desired.
b) Candidates will be notified in writing when their nomination will appear before the Board of Supervisors and following appointment.
c) A newly appointed Commission member is expected to begin his/her service on the Commission at the next scheduled Commission meeting following Board appointment.
d) Each Commission seat has a pre-designated term of office in which the Commission member will serve until the term expires or he/she resigns from the seat. Should a member's seat change during their membership which prompts a change in their term of office, an updated signed SOQ must be resubmitted to the Executive Office to place the member on the BOS agenda for reappointment to formalize the change in term of office.

NOTED AND APPROVED: Cheryl A Barnit **EFFECTIVE DATE:** 5/10/18

Original Approval: 9/6/2004
Revision(s): 5/12/2011; 2013; 4/27/16; 4/12/16; 5/12/16; 5/2/17; 5/22/17; 9/14/17; 05/10/18; 2/9/23

LOS ANGELES COUNTY
COMMISSION ON HIV

REVISED 2023 Training Schedule

- All trainings are open to the public.
- Click on the training topic to register.
- Recordings will be available on our website for those unable to join live trainings.
- Certifications of Completion will be provided.
- All trainings are virtual.

Topic	Date
General Orientation and Commission on HIV Overview *	March 29 3:00 - 4:30 PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 12 3:00 - 4:30 PM
Tips for Making Effective Written and Oral Public Comments	May 24 3:00 - 4:00 PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 19 3:00 - 4:30 PM
Public Health 101	August 16 3:00 - 4:30 PM
Sexual Health and Wellness	September 20 3:00 - 5:00 PM
Health Literacy and Self-Advocacy **Changed from Oct. 18 to 24th**	October ~~18~~ 24 3:00 - 4:30 PM
Policy Priorities and Legislative Docket Development Process *	November 15 3:00 - 4:30 PM
Co-Chair Roles and Responsibilities **Changed from Dec. 6 to Feb. 13, 2024**	FEB. 13, 2024 ~~December~~ 6 4:00 - 5:00 PM

Mandatory core trainings for all commissioners.

MEDICAL CARE COORDINATION SERVICE STANDARDS

DRAFT FOR EXECUTIVE COMMITTEE REVIEW 10/26/23

DRAFT FOR EXECTUIVE COMMITTEE REVIEW

MEDICAL CARE COORDINATION SERVICE STANDARDS

IMPORTANT: The service standards for Medical Care Coordination adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

- Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 (Revised 10/22/18): Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
- HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
- Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The purpose of the standards is to ensure that all RWHAP service providers offer the same fundamental components of the given service category. Additionally, the standards set the minimum level of care Ryan White-funded service providers may offer clients, however, service providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV (COH) developed the Medical Care Coordination (MCC) service standards to establish the minimum service necessary to provide coordinated medical and non-medical care to people living with HIV regardless of where services are received in the County. The developed of the standards included review of an alignment with the 2018 HIV/AIDS Medical Care Coordination Service Guidelines from the Los Angeles County Department of Public Health Division of HIV and STD Programs, as well as feedback from service providers, people living with HIV, members of the COH's Standards and Best Practices (SBP) Committee, COH caucuses, and the public-at-large. All service standards approved by the COH align with the Universal Service Standards[1] approved by the COH on February 11, 2021.

MEDICAL CARE COORDINATION OVERVIEW

The Medical Care Coordination model is an integrated service model to fully respond to patient's unmet medical and non-medical support needs (e.g. mental health, substance use, and housing) through coordinated case management activities to support continuous engagement in care and adherence to antiretroviral therapy[2].

MCC services include:

- Comprehensive assessment/reassessment
- Development and monitoring of an Integrated Care Plan
- Brief interventions

[1] The Universal Service Standards document is currently under review by the Standards and Best Practices Committee. A revised version of the document will be uploaded to the Commission on HIV website in early 2024.

[2] Adapted from the 2018 HIV/AIDS Medical Care Coordination Service Guidelines.

- Referrals
- Case conferences
- Patient retention services

The goals of MCC include:

- Increase retention in HIV care
- Improve adherence to antiretroviral therapy (ART)
- Link patients with identified need to mental health[3], substance use, specialty care, and housing resources, and other support services
- Reduce HIV transmission through sexual risk and substance use reduction counseling and education

All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

MEDICAL CARE COORDINATION MODEL

All patients receiving medical care in Ryan White-funded clinics are routinely screened for Medical Care Coordination (MCC) based on clinical and psychosocial criteria. The patients who are identified as candidates for MCC services or who are directly referred by their medical provider are then enrolled into the MCC program.

Physical co-location of the medical outpatient clinics and MCC programs and medical team is necessary and will be determined based on the needs of the program, the patient population, and the providers delivering the service. MCC programs must operate from a central location that serves as an administrative hub and primary program venue. MCC is an integrated approach to care, rather than a location where care is provided.

MCC teams are integrated into the medical home as part of the medical care team to ensure the Medical Care Manager, Patient Care Manager, Case Worker, and Retention Outreach Specialist are able to work together and directly with the patient. The Medical Care Manager is responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan, which is developed by the MCC team and patient, for anyone eligible for the service. The Patient Care Manager will work with the Medical Care Manager to address the patient's psychosocial needs, and track and supervise these components of the Integrated Care Plan.

Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Depending on the size of the program and volume of patients, the program may employ additional case workers who are directly supervised by the care manager. In the case of a smaller program, the Medical and Patient Care Managers directly support all patients on an ongoing basis.

[3] The terms *mental health* and *behavioral health* are often used interchangeably. For the purposes of the Medical Care Coordination service standards, *mental health* is used and is intended to encompass a broad range of related diagnoses and services necessary to achieve optimal patient health outcomes.

The retention outreach specialist will directly engage clients who are at-risk of falling out of care or are lost to care. The retention outreach specialist is responsible for reaching the patients through all available means of communication, including but not limited to phone calls, text messages, emails, physical mail, and street outreach to parks, food pantries, and shelters.

All members of the MCC team have a responsibility to serve as a contact to each patient for continued care and support. Care coordination programs may choose to engage additional providers for specific services (e.g., mental health, substance use,) or may establish comprehensive service agreements with such providers that will facilitate the program's access to those additional services. Memoranda of Understanding between the grantee and the provider/agency must be submitted to the Los Angeles County Department of Public Health Division of HIV and STD Programs.

SERVICE COMPONENTS

MCC services are patient-centered activities that focus on facilitating access to, utilization of, and engagement in primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. All MCC services should aim to increase the patient's sense of empowerment, self-advocacy, and medical self- management, as well as enhance the overall health status of the patient. Programs must ensure patients are given the opportunity to ask questions and receive accurate answers regarding services provided by MCC staff and other professionals to whom they are referred. These discussions build the provider-patient relationship, serve to develop trust and confidence, and empower patients to be active partners in decisions about their health care. In addition, MCC services will be culturally and linguistically appropriate.

The overall emphasis of ongoing MCC services should be on facilitating the coordination, sequencing, and integration of primary health care, specialty care, and all other services in the continuum of care to achieve optimal health outcomes.

MCC services in Los Angeles County will include (at minimum):

- Comprehensive assessment/reassessment
- Integrated Care Plan
- Brief interventions
- Referrals, coordination of care, and linkages
- Case conferences
- Patient retention services

PATIENT ELIGIBILITY

Patient eligibility is determined at intake, which includes the collection of demographic data, emergency contact information, relative/significant other, and eligibility documentation. Although MCC is a Ryan White Program, patients do not need to be receiving Ryan White funded medical care or support services to receive MCC services.

Ryan White Program eligibility includes individuals who:

- Reside in Los Angeles County
- Are age 12 years or older
- Have a household income equal to or below 500% Federal Poverty Level, and
- Are living with HIV

An intake process, which includes registration and eligibility, is required for every patient's point of entry into the MCC service system. If an agency or other funded entity has the required patient information and documentation on file in the agency record or in the countywide data management system, further intake is not required to avoid burden on client. Patient confidentiality will be strictly maintained and enforced.

The client file will include the following information (at minimum):

- Date of intake
- Client name, mailing address[4] and telephone number
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Verification of medical insurance
- Emergency contact's name, home address and telephone number
- Required Forms: Programs must develop the following forms in accordance with State and local guidelines.
- Release of Information[5]
- Confidentiality policy
- Consent to Receive Services
- Patient Bill of Rights and Responsibilities[6]
- Customer Support Program
- Notice of Privacy Practices (HIPAA)

PATIENT ASSESSMENT/REASSESSMENT

The Medical Care Coordination assessment is the systematic and continuous collection of data and information about the patient and their need for MCC services. The assessment is a countywide standardized acute assessment tool and is used to identify and evaluate a patient's medical, physical, psychosocial, environmental, and financial strengths, needs and resources. While the assessment helps guide discussion between the MCC team and the patient, and ensures specific domains are addressed, it is not exhaustive. The patient assessment and reassessments must be conducted collaboratively and in a coordinated manner by the Medical Care Manager and Patient Care Manager team. The medical information and medical assessment portions of the assessment and reassessment must be completed by the Medical Care Manager.

The comprehensive assessment determines the:

- Patient needs for treatment and support services, and capacity to meet those needs
- Integrated Care Plan
- Ability of the patient's social support network to help meet patient needs
- Involvement of other health and/or supportive agencies in patient care
- Areas in which the patient requires assistance in securing services

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[4] For patients without an address, a signed affidavit declaring they are homeless should be kept on file.

[5] Must specify what information is being released and to whom

[6] Service providers are to provide a copy of the Commission on HIV Patient Bill of Rights and Responsibilities to clients.
NOTE: The document is currently under review by the Standards and Best Practices Committee. A revised version of the document will be uploaded to the Commission on HIV website in early 2024.

Patient acuity levels will be determined based on responses of the comprehensive assessment. Emergencies or medical and/or psychosocial crisis may require quick coordination decisions to mitigate the acute presenting issues before completing the entire intake/assessment. Acuity levels will be updated through reassessment dependent on patient need but should be conducted annually at minimum. We need to add language that the re-assessment process should be shorter and verify the need to remain in MCC and update acuity levels. DHSP will need to develop a shorter re-assessment form.

The acuity levels are as follows:

- **Self-managed**: For patients presenting some need, but whose needs are easily addressed; refer to other Ryan White services.
- **Moderate acuity**: For patients presenting some need, but whose needs are relatively easily addressed.
- **High acuity**: For patients presenting the most complex and challenging needs; and
- **Severe acuity**: For patients presenting in crisis who require immediate, high frequency and/or prolonged contact.

Acuity levels may by adjusted based on MCC team's understanding of patient needs not captured on the assessment/reassessment

INTEGRATED CARE PLAN

The Integrated Care Plan (ICP) is an individualized multidisciplinary service plan to be completed following the completion of the comprehensive assessment. The ICP is patient centered with the patient as an active participant in its development together with the Medical Care Manager and Patient Care Manager. The plan should be guided by needs identified by domains from the assessment and additional information expressed to the MCC team.

Assessment domains are based on the following:

- Health Status
- Quality of Life/Self-Care
- Antiretroviral Knowledge & Adherence
- Medical Access, Linkage and Retention
- Housing
- Financial Stability
- Transportation
- Legal Needs/End of Life Needs
- Support Systems and Relationships
- Risk Behavior
- Substance use and Addiction
- Mental Health

In rare cases, due to the type of treatment, immediacy of services and/or their confidential nature (e.g., mental health, legal services), the ICP may be limited to referencing, rather than detailing, a specific treatment plan and/or the patient's agreement to seek and access those specific services.

PROGRESS NOTES/MONITORING PATIENT PROGRESS

ICP implementation and evaluation involve ongoing contact and interventions with, or on behalf of, the patient to ensure goals are addressed that work towards improving a patient's health and resolving psychosocial needs. Current dated and signed progress notes, detailing activities related to implementing and evaluating, will be kept on file in the patient record.

The following documentation is required (at minimum):

- Date, type, and description of all patient contact, attempted contact and actions taken on behalf of the patient
- Changes in the patient's condition or circumstances
- Progress made towards achieving goals identified in the ICP
- Barriers identified in reaching goals and actions taken to resolve them
- Current status, results, and barriers to linking referrals and interventions
- Time spent with, or on behalf of, the patient
- Care coordination staff's signature and professional title
- Follow up within 1-5 business day with patients who miss an MCC appointment. If follow-up activities are not appropriate or cannot be conducted within the prescribed time, care coordination staff will document reason(s) for the delay.
- Collaborating with the patient's other service providers for coordination and follow-up

BRIEF INTERVENTIONS

Brief interventions are short sessions that raise awareness of risks and motivates patient toward acknowledgement of an identified behavioral issue. The goal of the brief intervention is to help the patient see a connection between their behavior and their health and wellbeing. Based on the goals and objectives identified in the patient's ICP, MCC team members shall deliver brief interventions designed to promote treatment adherence and overall wellness for MCC patients. The brief interventions are not a substitute for long-term care for patients with a high level of need; referrals to more intensive care may be warranted in those situations. For example, patients with severe or complex mental health needs should be referred to the appropriate specialist.

MCC intervention activities primarily focus on:

- Promoting Antiretroviral Therapy Adherence
- Risk Reduction Counseling[7]
- Engagement in HIV care
- Mental Health
- Re-engagement in HIV care
- Disclosure Assistance
- Housing support and referrals
- Other activities that improve the overall patient wellness

PATIENT SELF-EFFICACY AND CARE

MCC teams will teach patients and their caregiver's effective HIV disease self-efficacy skills to improve self-sufficiency health outcomes with attention to meeting the cultural needs and challenges of the patients. Staff will educate clients and caregivers about maintaining an undetectable viral load will result

[7] Includes sexual and substance use risk reduction counseling.

in little to no risk of HIV transmission. MCC teams will educate and empower clients to interact effectively with all levels of service providers and to become increasingly informed and independent consumers.

REFERRALS

Programs providing MCC services will actively collaborate with other agencies to maximize their capacity to provide referrals to the full spectrum of HIV-related services. Programs must maintain a comprehensive list of service providers--both internal and external-- for the full spectrum of HIV-related and other services. The MCC team should refer patients to appropriate services based on needs identified in the assessment and reassessment and described in the Integrated Care Plan.

Programs will develop written protocols, or use existing agency protocol, for referring patients to other providers, networks and/or systems. Referrals must be tracked and monitored to ensure linkage to referrals are documented. MCC teams are responsible for working with patients to increase follow through in linking referrals.

CASE CONFERENCES

Multidisciplinary case conferences, formal and informal, are a critical component of MCC services and help integrate the MCC team into the medical care team. Case conferences convene a patient's MCC team and other key care providers (e.g. physician, nurse practitioner, physician assistant) to assess progress in meeting the needs identified in the patient's ICP and to strategize further responses.

Case conferences are an opportunity to address major life transitions and changes in health status for the patient with other members of the care team and should be conducted when possible. Programs are expected to convene case conferences based on patient need and acuity level.

Documentation of case conferences shall be maintained within each patient record and include:

- Date of case conference
- Names and titles of participants
- Medical and psychosocial issues and concerns identified
- Description of recommended guidance
- Follow-up plan
- Results of implementing guidance and follow-up

PATIENT RETENTION

Agencies or medical homes providing MCC services will develop and implement a plan that guides the agency's efforts to re-engage patients into care:

- Patients at the clinic who have fallen out of care
- Patients who are aware of their HIV status, but not in care (i.e. unmet need)
- Patients at risk for falling out of care

Retention Outreach Specialists (ROS) are responsible for following up with patients that the MCC team has not been able to engage or re-engage through existing resources. This includes attempting to locate patients that have missed an HIV medical or MCC appointment. Locating patients may entail visiting the patient's last known address and/or sites of frequent socialization (e.g. food pantry, parks, community centers), contacting patients' other service providers, researching whether the patient is incarcerated, or other methods to bring the patient back into HIV care.

Retention Outreach Specialist will:

- Identify clinic patients not engaged in HIV medical care within the past 7 months.
- Work as an integral part of the medical care coordination (MCC) services team, including participating in team meetings.
- Act as liaison for clinic patients recently released from incarceration to ensure timely reengagement into HIV medical care.
- Work with out of care clinic patients to identify and address potential and/or existing barriers to engagement in medical care.
- Utilize motivational interviewing techniques to encourage patients to engage in and/or reengage into HIV medical care.

Programs will strive to retain patients in medical care coordination services. To ensure continuity of service and retention of patients, programs should follow existing agency specific policies regarding broken appointments. Follow-up may include telephone calls, written correspondence and/or direct contact. Programs will demonstrate due diligence through multiple efforts to contact patients by phone or by mail and document efforts in progress notes within the patient record. In addition, programs will develop and implement a contact policy and procedure to ensure that patients who are homeless or report no contact information are not lost to follow-up.

DISENROLLMENT

The disenrollment process includes formally notifying patients of pending disenrollment and completing a disenrollment summary to be kept on file in the patient record. All attempts to contact the patient and notifications about disenrollment will be documented in the patient file, along with the reason for disenrollment. Note that cases often remain open, and should not be closed, so that the Retention Outreach Specialists can locate and rescreen patients.

Clients may be disenrolled if:

- Relocates out of the service area
- Has had no direct program contact in the past six months despite multiple attempts by staff to contact the client
- Is ineligible for the service
- Discontinues the service
- Uses the service improperly or has not complied with the client services agreement
- Is deceased
- No longer needs the service

When appropriate, disenrollment summaries will include a plan for continued success and ongoing resources to potentially be utilized. At minimum, disenrollment summaries will include:

- Date and signature of both the Medical and Patient Care Managers
- Date of disenrollment
- Status of the Integrated Care Plan
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for reentry into services

STAFFING REQUIREMENTS AND QUALIFICATIONS

Individuals on the MCC team must be in good standing and hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all MCC staff will be able to provide timely, linguistically, and culturally competent care to people living with HIV. MCC staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs.

Staff should also be trained by their agency on patient confidentiality and HIPAA regulations, and de-escalation techniques. It is recommended that MCC teams across agencies convene at least once a year to discuss best practices, outcomes, and exchange ideas on how to best provide patient care through MCC.

The minimum requirements for MCC staff are:

- Medical Care Manager must possess a valid license as a registered nurse (RN) in the state of California.
- Patient Care Manager must possess a master's degree in one of these disciplines: Social Work, Counseling, Psychology, Marriage, and Family Counseling, and/or related Human Services field.
- Case Worker(s) must possess a bachelor's degree in nursing, Social Work, Counseling, Psychology, Human Services; OR possess a license as a vocational nurse (LVN) or have demonstrated experience working in the HIV field.
- Retention Outreach Specialist shall possess the following requirements:
  - Experience in conducting outreach to engage individuals; and
  - Shall have good interpersonal skills; experience providing crisis intervention; knowledge of HIV risk behaviors, youth development, human sexuality, or substance use disorders; ability to advocate for clients; and be culturally and linguistically competent.

The core MCC team members above may engage other specialists, such as but not limited to, mental health therapists, housing specialists, and geriatricians to address the needs of the client.

TRANSLATION/LANGUAGE INTERPRETERS

Federal and State language access laws[8,9] require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. MCC staff must develop procedures for the provision of such services, including the hiring of staff able to provide services in the native language of limited English proficiency patients and/or staff reflective of the population they serve.

[8] Civil Rights Division | Title VI of the Civil Rights Act of 1964 (justice.gov)
[9] California 1973 Dynally-Alatorre Bilingual Services Act can be access here https://www.bsa.ca.gov/pdfs/reports/99110.pdf

SERVICE STANDARDS—MEDICAL CARE COORDINATION

All contractors must meet the Universal Service Standards approved by the COH in addition to the following Medical Care Coordination service standards[10]. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

SERVICE COMPONENT	STANDARD	MEASURE
PATIENT ELIGIBILITY	Eligibility determined by provider	Patient file includes: • Los Angeles County resident • Age 12 years or older • Household income equal to or below 500% FPL
	Required forms are discussed and completed	Signed and dated forms: • Release of information • Confidentiality policy • Consent to receive services • COH Patient Bill of Rights and Responsibilities • Grievance procedures • Notice of privacy practices (HIPAA)
PATIENT ASSESSMENT AND REASSESSMENT	Acuity level assigned to patient based on assessment results.	Completed tool kept on file in patient record. Patient acuity level assigned as: • Self-managed • Moderate • High • Severe
	Reassessments are conducted based on patient need, but annually at minimum to update patient acuity.	Program monitoring and reassessment on file
	Patients unable to actively participate in Medical Care Coordination services will be referred to home-based case management, skilled nursing, psychiatric services, or hospice care.	Documentation of linked referral on file in patient record
INTEGRATED CARE PLAN	Integrated Care Plan will be developed collaboratively with the patient within 30 days of completing the assessment.	Integrated Care Plan on file includes: • Patient Name • Patient Care Manager Name • Medical Care Manager Name

[10] The Universal Service Standards can be accessed at https://hiv.county.gov/service-standards. **NOTE:** The Universal Service Standards document is currently under review by the Standards and Best Practices Committee. A revised version of the document will be uploaded to the Commission on HIV website in early 2024.

		• Date and patient signature • Date and PCM and MCM signature. Electronic signatures are acceptable
PROGRESS NOTES/MONITORING PATIENT PROGRESS	MCC team will monitor: • Implementation of Integrated Care Plan • Changes in the patient's condition or circumstances • Lab results • Adherence to medication • Completion of referrals • Delivery of brief interventions • Barriers to care and engagement	Progress notes on file include: • Date, type, and description of all patient contact, attempted contact and actions taken on behalf of the patient • Changes in the patient's condition or circumstances • Progress made toward achieving goals • Barriers to reaching goals and actions taken to resolve them • Current status and results of recommended referrals • Current status and results of recommended interventions • Time spent with patient • Care Team signatures. Electronic signatures are acceptable.
BRIEF INTERVENTIONS	Brief interventions may focus on: • Promoting Antiretroviral Therapy (ART) adherence • Risk Reduction Counseling • Engagement in HIV care • Mental Health	Documentation of recommended interventions in progress notes.
PATIENT SELF-EFFICACY AND CARE	MCC team will education patients on the importance of maintaining an undetectable viral load, the importance of adhering to care, and increase their capacity to engage their own care.	Documentation of education on file in patient record.
REFERRALS	MCC team will provide referrals as needed based on assessment and reassessments. Agency or medical care home will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals.	Identified resources for referrals at provider agency (e.g. lists on file, access to websites).
	If needed, engage additional providers for specific support services (e.g. mental health, substance use).	Memoranda of Understanding (MOU) on file.
CASE CONFERENCES	MCC team will convene case conferences, formal and informal, to	Documentation on file includes: • Date • Name/Titles of participants

	ensure coordination of care for patient.	• Identified medical and psychosocial issues and concerns • Description of recommended guidance • Follow-up plan • Results of implemented guidance
PATIENT RETENTION	Agency or medical home will develop procedures or follow existing agency-specific policies to work with patients: • At the clinic who have fallen out of care • Who are aware of HIV status, but not in care • At risk for falling out of care	Documentation of attempted patient contact on file.
DISENROLLMENT	MCC team will follow up with patients who have missed appointments and may be pending disenrollment.	Number of attempts to contact and mode of communication documented in patient file.
	Cases may be disenrolled when the patient: • Relocated out of the service area • Has had no direct program contact in the past six months despite multiple attempts by staff to contact the client • Is ineligible for the services • Discontinues the service • Uses the service improperly or has not complied with the client services agreement • Is deceased • No longer needs the service	Justification for disenrollment documented in patient file.
STAFFING REQUIREMENTS	MCC team will include: • Medical Care Manager • Patient Care Manager • Case Worker(s) • Retention Outreach Specialist The core MCC team members above may engage other specialists, such as but not limited to, mental health therapists, housing specialists, and geriatricians to address the needs of the client.	Documentation of required licenses on file: • Medical Care Manager: RN license in the State of CA • Patient Care Manager: master's degree in social work, Counseling, Psychology, Marriage and Family Counseling, and/or related Human Services field. • Case Worker(s): bachelor's degree in nursing, Social

		Work, Counseling, Psychology, Human Services OR possess a license as a vocational nurse (LVN) OR have demonstrated experience working in the HIV field. • Retention Outreach Specialist: 1) Experience in conducting outreach to engage individuals; and 2) Shall have good interpersonal skills; experience providing crisis intervention; knowledge of HIV risk behaviors, youth development, human sexuality, or substance use disorders; ability to advocate for clients; and be culturally and linguistically competent.
TRANSLATION AND LANGUAGE INTERPRETERS	MCC programs will develop or utilized existing agency-specific policies to provider interpretation services to patients at no cost.	Policy on file at agency.

REFERENCES

Care Coordination. Content last reviewed August 2018. Agency for Healthcare Research and Quality. Rockville, MD. http://ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

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Garland WH, Oksuzyan S, Mejia M, and Kulkarni S. Medical Care Coordination Services for Persons Living with HIV in Los Angeles County: A Robust Strategy to Strengthen the HIV Care Continuum. Los Angeles County Department of Public Health. October 2017.

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Maina G, Mill J, Chaw-Kant J, and Caine V. A systematic review of best practices in HIV care. Journal of HIV AIDS Social Services; 2016; March 22; 15(1): 114-126.

DRAFT FOR EXECTUIVE COMMITTEE REVIEW

MEDICAL CARE COORDINATION SERVICE STANDARDS

DEFINITIONS AND DESCRIPTIONS

Assessment is a cooperative and interactive face-to-face interview process during which the patient's medical, physical, psychosocial, environmental, and financial strengths, needs and resources are identified and evaluated.

Intake determines a person's eligibility for Medical Care Coordination services.

Medical Care Coordination (MCC) integrates the efforts of medical and social service providers by developing and implementing an integrated care plan.

Medical Care Managers will be licensed RNs and be responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan.

Retention Outreach Specialists promote the availability of and access to Medical Care Coordination services to service providers and patients at higher risk of falling out of continuous care or are lost to care.

Patient Care Managers will hold a master's degree in social work (MSW) or related degree (e.g., psychology, human services, counseling) and are responsible for the patient's psychosocial needs ad will track, address and or supervise these components of the Integrated Care Plan.

Case Workers must possess either a bachelor's degree in nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling (requires a master's degree), Human Services, a license as a vocational nurse (LVN) or demonstrated experience working in the HIV field. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion.

Reassessment is a periodic assessment of a patient's needs and progress in meeting the objectives as established within the Integrated Care Plan.

Disenrollment is a systematic process of disenrolling patients from active MCC services.

Ryan White Program Year 32

Care Utilization Data Summary

Part 3 – Housing, Emergency Financial Assistance, Nutrition Support

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

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

HOUSING, EMERGENCY FINANCIAL ASSISTANCE AND NUTRITION SERVICES

BACKGROUND

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

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

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

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

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

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

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

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

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

Outcomes and Indicators

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

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

DATA SOURCES

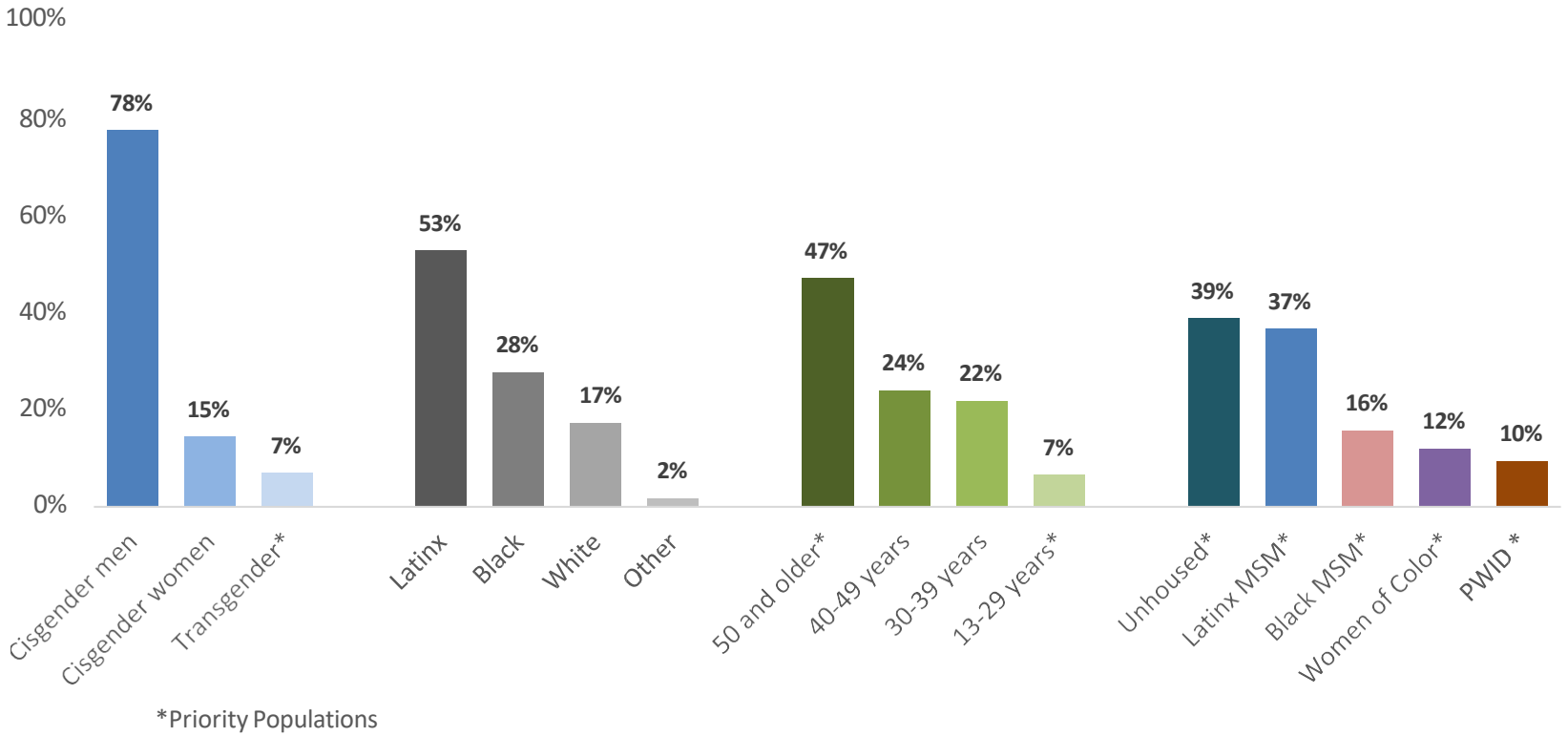
- HIV Casewatch (local RWP data reporting system)
  - Client characteristics and service utilization data reported by RWP contracted service agencies
  - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance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

HOUSING SERVICES

Population Served:

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

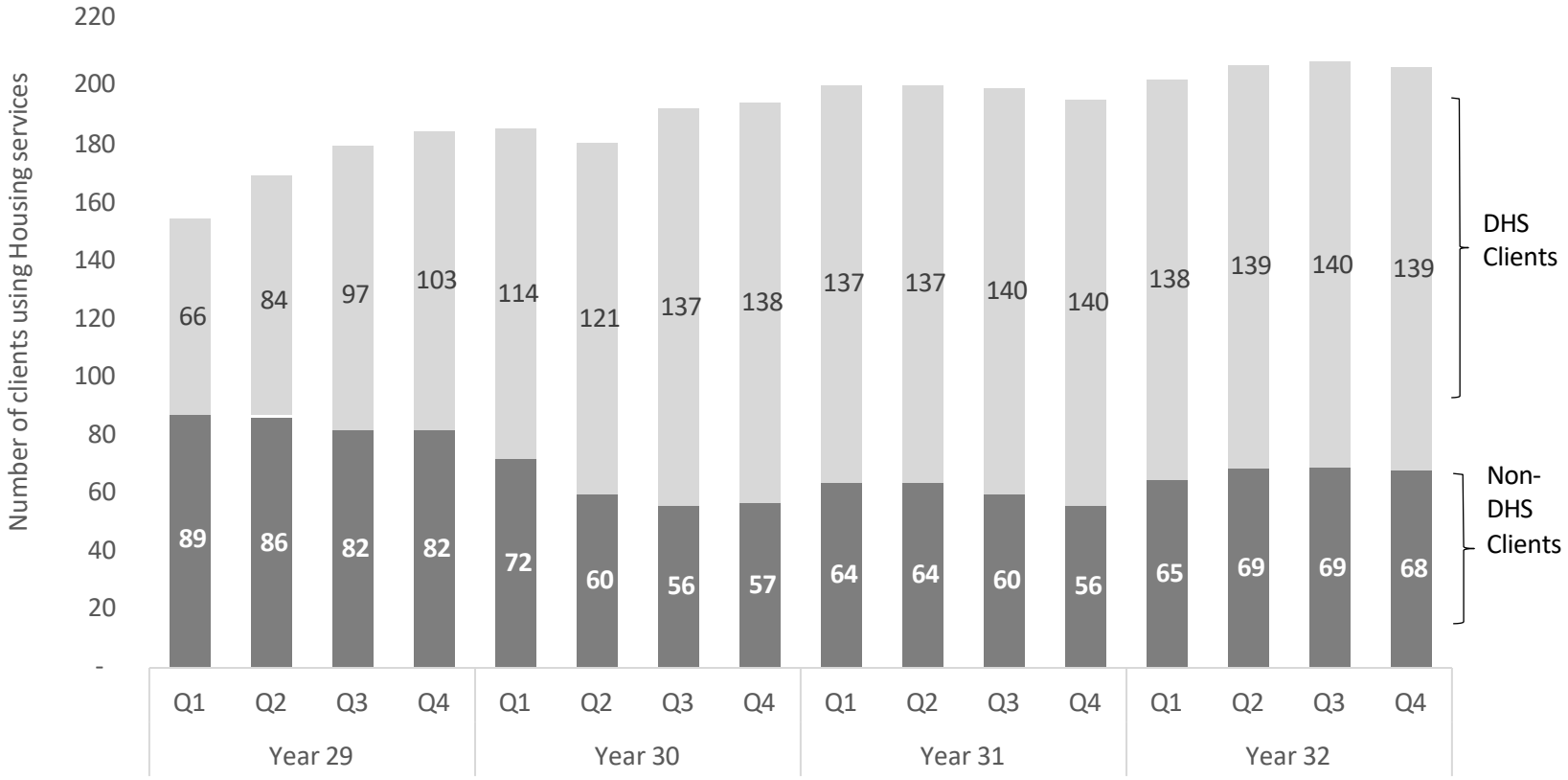
Figure 1. Key Characteristics of RWP Clients in Housing Services in LAC, Year 32



Service Utilization

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

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



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

Service Units and Expenditures

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

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

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

Table 1 Highlights

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

  - The percent of HS in days was slightly higher relative to their population size among clients ≥ age 50 (47% vs 50%).
  - The percent of HS in days was slightly lower relative to their population size among Latinx MSM (37% vs 35%).
- *Expenditures:*
  - Expenditure per client were highest among Black MSM and women of color, although those subpopulations did not represent the highest percentage of HS clients.
  - Expenditures per client were the lowest among clients who were unhoused in the contract year despite being the second largest subpopulation served by HS (39%).

HIV Care Continuum (HCC) Outcomes

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

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

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

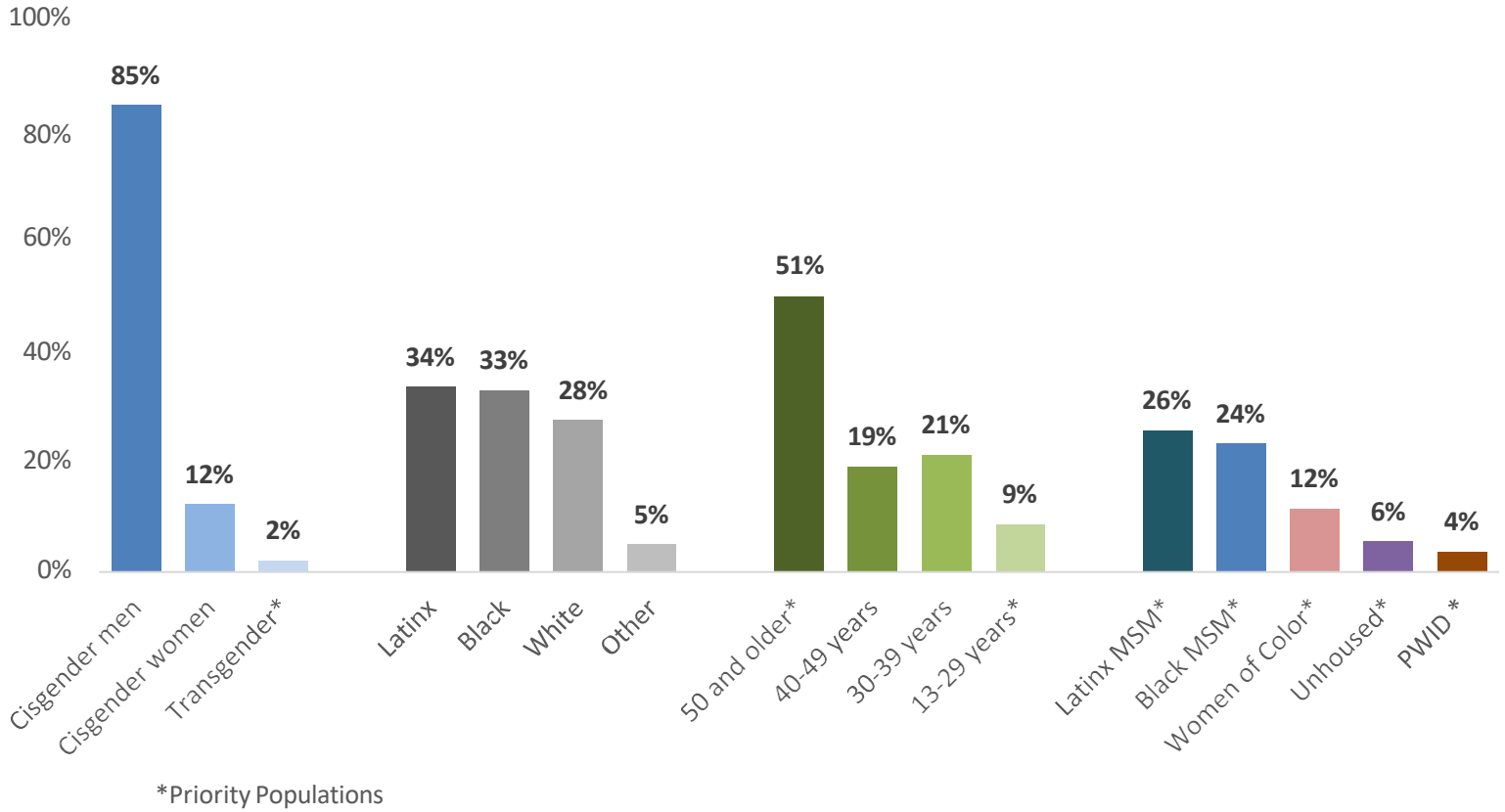
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period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

EMERGENCY FINANCIAL ASSISTANCE (EFA) SERVICES

Population Served:

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

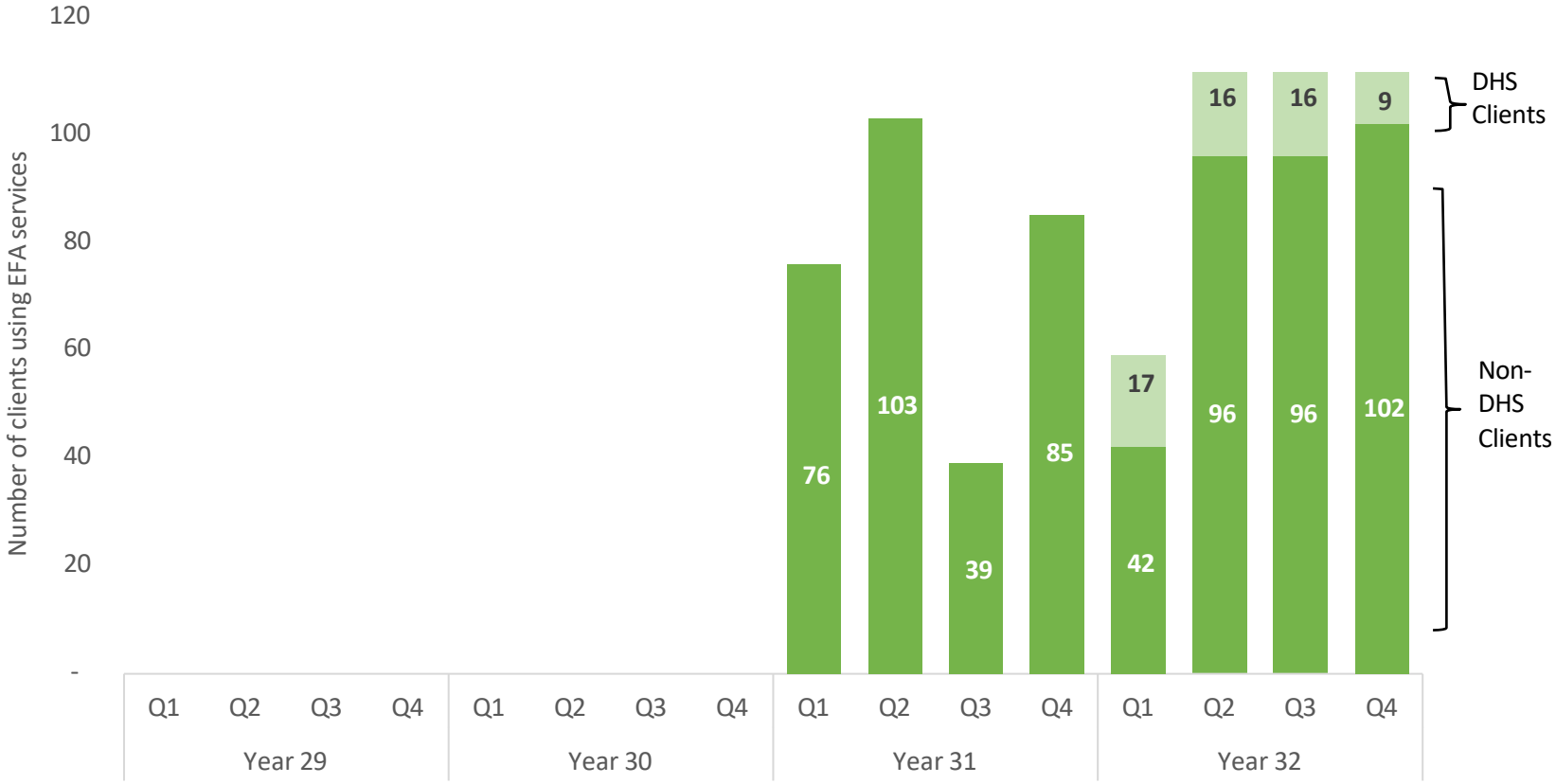
Figure 3. Demographic Characteristics and Priority Populations among EFA Clients in LAC, Year 32



Service Utilization

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

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



Service Units and Expenditures

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

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

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

Table 3 Highlights

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

HIV Care Continuum (HCC) Outcomes

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

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

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

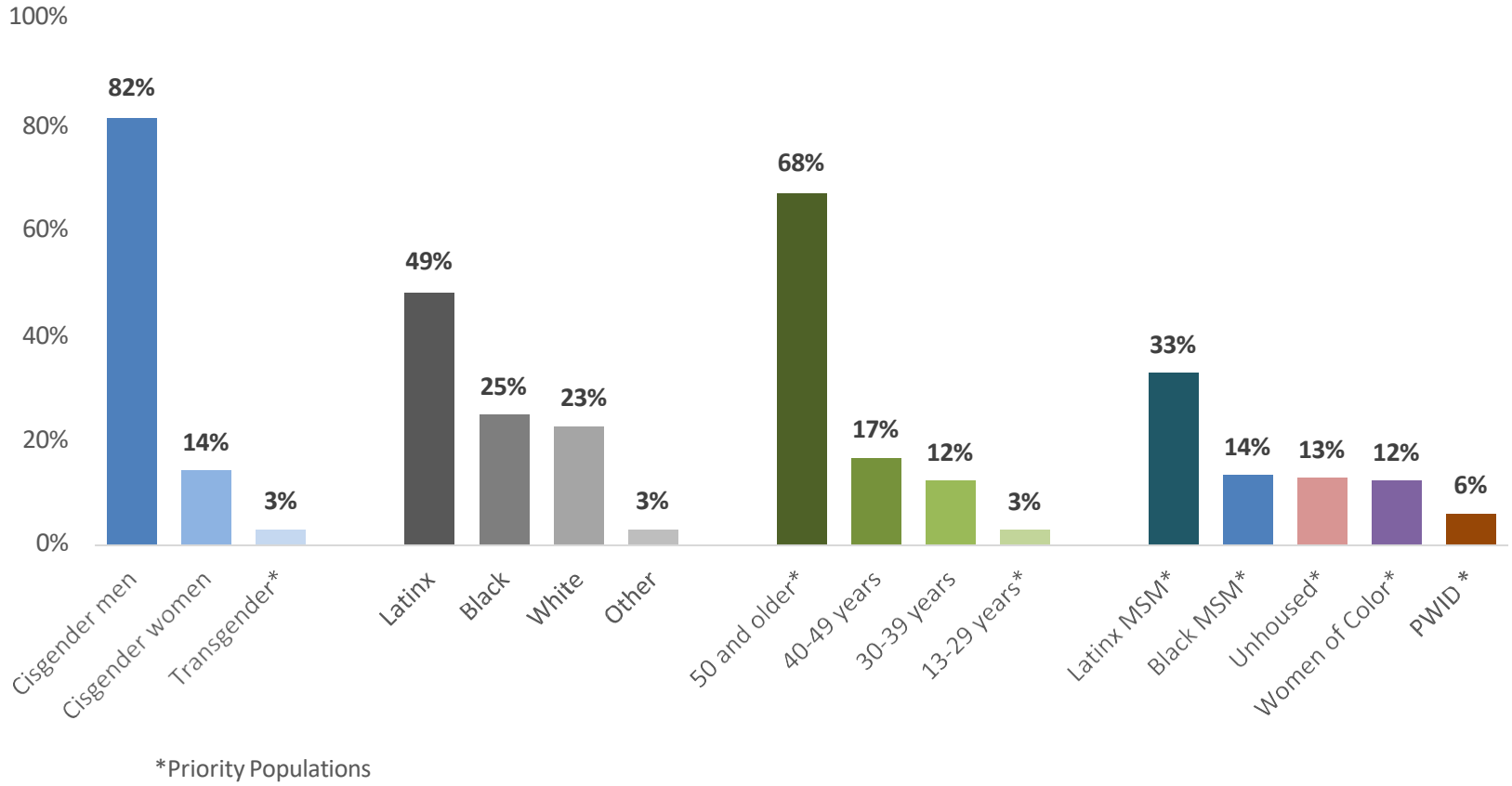
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period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

NUTRITION SUPPORT SERVICES

Population Served:

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

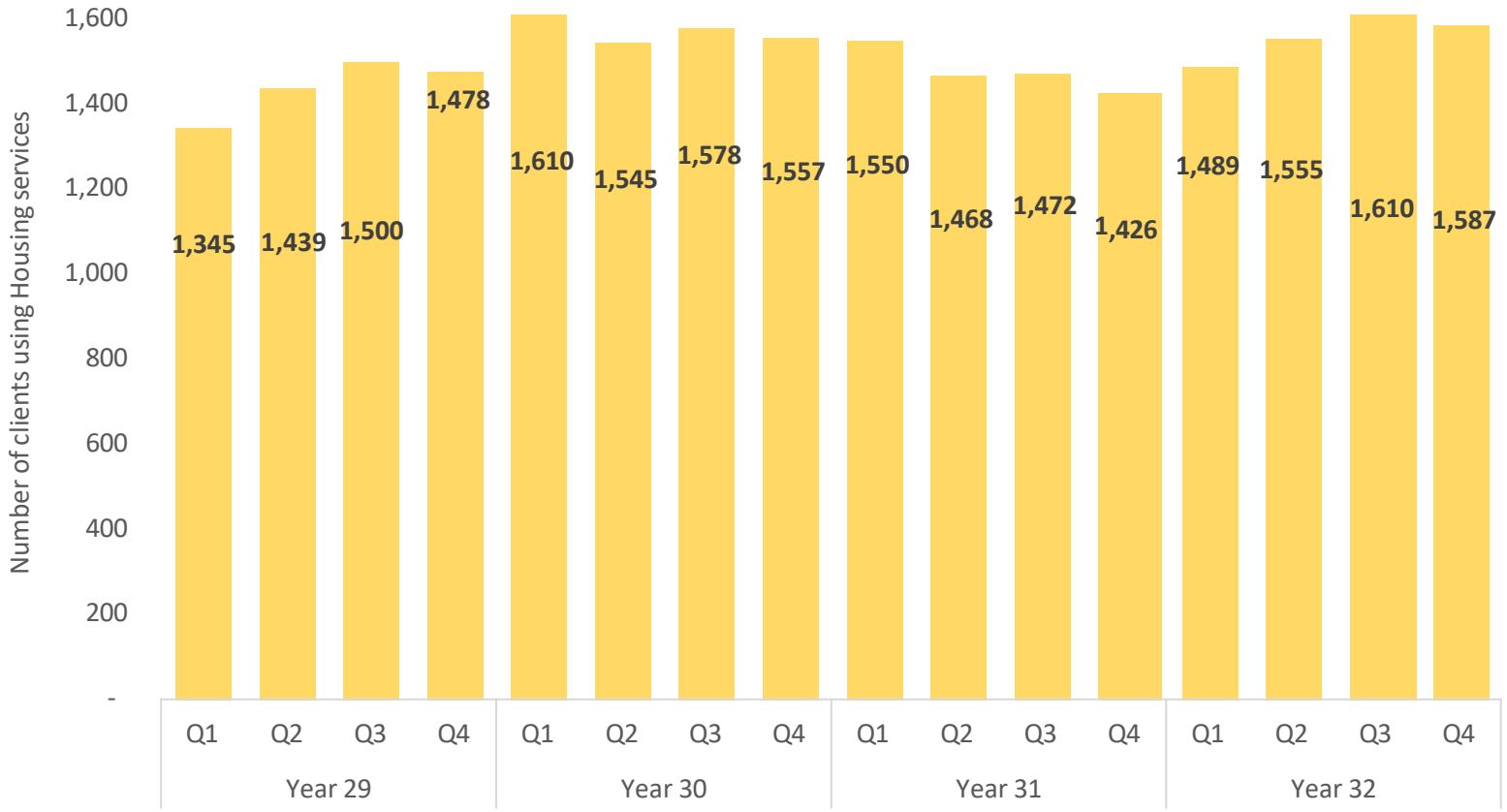
Figure 5. Demographic Characteristics and Priority Populations among Nutrition Service Clients in LAC, Year 32



Service Utilization

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

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



Service Units and Expenditures

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

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

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

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

Table 5 Highlights

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

HIV Care Continuum (HCC) Outcomes

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

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

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

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

Overlap of Services Provided

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

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

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

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 8.

Table 8. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Housing Service (Permanent Supportive Housing (H4H), RCFCI, TRCF)	Emergency Financial Assistance (Food, Rental Assistance, Utilities)	Nutrition Support (Delivered Meals, Food Bank)
Main population served	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to AOM, MCC, and MH services stopping at DHS sites • However, number of clients at remaining agencies was steady	• Service still provided by DHS • Increase in total clients, largely from DHS sites	• Service still provided at DHS • Increase in total clients from Year 31 to 32 primarily from non-DHS sites	• Steady decrease in number of clients since Year 29
Service units per client	N/A (units vary)	• Days	• Dollars	• Meals • Bags of grocery
Total expenditures	$45.9 million	• $7,965,955 (Part A, B, MAI) • $33,054 per client	• 1,741,442 (part A) • $4,607 per client	• 3,740,480 (Part A) • $ 1,767 per client
HCC outcomes	• HCC outcomes were higher among RWP clients compared to PLWH in LAC	• Engagement and RiC were higher among HS clients compared to non-HS clients but no difference in VS	• HCC outcomes were higher among EFA clients compared to clients not accessing EFA	• HCC outcomes were higher among NS clients compared to clients not accessing NS

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

	RWP	Housing Services	EFA	Nutrition Support
Latinx MSM	• Largest RWP population (52%) • Largest percentage of uninsured clients	• Third largest priority population (37%) and accounted for about 35% of services provided • Expenditure per client slightly lower than the overall average	• Second largest priority population (26%) and accounted for 26% of services provided • Expenditure per client similar to the overall average	• Second largest priority population (33%) and accounted for 31% of NS provided • Expenditure and average units per client were lower than overall average for all NS clients
Black MSM	• About 4% of RWP clients • Over 2/3 living ≤ FPL	• Represented 16% of HS clients and 17% of services provided • Highest number of days per client and second highest per client expenditures	• Represented 24% of EFA clients and of services provided • Second highest number per client service units (dollars) and expenditures	• Represented 14% t of NS clients and 12% of services provided • Per client number of meals, bags and expenditures were lower than those overall averages
Youth 13-29 years old	• 12% of RWP clients • The lowest percentage of RiC among priority populations	• Smallest population by number and percent of clients (7%) • Lowest per client number of days and expenditures	• Represented 9% of EFA clients and services provided • Highest utilizers of EFA services, by service units and expenditures per client	• Smallest percent of clients (3%) & services provided (1%) • The lowest per client number of meal/bags and expenditures
Women of color	• 8% of RWP clients • The highest percentage of engagement in care and the second highest percentage of RiC among priority populations	• Represented 12% t of HS clients and 13% of services provided • Highest per client number of days and expenditures	• Represented 12% of EFA clients and 9% of services provided • Lowest per client service units (dollars) and expenditures	• Represented 12% of NS clients and 13% NS services provided • Third highest per client number of meals/bags and expenditures
PLWD ≥ age 50	• Over a third of RWP clients • The highest percentage of RiC and VS and the 2nd highest percentage of engagement among priority populations • The highest percentage of people living ≤ FPL and PWID • Second highest percentage of uninsured and unhoused	• Highest utilizers of HS, by percent of clients (47%) and services provided (50%) • Second highest per client use by service days. • Third highest overall expenditures among priority populations	• Highest utilizers of EFA services by the highest percentage of EFA clients (51%) and services provided (45%)	• Highest utilizers of NS services percentage of clients and services provided • Highest per client number of meals/bags and expenditures

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

	RWP	Housing Services	EFA	Nutrition Support
Transgender clients	• 4% of all RWP clients • Highest percentage of clients unhoused in the contract period • Second largest percentage of people living ≤ FPL	• Represented a small number and percent of HS clients and services provided (7%) • Days per client slightly higher than overall average • Per client expenditure slightly lower than overall average	• Smallest percent of EFA clients and services provided • Per client service units (dollars) expenditures were lower than the overall average however based on small numbers	• Represented small percent of NS clients (3%) and services provided (3%) • Average meals/bags provided and expenditures per client were lower than overall averages
Unhoused in the contract year	• 18% of all RWP clients • Largest percent of clients living ≤ FPL and PWID	• Second highest utilizers by HS percent of clients and services provided • Lowest per client expenditures by only third lowest per client number of days.	• Represented 6% of EFA clients and 5% of services provided • Second lowest per client units (dollars) provided and expenditures	• Represented 13% of NS clients but received only 7% of provided • Second lowest average number of meals/bags and expenditures per client
PWID	• 5% of RWP clients • Second highest percent of clients unhoused in past 12m	• Represented 10% percent of clients and 9% of services provided • Second lowest per client days and expenditures compared to overall averages	• Represented a small number and percent of EFA clients and services provided • Average amount of dollars and expenditures were considerably lower than respective averages for all EFA clients • Third lowest per client service units (dollars) and expenditures	• Represented 6% of NS clients and 7% of services provided • Second highest average number of meals/bags and expenditures per client among priority populations

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Ryan White Program Agencies, Providers and Clients

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