LOS ANGELES COUNTY
COMMISSION ON HIV

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Planning, Priorities, and Allocations Committee Meeting

Tuesday, June 20, 2023
1:00pm-3:00pm (PST)

510 S. Vermont Ave,
Terrace Conference Room TK11
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/planning-priorities-and-allocations-committee

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-616, Sacramento, CA 95814

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For Members of the Public Who Wish to Join Virtually, Register Here:
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To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2591 520 1023

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 to access the Terrace Conference Room (9th flr) where our meetings are held.*

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
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AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, JUNE 20, 2023 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room A/TK11, Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
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MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
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Password: PLANNING Access Code: 2591 520 1023

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros MBA, Co-Chair	Felipe Gonzalez	Joseph Green
Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW	Anthony M. Mills, MD
Derek Murray	Jesus "Chuy" Orozco	LaShonda Spencer, MD	Michael Green, PhD
Redeem Robinson	Jonathan Weedman		
QUORUM: 8			

AGENDA POSTED: June 15, 2023.

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

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

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

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

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

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

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Roll Call & Conflict of Interest Statements		1:00 PM – 1:03 PM
3.	Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	1:03 PM – 1:05 PM
4.	Approval of Agenda	**MOTION #2**	1:05 PM – 1:07 PM
5.	Approval of Meeting Minutes	**MOTION #3**	1:07 PM – 1:10 PM

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

6. 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

7. Opportunity for Committee members to recommend new business items for the full body or a

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

IV. REPORTS

8. Executive Director/Staff Report 1:15 PM – 1:25 PM
    a. LAHSA Report Update
    b. CDC/HRSA Feedback on Integrated Plan
    c. Anti-LGBTQ+ Legislation Impact Report
9. Co-Chair Report 1:25 PM – 1:40 PM
    a. May 24th Prevention Planning Workgroup Meeting Recap
    b. Bylaws Review Taskforce Updates
    c. Memo to DHSP Regarding Medi-Cal Expansion Strategies
10. DHSP Report 1:40 PM – 2:00 PM
    a. Review Revised Fiscal Year 2023 Service Category Allocations
    Fiscal and Programmatic Updates

V. DISCUSSION ITEMS 2:00 PM—2:50 PM

11. DHSP Unmet Needs Report III – In Care, Not Virally Suppressed
12. Explore Opportunities to Increase HIV/STI Screening in SPA 6
13. Review Revised Stakeholder Engagement Implementation Timeline & Development of CAB Questionnaire

VI. NEXT STEPS 2:50 PM – 2:55 PM

14. Task/Assignments Recap
15. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

17. Adjournment for the meeting of June 20, 2023

PROPOSED MOTIONS	
MOTION #1:	Approve remote attendance by members due to "emergency circumstances", per AB 2449.
MOTION #2	Approve the Agenda Order as presented or revised.
MOTION #3	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 6.12.23)

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

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

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

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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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.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES APRIL 18, 2023

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	P
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	A
Felipe Gonzalez	P	Anthony M. Mills, MD	P
Joseph Green	A	Derek Murray	P
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	P
Karl T. Halfman, MS	EA	LaShonda Spencer, MD	P
Reverend Redeem Robinson	A	Jonathan Weedman	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Jose Rangel-Garibay, Lizette Martinez			
DHSP STAFF			
Victor Scott			

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

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Al Ballesteros, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:10pm and opened with news of the passing of Dr. Wilbert Jordan. He shared fond memories of Dr. Jordan and Dr. Spencer and Dr. King also shared memories and kind words.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly led introductions and requested that Committee members state conflicts of interest. Cheryl Barrit, Executive Director, COH, conducted roll call vote.

ROLL CALL (PRESENT): A. Ballesteros, K. Donnelly, F. Gonzalez, D. Murray, Dr. King, Dr. Mills, Dr. Green, Dr. Spencer, J. Orozco

3. **Approval of Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"**
   MOTION #1: Approve remote attendance by members due to "emergency circumstances," per AB 2449. **(No Committee members invoked attendance under AB 2449; no vote held.)**

4. **Approval of Agenda**
   MOTION #2: Approve the Agenda Order **(✓Passed by Consensus)**

5. **Approval of Meeting Minutes**
   MOTION #3: Approval of Meeting Minutes **(✓Passed by Consensus)**

II. PUBLIC COMMENT

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

   There were no public comments.

III. COMMITTEE NEW BUSINESS

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

   There was no committee new business.

IV. REPORTS

8. **Execute Director/Staff Report**
   - Cheryl Barrit noted the Health Resources and Services Administration (HRSA) site visit report is still pending but noted the Commission is already working to address areas for improvement that were noted during the exit interview with DHSP. The report will be shared with Commissioners as soon as it is available.
   - C. Barrit also reminded the Planning, Priorities, and Allocations (PP&A) Committee of the Mandatory and Supplemental Training series. She noted that the trainings are open to the public and encouraged committee members to share the registration links for the virtual sessions with any interested stakeholders. The training schedule is available on the Commission website under the "Events" tab. She reminded commissioners that HRSA requires annual training for commissioners and that this training series covers that requirement. For those not able to attend the live training session, they can access the training recordings on the Commission website and notify Commission staff that they viewed the training to receive credit for the mandatory trainings. Lastly, C. Barrit thanked PP&A co-chair, K. Donnelly for leading the Priority Setting and Resource Allocation (PSRA) section of the most recent training.
   - C. Barrit shared that the Women's Caucus will be reviewing the most recent directives to DHSP

in their upcoming July meeting to provide feedback and recommendations to the PP&A Committee in preparation for the next PSRA cycle.

- C. Barrit called attention to the April 12, 2023, Dear Colleague letter from HRSA focusing on HIV and housing. See meeting packet for details. She reminded the PP&A Committee to consider housing (and other) data needs to help fill in gaps and inform the PSRA process while reviewing the document.
- Finally, C. Barrit noted a summary of status neutral recommendations from the Prevention Planning Workgroup (PPW) were available and in the meeting packet. See meeting packet for details. She noted that PPW has been having continued discussions on how to incorporate prevention into status neutral approaches and have several recommendations that will be shared with the PP&A Committee for review and approval.

9. Co-Chair Report

- There was no co-chair report.

10. PPW Recommendations on Status Neutral

- The report was deferred to next month. Recommendations regarding status neutral will be provided.
- Dr. King noted a major goal of incorporating prevention strategies into existing programs such as incorporating HIV and STI testing in Syringe Services Programs (SSPs).
- A. Ballesteros noted the need to connect with Substance Abuse Prevention and Control (SAPC) program and the Public Health Commission to collaborate to push through recommendations and create policy/practice changes. He mentioned how he wonders how the various programs within the Department of Public Health (DPH) collaborate and come together to create synergy between HIV and SUD strategies. Dr. King noted HIV and STIs have not been discussed in the few SAPC Medical Director Meetings he has attended in the past.
- A. Ballesteros noted to move the agenda forward, the Commission on HIV (COH) needs to a develop specific, shared priorities and action items and take them directly to the Board of Supervisors (BOS). For example, HIV screening tests for all individuals entering a residential SUD program within the first 30 days.
- Dr. King asked Dr. Mills and Dr. Spencer, both of whom work with residential substance abuse programs, if an HIV or STI screening is included in part of the required physical examination for individuals entering a residential SUD program. Both Dr. Spencer and Dr. Mills commented that they do not recall a requirement of HIV or STI screening as part of the physical examination. Dr. King noted it may be a recommendation that may be easy to implement.
- D. Murray asked if there were any SSPs that do not include routine HIV screening tests noting he was under the assumption that all SSPs are required to conduct HIV screening tests. Dr. King shared that some mobile outreach teams offer HIV screening tests based on information that was shared at a previous PPW meeting but he was unsure if it was done at all SSP sites or during all mobile outreaches. A Ballesteros confirmed it is not a requirement. Dr. Green added that routine HIV cannot currently be mandated at SSPs because programs are funded with federal dollars. He noted he was shocked when he discovered HIV screening tests were not mandated and that many SSP programs that do offer HIV tests need to collaborate with other programs to

provide this service.

- Dr. Green continued to say DHSP has worked extensively to develop a partnership with SAPC to help extend and complement services, but efforts have not been successful. He noted that DPH remains siloed within itself, and programs do not share data or have a willingness to share data. He urged the Committee to go directly to the BOS with their recommendations rather than DPH.
- A. Ballesteros agreed and reiterated the need to think and approach the HIV epidemic more broadly within the County. He noted the process should be formalized and methodical going through a vetting process within the Commission starting with PP&A and getting full support from the entire COH and forwarding for action to have conversations with SAPC and the BOS on recommendations and provide services that would be mutually beneficial. He noted the process will take some time to accomplish as County processes take time to implement. He recommended that the COH attend health deputy meetings and provide testimony to help further the COHs agenda.
- Dr. Green recommended finding a champion within a Board office to help and noted Supervisor Horvath may be a great ally. He noted Federal agencies are not reliable to help move the agenda forward and have no concrete solutions. He also recommended engaging with SAPC to have a representative on the COH, noting SAPC previously had a representative participate on the COH.
- A. Ballesteros noted with renewed energy the work can be accomplished. Dr. Green added that there is still a lot of money available that can be used towards large scale public health infrastructure improvements. He noted the COVID pandemic opened new opportunities to be creative/innovative in public health approaches.
- Dr. King asked what the timeline was for the next PSRA process to ensure PPW recommendations are incorporated with the new funding cycle. Dr. Green confirmed a timeline of 1-2 years. He noted new funding cycle discussions may take place in approximately 10 months and noted a new CDC funding cycle will be coming as well opening the door for innovative programming.
- K. Donnelly recalled a presentation from SAPC during a PPW meeting last October noting their mobile outreach team's willingness to provide HIV tests but facing challenges with navigating dangerous situations and difficulty collecting demographic data from clients.

- C. Orozco provided a HOPWA update to the PP&A Committee. He noted HOPWA will be undergoing a handful of structural changes to help streamline efforts around the Mayor of LA's the homelessness "state of emergency" to help. One change is the proposal of contracts being extended to five years, a two-year increase from the current three-year model. HOPWA providers noted challenges as the first year of a three-year cycle is spent learning the program/requirements, second year continuing to make large strides and by the third year the programs are running smoothly only to result in a new cycle at the close of the year. The current cycle makes it challenging to gain momentum. The change to a 5-year cycle will need city council approval but other contracts within the city use a 5-year cycle, such as Community Development Block Grants, as a model for the proposed RFP. In addition, procurement processes will be added to allow providers to subcontract with other groups to allow better engagement with hard-to-reach communities. New HOPWA services RFPs will be released in July 2023 with program services set to begin in July 2024. In addition, HOPWA will be reverting previous changes that had cut down on the number of contracts

but inadvertently resulted in legal services being subcontracted out from a provider, making it challenging to monitor directly as well as challenges with coordination/communications between regional offices. HOPWA will move toward directly monitoring legal services. Walk-ins will no longer be allowed, and referrals will be needed so that services remain strictly housing related. The HOPWA data system will also change. It previously aligned with the Los Angeles Homeless Services Authority (LAHSA) system, but it did not work well to provide timely case management and reports. The new system is familiar with HOPWA needs/requirements will streamline data management, reporting, and coordination with providers. HOPWA will also reinstate the Central Coordinating Agency that will start on July 1, 2023. HOPWA will also be reassessing the goals of the Supportive Services and Housing Assistance services as both saw a decline from previous years. HOPWA believes the decline may be due to the restructuring of HOPWA. Finally, Chuy announced HOPWA received 5% increase in funding, the majority of which will be allocated to the scattered site lease program.

- D. Murray asked if the federal government requires HOPWA providers to lease housing units for the scattered site lease program and, if so, are there are challenges with evictions. C. Orozco confirmed HOPWA providers do lease housing units and sublease to individuals/families and are required to report on numbers. He noted the program has seen challenges but not due to evictions but rather high maintenance and repair costs.
- Dr. Spencer asked if there were additional funding sources to help individuals avoid eviction and pay back rent through Emergency Financial Assistance on top of the $5,000 that is provided. Dr. Green noted the funding can be increased and that DHSP has considered increasing the amount to $10,000 but noted current participants are not exhausting the $5,000. C. Orozco highlighted HOPWA legal services that focus on evictions and coordination with Measure ULA on legal services related to eviction. C. Barrit also reminded the group of the no-cap rental and utilities assistance that is available under the City of Los Angeles Short-term Rental, Mortgage and Utilities (STRMU) program. C. Orozco noted there is still approximately $1 million in left funding for the program from COVID response dollars.

V. DISCUSSION

11. DHSP Unmet Needs Report

- Dr. Green opened the discussion on the DHSP Unmet Needs Report that was provided by Wendy Garland during the April 13 COH meeting. He noted there was a question from D. Murray regarding HIV among the growing unhoused population. Dr. Green noted the unmet needs report does not factor housing status but offered other data sources to help address HIV among people experiencing homeless noting the Ryan White Program Utilization report (found here) and the 2021 HIV Surveillance Report (found here). He also recommended reviewing LAHSA 2022 Homeless Count data (found here). He noted that 1337 individuals who have diagnosed HIV were identified in the 2022 homeless count.
- Dr. Green noted a big challenge to DHSP and the COH on ending HIV is identifying individuals who are at risk for experiencing homelessness. He is not aware of any reliable data where this information can be found.
- D. Murray inquired if the RWP Utilization report and the HIV Surveillance Report include information on Linkage Retention and Viral Suppression among the unhoused. Dr. Green

confirmed that they do include this information.

- Dr. King asked if intake questions for RWP providers ask about risk of becoming unhoused. Dr. Green confirm that they do but noted the risk of becoming unhoused goes beyond RWP clients. He noted of the 50,000 people with confirmed HIV within LA County, only 20,000 to 22,000 people utilize RWP services.
- D. Murray commented that conversations around the unhoused are needed when discussing unmet needs and should include needs for supportive services/resources in addition to housing needs. He noted the high number of unhoused people expiring on the street and stated information is needed on the number of people experiencing homelessness, what their needs are and what resources are available to them. This would help determine which resources to allocate.
- Dr. Green reminded the group that homelessness continues to be a key issue in the mayor's office but is unsure if conversations are being had regarding data gathering on people experiencing homelessness, their health outcomes, and their needs and conceptualizing innovative strategies. He noted the City of LA, and the BOS are reluctant to partner but people need to be asking key questions in these spaces.
- C. Orozco noted that the City of LA was looking at the cost of living measure to assess if people are in danger of becoming unhoused before the pandemic because the federal government did not do a good job of defining poverty in LA. He is unsure if discussions are continuing now with the current mayor.
- Dr. Green also noted that a large number of LA County residents would not qualify for HUD assistance due to residency status and that needs to be taken into account during these discussions as well as identifying other funding options for those who are ineligible.
- D. Murray added that another issue is outreach providers who not affiliated with DHSP funded organizations not having enough knowledge around HIV or working with individuals who have HIV, particularly those who are chronically homeless with severe mental illness. He noted more education/training and outreach is need for these providers in addition to resource sharing.
- Dr. Green noted that LAHSA Homeless Count data does not include how the data is used aside from providing a snapshot of homelessness at the time the data is gathered. He noted the data lacks specifics, does not include comorbidities, and does not answer questions the COH may have such as the number of people with mental illness who are HIV positive, that have a physical impairment who are veterans. He noted if their data system is Power BI, the information can be drilled down to get more specifics.
- D. Murray asked C. Barrit if a formal report from LAHSA can be requested. C. Barrit noted LAHSA report can be requested and preparing specific questions ahead of the report are needed to give to LAHSA. She cautioned that previous reports have failed to answer specific questions despite COH staff meeting with the LAHSA team to identify information needed or discrepancies in the data.
- A. Ballesteros recommended requesting LAHSA to modify their questions to include more robust information. He noted the request was made before but is not sure what came of the suggestion.
- F. Gonzalez asked if housing services are available to homeowners or just renters. C. Orozco

confirmed services are available for homeowners and renters. F. Gonzalez noted the need to promote services for homeowners who are at risk of losing their homes as they may not be aware that programs are available to them.

12. Data Request for Priority Setting and Resource Allocation Process

- C. Barrit asked the PP&A Committee to start to think of the data needed to inform the upcoming Priority Setting and Resource Allocation (PSRA) process to allow DHSP enough time to prepare. She noted starting with requesting a report from LAHSA.
- DHSP staff noted the next funding cycle will begin in 2025 and a Notice of Funding Opportunity will be released next year pushing the beginning of the PSRA process to Feb. 2024.

13. Stakeholder Engagement Implementation Timeline

- L. Martinez, Commission staff, provided a brief overview of a proposed timeline for community engagement/feedback activities. See meeting packet for details. C. Barrit noted the Unmet Needs Report will help identify target locations and populations for engaging Community Advisory Boards (CABs) and planning regional townhalls.
- A. Ballesteros recommended engaging with CABs that do not engage in the RWP. C. Barrit noted potential to reach out to Federally Qualified Health Centers who are receiving HIV prevention funding for the first time. She noted the potential to connect to other CABs through collaboration efforts with other County Commissions.
- C. Barrit reminded the group of the goal behind engaging with CABs to identify how to create a status neutral system – how does an individual travel through their system and access care and resources regardless of their HIV status.
- A. Ballesteros noted it may be beneficial to include information on newly infected on where they were in the healthcare system when first learning of their positive status to identify potential gaps in the system, engagement in the system and general HIV-related knowledge.
- F. Gonzalez agreed with the suggestion noting the lack of knowledge on HIV in the community. He also expressed concern in hearing of an individual engaging in risky behaviors and not taking preventative medication because if they do become positive, they will need to take medication.
- A. Ballesteros also expressed shock and noted the shift in thinking around HIV among younger populations.
- Dr. Mills noted a similar situation he had with a PhD student who also indicated no desire to use PrEP noting if they become positive, they will need to take medication anyway quoting “why would I take a pill everyday to keep me from taking a pill every day?”
- Dr. Spencer noted the need to change messaging around PrEP. A. Ballesteros commented that he checked PrEP brochures and noted it does not include information on the advantages of taking PrEP and not becoming positive. A. Ballesteros indicated that many providers do not deliver U=U messages to their clients.
- Dr. Spencer added that more provider education is needed noting that some of her new patients were in regular care with their providers when diagnosed and the only reason they were tested was because DHS now has a tickler for an HIV test. F. Gonzalez noted the need to increase testing among heterosexual individuals noting it is standard for gay individuals to be test.

- Dr. King noted there are challenges in covering everything in one patient visit especially if a patient comes in with a specific need for instance high blood pressure. He noted most providers are focused on primary care and few have a vested interest in HIV care/prevention. He suggested providing a premium for an HIV test.
- F. Gonzalez also suggesting placing HIV-related posters/materials in medical offices to help encourage patients to discuss HIV with their providers.
- It was noted that the next funding cycle will begin in 2025 and not 2024 as previously thought. The community engagement timeline will be adjusted to the new timeline and will be proposed at the next PP&A Committee meeting.
- In preparation for the PSRA process, Dr. Green suggested reviewing data in cluster of services and dividing into smaller pieces to allow for a deeper review and understanding and voting on priority before moving onto the next cluster of data. A. Ballesteros recommended the PP&A Committee begin to look at data in August/September of this year.
- F. Gonzalez recommended simplifying the data as much as possible and creating data sheets/infographics to help make the information easier to review and understand.

VI. NEXT STEPS

14. Task/Assignments Recap

a. C. Barrit noted revising the timeline and approaches for stakeholder engagement

b. Allow time for continued discussion of the second unmet needs presentation

15. Agenda Development for the Next Meeting

a. Continue planning on three strategies to help inform the planning around status neutral.

VII. ANNOUNCEMENTS

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

D. Murray announce the City of West Hollywood would be highlighting their "Yes Means Yes" campaign in April for Sexual Assault Awareness month on April 28th from 6:00-8:00pm. The City will be handing out test strips to test drinks for drugs around the Rainbow District and the Sunset Strip. He also announced the City of West Hollywood opted into the Janssen opioid settlement money and will be receiving 0.001% for 18 years. The City will be using the settlement money to purchase Narcan for the community and service providers located within the City.

VIII. ADJOURNMENT

17. Adjournment for the Meeting of April 18, 2023.

The meeting was adjourned by K. Donnelly at 3:10pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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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.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES MAY 16, 2023

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	P
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	EA
Joseph Green	EA	Derek Murray	EA
Michael Green, PhD, MHSA	A	Jesus "Chuy" Orozco	P*
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
Reverend Redeem Robinson	A	Jonathan Weedman	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Jose Rangel-Garibay, Lizette Martinez			
DHSP STAFF			
Victor Scott, Pamela Ogata			

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

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:15pm.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly led introductions and requested that Committee members state conflicts of interest. Cheryl Barrit, Executive Director, COH, conducted roll call vote.

ROLL CALL (PRESENT): K. Donnelly, F. Gonzalez, K. Halfman, Dr. King, M. Martinez, Dr. Spencer, J. Orozco (just cause)

3. **Approval of Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"**
   MOTION #1: Approve remote attendance by members due to "emergency circumstances," per AB 2449. **(No Committee members invoked attendance under AB 2449; no vote held.)**

4. **Approval of Agenda**
   MOTION #2: Approve the Agenda Order **(✓Quorum was not reached; no vote held.)**

5. **Approval of Meeting Minutes**
   MOTION #3: Approval of Meeting Minutes **(✓Quorum was not reached; no vote held.)**

II. PUBLIC COMMENT

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

   There were no public comments.

III. COMMITTEE NEW BUSINESS

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

   F. Gonzalez recommended exploring ways to allocate increased funding to SPA 6 to help facilitate increased HIV testing to the June PP&A Committee meeting agenda.

IV. REPORTS

8. **Execute Director/Staff Report**
   - C. Barrit also reminded the Planning, Priorities, and Allocations (PP&A) Committee of the Mandatory and Supplemental Training series. She noted that the trainings are open to the public and encouraged committee members to share the registration links for the virtual sessions with any interested stakeholders. The training schedule is available on the Commission website under the "Events" tab. She reminded commissioners that HRSA requires annual training for commissioners and that this training series covers that requirement. For those not able to attend the live training session, they can access the training recordings on the Commission website and notify Commission staff that they viewed the training to receive credit for the mandatory trainings.
   - C. Barrit shared the Equity Lens for Decision Making handout with the Committee as a resource to help priority setting and resource allocation discussions ensure equity; see meeting packet for details.
   - C. Barrit provided an update to the committee's request for Los Angeles Housing Services Authority (LAHSA) data on PLWH who are homeless discussed during the April PP&A Committee meeting. She noted the report was requested to include information on PLWH

experiencing homelessness along with demographic data and service utilization. LAHSA has indicated the report will be ready on May 19th. The data will be reviewed during the June PP&A Committee meeting.

- Dr. King asked how data is presented – whether in terms of Health Districts or Service Planning Areas (SPAs). C. Barrit noted both methods are used and P. Ogata, DHSP staff, confirmed data is presented at both the Health District and SPA level as a way of understanding different geographic level data. She noted it has been challenging to cluster health district data in a way that is meaningful due to variability of size and proximity to adjacent districts as well as location of service providers.

9. Co-Chair Report

- K. Donnelly reminded the Committee of the January 2024 Medi-Cal expansion to individuals ages 26-49 regardless of immigration status and the need to begin planning on how that would impact RWP allocations.
- Dr. King asked which health care systems eligible individuals would be migrated to and K. Donnell noted any Medi-Cal delivery is through third party administrators. Dr. King noted that the transition would result in delays in care and asked approximately how many people would transition from RWP to Medi-Cal.
- A. Ballesteros recalled approximately 5,300 individuals would transition from RWP to Medi-Cal noting those whose income is above 138% of the federal poverty line would not be eligible.
- Dr. King asked how the COH can work to create a smooth transition so individuals can quickly find providers and ensure continuity of care. K. Donnelly suggested early enrollment beginning in Nov/Dec 2023 and recommend individuals select their provider in advance. Dr. Spencer commented that many LA County sites may already be preparing for the transition. Dr. King added that the transition would require a lot of hand holding/navigation assistance.
- M. Martinez asked if the Rapid Start program can be used as a model to assist with covering costs for individuals during the transition period to avoid gaps in care. He added that the existing cap of 45 days is too short and should be extended to at least 60 days. A. Ballesteros recommended following up with DHSP to see if funding would be allowed for a transitional visit and to cover costs associated with Medi-Cal enrollment (collection of paperwork, documentation of income, etc.). The Committee agreed with this potential strategy.
- A. Ballesteros recommended making a formal request to DHSP if there is a transitional billing code that can be used as people transition from RWP to Medi-Cal to cover expenses incurred during an individual's transition period using the Rapid Start program as a model for implementation but with an extended the time frame of at least 120 days. Additionally, if this transition coverage is feasible, DHSP should provide an estimated allocation amount for all eligible individuals.

Dr. King provided an update on the Prevention Planning Workgroup's (PPW) work around status neutral.

- Dr. King noted a full report would be provided to PP&A in June. PPW co-chairs Dr. King, M. Martinez, and G. Wilson met to discuss final edits to recommendations on status

neutral which will be presented to the full workgroup at their next meeting on May 24th for final review and approval.

- Dr. King commented that the workgroup expressed concern on developing recommendations on status neutral that include prevention interventions and strategies without specific funding allocated towards prevention services.
- M. Martinez added that it is unclear how much input and guidance towards the priority setting and resource allocation process the PP&A Committee has noting that prevention funding flows into various departments and programs within the County, not just DHSP. Dr. King added that the workgroup will also review prevention standards.
- Dr. King asked if funding is available for HIV/STI testing in specific geographic areas. P. Ogata confirmed targeting specific geographic areas is part of the current DHSP planning process for services. She added that it is always important to continue to develop prevention strategies that help address the needs of vulnerable populations and that prevention standards should be reviewed and updated with status neutral methodologies in mind. She noted DHSP can also do an addendum to the Comprehensive HIV Prevention plan to include the updated prevention standards to serve as part of the service roadmap and potential to leverage partnerships with other County programs that receive prevention funding such as SAPC.
- M. Martinez commented it is critical to know if DHSP is open to a priority setting and resource allocation (PSRA) process for prevention that parallels the current PSRA process focused on care. He noted receptivity will help dictate what strategies can be recommended.
- A. Ballesteros commented the COH is more than just a RWP Planning Council and that the COH has the authority to make recommendations to the Board of Supervisors that ensure HIV/STI prevention strategies are infused in various County programs and not just DHSP. He gave an example of mandating HIV/STI screening in substance use disorder treatment facilities and the Department of Mental Health screening for PrEP noting collaborative/ integrated efforts are what is needed to end the HIV epidemic.
- Dr. King commented adding bloodwork for HIV and Hepatitis C testing be integrated into mandated medical assessments in substance use disorder treatment centers. M. Martinez recommended looking into what County contracted agencies have HIV/STI screening/testing requirements and, if so, are they adequate.
- Dr. Spencer commented that DHS has HIV screening as a reminder in their electronic health system but noted it is not mandatory and less likely to be enforced.
- A. Ballesteros noted that the large systems are they key to identifying HIV+ individuals and identifying those who are at high risk and prescribing PrEP due to the large volume of people within each system. He recommended meeting with LA Care and HealthNet to discuss what is being done and potential recommendations.

10. DHSP Report

a. Ryan White Program Fiscal Year 2022 Expenditures

- DHSP staff, Victor Scott, provided a review of the Ryan White Program 2022 Program Year Expenditures. DHSP is still processing invoices and is expected to close out the fiscal year by the end of June. See meeting packet for expenditure table.
- Part A award and FY 2021 carry over funds are anticipated to be fully expended and there will be approximately $1.3 million of Minority AIDS Incentive (MAI) funds that will be carried over to the next fiscal year in addition to the FY 2023 award amount.
- Dr. King asked if MAI funds be used for targeted interventions for priority populations. DHSP staff confirmed it was possible, but it would depend how quickly money would be released through an RFP process. They also reminded the Committee that interventions must align with Part A service categories.
- Dr. Spencer asked if the carry over funds could be diverted to a third-party administrator (such as Heluna Health, as done previously) for a short-term intervention to bypass the length County contracting process and expedite funding needed services.
- M. Martinez asked if standards are required or if there was flexibility in the standards to allow for more innovation, like Ending the HIV Epidemic (EHE) funds. V. Scott noted EHE does allow for more innovation but still has perimeters that it must follow. P. Ogata also noted standards are helpful for developing RFPs.
- P. Ogata asked the group if they had any potential short-term projects in mind. M. Martinez recommended navigation support for cisgender women in targeted geographic areas. Other recommendations included retention in care programs, rapid start programs and Doxy-PEP programs.
- Transportation support was also recommended as a potential short-term intervention. A. Ballesteros recommended creating a transportation hub to coordinate transportation to medical visits for clients alleviating the burden on both clients and providers. C. Orozco noted that HOPWA utilized a similar central transportation hub model with APLA that was successful.

b. Approve Revised Fiscal Year 2023 Service Category Recommendations MOTION #4 - Item moved to June meeting due to lack of quorum.

V. DISCUSSION

11. DHSP Unmet Needs Report II – Out of Care

- K. Donnelly opened the discussion will a brief recap of the Unmet Needs report; see meeting packet for details.
- A. Ballesteros commented that unmet needs are calculated annually yet there is no mention of what strategies are being done to address these unmet needs. He is unsure if the community understands why unmet needs are measured and that the COH recommendations and DHSP led services, such as retention and reengagement, are developed to address the unmet needs.
- F. Gonzalez agreed it is unclear what is being done and how progress is measured.

- Dr. King asked how much the Data to Care and Linkage to Care programs cost. P. Ogata shared that one program that focuses on reengagement in care costs approximately $900,000 annually and serves roughly 120 of the hardest to reach clients.
- P. Ogata noted that EHE funding will be used for street medicine providers to provide care on the street.
- P. Ogata reminded the Committee that Wendy Garland, DHSP staff, and her team are analyzing data to identify the predictors of unmet need and will share results once available that will contribute to future priority ranking and resource allocation discussions.
- A. Ballesteros noted that PP&A can make the recommendation to allocate a large portion of funding to linkage and reengagement programs if determined to be critical to ending the HIV epidemic. He noted that anticipated savings due of Medi-Cal expansion would allow for a large investment into case finding programs.
- A suggestion was made to take the idea to the EHE Steering Committee. K. Donnelly noted that he would like the COH to partner with EHE strategies but noted funding is much smaller at approximately $7 million. V. Scott commented that EHE funds end in 2025 and is unsure if funding will continue beyond 2025.
- C. Barrit requested a detailed report from DHSP on EHE funding and programs with a formal presentation to PP&A. This would allow the Committee a full understanding of all DHSP programs/services and funding being use toward HIV. This would give the Committee a complete picture from a status neutral perspective and aid in determining priorities and allocations as well as opportunities for innovation. She noted that some members of the COH are unaware of the much of the progress that is being made via EHE efforts.
- M. Martinez added that it would be helpful to have an EHE member in each COH Committee as a shared learning opportunity to give perspective and help inform decisions.

12. Review Revised Stakeholder Engagement Implementation Timeline & Development of CAB Questionnaire

- Review of the revised stakeholder engagement implementation timeline and development of CAB questionnaire was pushed back to the June PP&A Committee meeting due to time constraints.

VI. NEXT STEPS

13. Task/Assignments Recap

a. Prevention Planning Workgroup Status Neutral Recommendations
b. Review revised stakeholder engagement implementation timeline and begin developing CAB questionnaire.
c. Recap of reallocations proposed by DHSP

14. Agenda Development for the Next Meeting

a. Review LAHSA report
b. Recap of the third installment of the unmet needs report
c. Questions to DHSP regarding Medi-Cal Expansion and FY 2022 Carry Over Allocation

Exploring ways to allocate increased funding to SPA 6 to help facilitate increased HIV testing

VII. ANNOUNCEMENTS

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

C. Orozco called attention to a Los Angeles Times news article (found here) where a recent study found that many LA County homeless service workers cannot afford housing themselves due to low wages which often results in high staff turnover.

VIII. ADJOURNMENT

16. Adjournment for the Meeting of April 18, 2023.

The meeting was adjourned by K. Donnelly at 3:03pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 5/12/23

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**LUCKIE**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (No Affiliation)	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks

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

CDC DHP and HRSA HAB, HIV Integrated Prevention and Care Plan, CY2022-2026
Summary Statement

CENTERS FOR DISEASE CONTROL AND PREVENTION

Health Resources & Services Administration

SECTION I: Integrated Plan Submission and Review Summary	
Jurisdiction	**Los Angeles County Department of Public Health**
Submission Type	☐ Integrated state/city prevention and care plan ☐ Integrated state-only prevention and care plan ☒ Integrated city-only prevention and care plan ☐ Other:_____
RWHAP Part A Jurisdictions (EMA/TGA) or MSAs included in the plan	**Los Angeles EMA**
Did the jurisdiction use portions of other plans to satisfy requirements (e.g., EHE plan)?	☒ Yes ☐ No or Not Applicable **Name of Plan(s) Used:** EHE Plan **If available, URL to other Plan(s):** https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf
Executive Summary Included	☒ Yes ☐ No
CDC and HRSA Reviewer's Name(s)	
CDC Reviewer's Name:	Kevin Ramos
CDC Reviewer's Name:	Benjamin T. Laffoon
HRSA Reviewer's Name:	Babak Yaghmaei
HRSA Reviewer's Name:	Tonia Schaffer

SECTION II: Community Engagement and Planning Process	
Please select all planning bodies that participated in developing the Integrated Plan.	☒ Integrated HIV Prevention and Care Planning Body ☒ RWHAP Part A Planning Council/Planning Body ☐ RWHAP Part B Advisory Group ☐ HIV Prevention Group (HPG) ☒ EHE Planning Body

	☐ Other, please specify:
1. Jurisdiction Planning Process: Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals, and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans, such as the EHE plan. Please be sure to address the items below in your description.	**CDC-HRSA Response** Yes
a. **Entities Involved in Process:** List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities, such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. See *Appendix 3* for a list of required and suggested stakeholders.	**CDC-HRSA Response** Yes
b. **Role of RWHAP Part A Planning Council/Planning Body (not required for state-only plans):** Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.	**CDC-HRSA Response** Yes
1. **Role of Planning Bodies and Other Entities:** Describe the role of the CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement that occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.	**CDC-HRSA Response** Yes

2. **Collaboration with RWHAP Parts:** Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system.	**CDC-HRSA Response** Yes
3. **Engagement of People with HIV:** Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan.	**CDC-HRSA Response** Yes
4. **Priorities:** List key priorities that arose out of the planning and community engagement process.	**CDC-HRSA Response** Yes
5. **Updated to Other Strategic Plans Used To Meet Requirements (Only for those jurisdictions that used sections of other plans):** If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe the following: 1. How the jurisdiction uses annual needs assessment data to adjust priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders. 3. Any changes to the plan because of updated assessments and community input. Any changes made to the planning process because of evaluating the planning process.	**CDC-HRSA Response** Yes

General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing):

- The Los Angeles Department of Public Health submitted a detailed Integrated HIV Prevention and Care Plan that meets the Integrated Plan Guidance submission requirements for the jurisdictional planning process. The Ending the HIV Epidemic in the U.S. (EHE) Plan was used to inform the Integrated HIV Prevention and Care Plan for setting goals and objectives. It was a collaborative effort between the HIV Planning Council, the Los Angeles County Division of HIV and STD Programs (LAC DHSP), as well as community stakeholders, including people with HIV. The jurisdiction provided a detailed list of community entities involved in the planning process. Additionally, the jurisdiction collaborates with Ryan White HIV/AIDS Program (RWHAP) planning bodies, specifically the RWHAP Part A Planning Council, where the Los Angeles Commission on HIV/AIDS serves as a member. It is important to note that RWHAP Part B, Part C, Part D, and Part F were also engaged in the planning process. As a result, of these collaborative efforts, the jurisdiction successfully identified, using current surveillance data and ongoing feedback from

stakeholders, 10 key priorities further addressed and discussed in the Integrated HIV Prevention and Care Plan.

SECTION III: Contributing Data Sets and Assessments	
1. **Data Sharing and Use:** Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data-sharing agreements and for what purpose.	**CDC-HRSA Response** Partial
2. **Epidemiologic Snapshot:** Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction that uses the most current available data (trends for the most recent five years). The snapshot should highlight key descriptors of people diagnosed with HIV and at risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at risk for exposure to HIV. This snapshot should also describe any HIV clusters identified and outline key characteristics of clusters and cases linked to these clusters. Priority populations for prevention and care should be highlighted and aligned with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction, showing the impact of HIV in the jurisdiction.	**CDC-HRSA Response** Yes
3. **HIV Prevention, Care, and Treatment Resource Inventory:** Create an HIV Prevention, Care, and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive: • Organizations and agencies providing HIV care and prevention services in the jurisdiction. • HRSA (must include all RWHAP parts) and CDC funding sources. • Leveraged public and private funding sources, such as those through HRSA's Community Health Center Program, HUD's HOPWA Program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding. • Describe the jurisdiction's strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services.	**CDC-HRSA Response** Yes

• Services and activities provided by these organizations in the jurisdiction and, if applicable, which priority population the agency serves. • Describe how services will maximize the quality of health and support services available to people at risk for or with HIV.	
a. Strengths and Gaps: Please describe strengths and gaps in the HIV prevention, care, and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools, such as injectable antiretrovirals, and other environmental impacts.	**CDC-HRSA Response** Yes
b. Approaches and Partnerships: Please describe the approaches the jurisdiction used to complete the HIV prevention, care, and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.	**CDC-HRSA Response** Yes

4. **Needs Assessment** Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data, including: 1. Services people need to access HIV testing, as well as the following status-neutral services needed after testing: a. Services people at risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs 2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression –Needs 3. Barriers to accessing existing HIV testing, including state laws and regulations, HIV prevention services, and HIV care and treatment services – Accessibility	**CDC-HRSA Response** Yes
a. Priorities: List the key priorities arising from the needs assessment process.	**CDC-HRSA Response** Yes
b. Actions Taken: List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.	**CDC-HRSA Response** Yes
c. Approach Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in *Appendix 3.*	**CDC-HRSA Response** Yes

General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing):

- The jurisdiction met the submission requirements for Section II: Contributing Data Sets and Assessments. The jurisdiction uses multiple data sources to monitor HIV/STD epidemics, as well as track service utilization. The jurisdiction provided an epidemiological snapshot, highlighting the impact that HIV is having on the 26 health districts, especially those in the Service Planning Areas (SPAs) that have the highest rates of HIV.
- The jurisdiction submitted a detailed resources inventory list and funding amounts of each entity; however, the list, per the jurisdiction, is incomplete, as it did not include the funding amounts from private donors.
- The jurisdiction met the requirements for the Needs Assessment section of the Integrated HIV Prevention and Care Plan. The jurisdiction discussed their use of multiple assessment activities

and methods to assess people with HIV and people affected by HIV in Los Angeles County. The jurisdiction also used numerous secondary data sources and reports to complete the Statewide Coordinated Statement of Need (SCSN). A detailed list of all sources and reports are denoted in the plan.

- HRSA: Data sharing is partially met. The submission includes lots of data sets but does not include language on how the jurisdiction will share the data.

SECTION IV: Situational Analysis	
1. Situational Analysis: Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues affecting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas: a. Diagnose all people with HIV as early as possible. b. Treat people with HIV rapidly and effectively to reach sustained viral suppression. c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs). d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. *Please note jurisdictions may submit other plans to satisfy this requirement if applicable to the entire HIV prevention and care service system across the jurisdiction.*	**CDC-HRSA Response** Yes
a. **Priority Populations:** Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.	**CDC-HRSA Response** Yes
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for the Situational Analysis section of the Integrated HIV Prevention and Care Plan. Specifically, the Situational Analysis highlights the disparities experienced by the seven identified key priority populations. These disparities are driven by structural and systemic issues, including housing status, poverty, recent incarceration, and comorbid conditions, i.e., substance use and mental health disorders.	

SECTION V: 2022-2026 Goals and Objectives	
Did the plan list and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent, and respond to HIV? Be sure the goals address any barriers or needs identified during the planning process. There should be at least three goals and objectives for each of these four areas. See Appendix 2 for the suggested format for Goals and Objectives.	
Diagnose	**CDC-HRSA Response** Yes
Treat	**CDC-HRSA Response** Yes
Prevent	**CDC-HRSA Response** Yes
Respond	**CDC-HRSA Response** Yes
a. Updates to Other Strategic Plans Used to Meet Requirements (applicable only if the recipient used other plans to satisfy this requirement): If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made because of the analysis of data.	**CDC-HRSA Response** Yes
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for the Goals and Objectives section (Section IV) of the Integrated HIV Prevention and Care Plan. As previously discussed, the Ending the HIV Epidemic in the U.S. Plan was used to inform the goals and objectives of the Integrated HIV Prevention and Care Plan. The plan includes specific, measurable, achievable, realistic, time-bound (SMART) goals and objectives that are aligned with the four pillars: Diagnose, Treat, Prevent, and Respond. Further, the jurisdiction also included key foundational and cross-pillar elements, which support each pillar's strategies and activities.	

SECTION VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up	
1. 2022-2026 Integrated Planning Implementation Approach: Describe the infrastructure, procedures, systems, or tools that will support the five key phases of integrated planning to ensure goals and objectives are met.	**CDC-HRSA Response** Yes

a. **Implementation** Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdiction's Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams, including but not limited to HAB and CDC funding.	**CDC-HRSA Response** Yes
b. Monitoring Describe the process for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. *<u>Note</u>: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.*	**CDC-HRSA Response** Yes
c. Evaluation: Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts an analysis of the performance measures and presents data to the planning group/s.	**CDC-HRSA Response** Yes
d. Improvement: Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.	**CDC-HRSA Response** Yes
e. Reporting and Dissemination: Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation, and improvements made to the plan.	**CDC-HRSA Response** Yes

2. Updates to Other Strategic Plans Used to Meet Requirements (applicable only if the recipient used other plans to satisfy this requirement): If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe the following: 1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities. 2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes. 3. Revisions are made based on work completed.	**CDC-HRSA Response** Yes
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for Section VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up. The Integrated HIV Prevention and Care Plan includes an implementation plan that also includes performance measures, responsible parties, and timelines related to each activity. The Commission on HIV, in collaboration with the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), is responsible for monitoring progress toward meeting plan goals and objectives, which were discussed in detail.	

SECTION VII: Letters of Concurrence	
1. CDC Prevention Program Planning Body Chair(s) or Representative(s) 2. Community Co-Chair	**CDC-HRSA Response** Concurrence
3. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	**CDC-HRSA Response** Concurrence
4. RWHAP Part B Planning Body Chair or Representative	**CDC-HRSA Response** Concurrence
5. Integrated Planning Body	**CDC-HRSA Response** Concurrence
6. EHE Planning Body	**CDC-HRSA Response** N/A
General Comments on Section and/or explanation for no/partial responses in the review tool (e.g., what information was missing): • The jurisdiction met the submission requirements for Section VII: Letters of Concurrence. A letter of concurrence from the Los Angeles Commission on HIV, including Ryan White HIV/AIDS Program Part A, is addressed to the Director of the Division of HIV and STD Programs and has been signed by the County Commission on HIV (COH) co-chairs.	

Integrated Plan Submission Review Summary

I. Highlights and Observations of Plan:

- Overall, the jurisdiction submitted an Integrated HIV Prevention and Care Plan that met all Integrated Plan Guidance submission requirements. As previously stated, the jurisdiction used the EHE Plan as the foundation for development and implementation. The jurisdiction engaged a wide breadth of internal and external partners, as well as diverse community stakeholders, especially people with HIV. Also, the jurisdiction used current epidemiological data from a variety of data resources. As a result, the jurisdiction identified six priority populations, as well as three priority jurisdictions (Hollywood, Wilshire, and Long Beach) that have the highest rates of HIV.

II. Plan Strengths:

- The Integrated HIV Prevention and Care Plan met all the Integrated Plan Guidance submission requirements.
- The Integrated HIV Prevention and Care Plan utilized current epidemiological data, which was abstracted from a variety of data resources listed in the plan.
- The status-neutral approach to HIV care and prevention is embraced by the jurisdiction. It was identified as one of the key priority areas of focus that arose out of the community engagement process.
- The Goals and Objectives (Section V) was comprehensive, with clearly laid out objectives and strategies to ensure that implementation has a positive impact on the communities. Additional goals were listed beyond the necessary requirements.

III. Programmatic/Legislative Compliance Issues:

None noted.

Action Items to Resolve Programmatic/Legislative Compliance Issues:

None noted.

IV. Recommendations for Plan Improvement:

- Improve how data sharing occurs within the entities involved. The submission includes data systems, along with data presentation, but it is unclear "how" data was shared and what agreements are in place.
- Additional information is needed as to how the community is being engaged and playing a key role within the components of the Integrated HIV Prevention and Care

Plan. Submission indicates that the community members will be engaged but does not go further to define how this engagement will occur in the long term.

V. Capacity Building/Technical Assistance Suggestions:

None noted.

VI. Items for Future Monitoring Discussions:

Discuss plan components and/or activities in the monthly call.

Dear Ryan White HIV/AIDS Program and Centers for Disease Control and Prevention Colleagues:

The Centers for Disease Control and Prevention (CDC), Division of HIV Prevention (DHP) and the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) thank you for submitting your jurisdiction's Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) covering calendar years 2022 – 2026 (referred to as the Integrated Plan). HIV planning bodies should use the Integrated Plan as a *living document* and as a roadmap to guide HIV prevention and care planning throughout the year. As a living document, jurisdictions are encouraged to make annual Integrated Plan updates using data and engaging community to reflect local needs and changes in the health care delivery system.

CDC and HRSA conducted a joint review of the jurisdictions' Integrated Plans, resulting in joint summary statements. The summary statement included with this letter will serve as CDC and HRSA's official feedback to jurisdictions regarding their Integrated Plan. Grant recipients are not expected to submit revisions of the Integrated Plan; however, in some cases CDC and HRSA may ask recipients to develop action plans to address programmatic or legislative compliance issues. Additionally, through regular monitoring and reporting mechanisms, HRSA and CDC will request updates on progress made in implementing the Integrated Plan.

In addition to the summary statements, CDC and HRSA will: (1) Coordinate a call between CDC and HRSA project officers and recipient representatives from HIV prevention and care to provide a high-level overview of the joint feedback; and 2) Continue discussions with the recipients during routine conference calls (i.e., incorporated into individual monthly monitoring calls) as an ongoing component of monitoring the Integrated Plan and integrated planning activities within the jurisdictions.

CDC DHP project officers will continue to work with the jurisdictions' prevention and epidemiology staff on using the epidemiologic profiles and identifying HIV workforce capacity needs to inform the Integrated Plan activities.

Additionally, as Integrated Plans are implemented and progress toward goals is monitored, technical assistance (TA) opportunities are available to jurisdictions and their planning bodies. Recipients should contact their CDC or HRSA project officer for specific details on how to access the available TA opportunities.

Integrated planning, including community involvement, is imperative for effective local and state decision making. It helps to ensure that systems of HIV prevention and care are responsive to the needs of people in need of HIV prevention services and people with HIV.

We look forward to continuing to work with all of our partners and stakeholders involved in HIV prevention and care to end the HIV epidemic.

Sincerely,

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

/Robyn Neblett Fanfair/
CAPT Robyn Neblett Fanfair, MD, MPH
Acting Director, Division of HIV Prevention National Center for HIV, Viral Hepatitis,STD, and TB Prevention
Centers for Disease Control and Prevention

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LGBTQ+ AMERICANS UNDER ATTACK: A REPORT AND REFLECTION ON THE 2023 STATE LEGISLATIVE SESSION

Last updated 6/8/23

Dear Reader:

I'm not going to sugarcoat this: For the first time in HRC's nearly half-century history, we're declaring a national state of emergency for LGBTQ+ people in the United States.

During this legislative session, there have been over 525 state bills introduced that attack the LGBTQ+ community, and over 220 of those target the transgender community. As of presstime, more than 70 of those have become law. These laws are fueled by an **anti-LGBTQ+ Republican establishment** — and coordinated, well-funded extremist groups like the **Alliance Defending Freedom, Heritage Foundation** and the **Family Policy Alliance** — insistent on trying to control our families and lives.

Just look at what's playing out in Texas and Tennessee and Florida. These states are banning educators from talking about LGBTQ+ issues and teaching Black history, and are banning gender-affirming care and abortion care. These same states do nothing to ensure the freedom of children to be safe from gun violence, and do nothing to protect the freedom of democracy when Black and trans voices are silenced in state legislatures.

Or look at Governor **Ron DeSantis**, who has weaponized his position as a lawmaker to target LGBTQ+ families, Black and brown Floridians, immigrants and private businesses. Even with the majority of Floridians forcefully opposing his anti-LGBTQ laws and despite surging support for LGBTQ+ families nationally, DeSantis has been criss-crossing the country to attack our community. This report details the political attacks like those he's waged on our community that have transpired in statehouses across the country.

The good news is that for every Florida, there's a Michigan, which became the 22nd state to sign LGBTQ+ non-discrimination protections into law. And for every Texas, there's a Pennsylvania, where because of our partnership and work and advocacy, they are on the cusp of becoming the 23rd state to put LGBTQ+ non-discrimination protections on the books. And for every Tennessee, there's a Minnesota, where they banned so-called "conversion therapy" this year.

And for every villain, there are countless heroes fighting back even as our opponents threaten democracy to punish them. Heroes like Oklahoma State Rep. **Mauree Turner**, who opened their office as a place of safety for a transgender constituent — and stood strong in the face of retribution as they faced an unjust censure. Heroes like Nebraska State Sen. **Michaela Cavanaugh**, who made a conscious decision to undertake a historic filibuster when she saw that her colleagues were going to use that session to hurt, not to help. And State Rep. **Zooey Zephyr** of Montana, who spoke out against a bill to ban gender-affirming care and faced an undemocratic expulsion as a result. Reps. Justin Jones and Justin Pearson in Tennessee, who have been outspoken LGBTQ+ advocates, bravely fought against the plague of gun violence in our country and were also expelled by a radical state house majority.

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But we need more heroes: **we need you**. As individuals, you can get active in our neighborhood and community. Stand up and advocate in your statehouses and hold your lawmakers — at all levels of government — accountable for their votes. Join movement organizations like HRC and LGBTQ+ equality groups in your states. For businesses and fair-minded community leaders, practice allyship, not just perform it by speaking out against the hate-filled legislation and attacks and supporting the community. Help make sure everyone knows someone who is trans, by lifting up trans employees and leaders, and standing with them when the water gets hot. Engage your clients and constituents in this work — show them what it means to lead on LGBTQ+ rights.

Together, we will get to a world where we are free and liberated without exception — without anyone left behind.

Let's get to work, y'all.

Kelley Robinson (she/her)
HRC President

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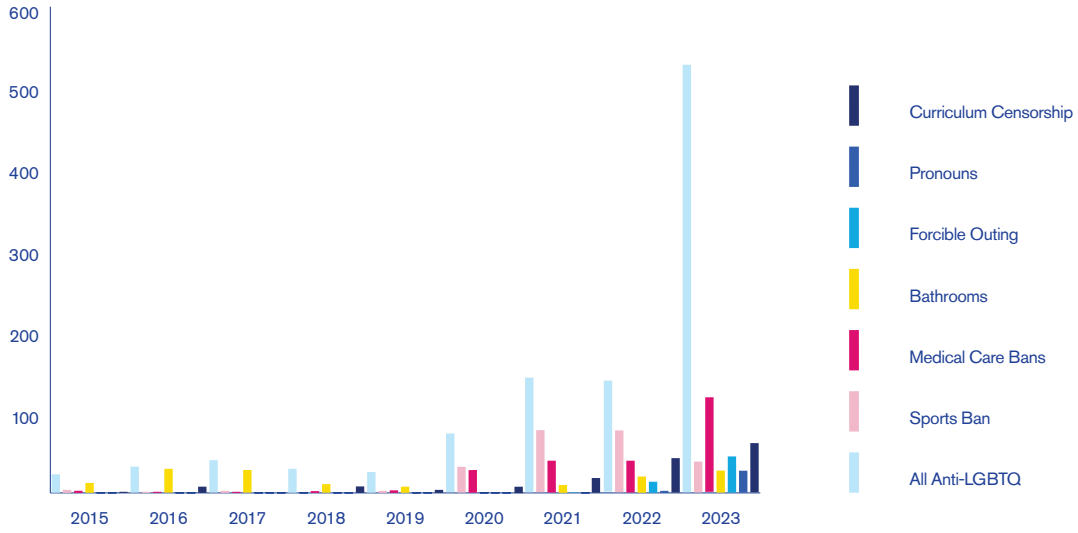
Executive Summary

+ The LGBTQ+ community is under attack in state legislatures across the country.

- Starting in 2015, we have seen a steady increase in anti-LGBTQ+ bills across state houses, from 115 bills introduced in 2015, to over 500 in 2023.
- In 2020, the primary focus of these bills shifted from LGBTQ+ people in general, to transgender and non-binary youth in particular

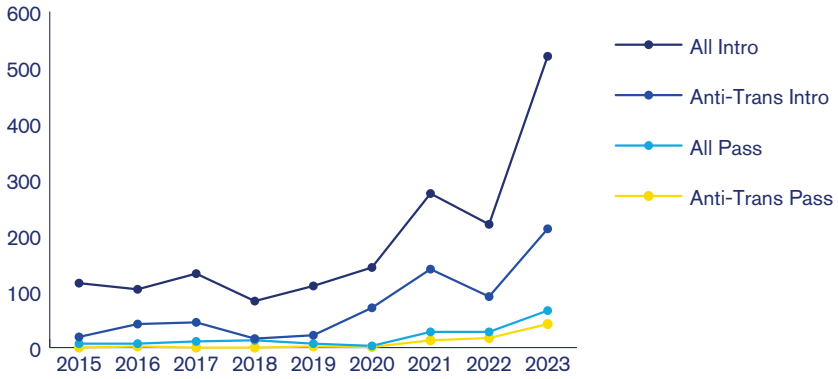
Snapshot of Anti-LGBTQ+ Bills Introduced by Year



+ The 2023 state legislative session was the worst one on record for anti-LGBTQ+ legislation

- More than 525 bills were introduced in 41 states. Over 220 of these bills explicitly targeted transgender people
- A total of 77 bills have been signed into law as of June 8, 2023 — more than any year on record.

Anti-LGBTQ+/Anti-Trans Bills Introduced and Passed



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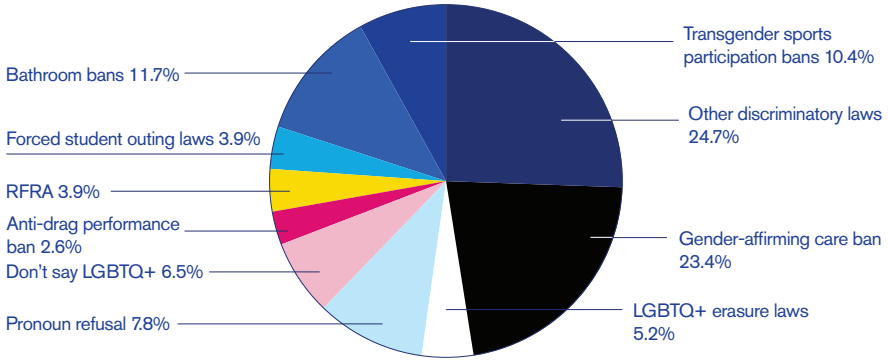
- **These attacks — a retread of vintage homophobic/transphobic campaigns of the past — are not reflective of emerging issues, but rather a coordinated, top-down moral panic, driven by a few well-funded and well-connected organizations.**
    - The overwhelming volume of anti-LGBTQ+ legislation introduced in state legislatures across the country in 2023 was not a coincidence:
    - Many individual bills rely on copy-and-pasted language from model legislation proposed by a national coalition of groups including the Heritage Foundation, Family Policy Alliance and Alliance Defending Freedom (ADF) who have been long-standing opponents of LGBTQ+ equality.
    - In several states, passage of anti-LGBTQ+ legislation was aided through subverting the democratic process, violating democratic norms, and silencing pro-equality advocates.

- **These bills aim to legislate LGBTQ+ people out of all aspects of daily life, through rolling back existing legal protections, reducing LGBTQ+ visibility, and attempts at reducing cultural and social acceptance of the LGBTQ+ community**

Type of Bills Passed in 2023



- **Using original data from HRC surveys, and storytelling from LGBTQ+ parents and families across the United States, this report details the impact of anti-LGBTQ+ legislative attacks for the LGBTQ+ community – ranging from threats to mental health and safety, to some choosing to relocate themselves and their family to more inclusive policy environments.**
    - For example, LGBTQ+ youth who attend schools with inclusive curriculum that discuss sexual orientation/gender identity (SOGI) feel safer, are safer, and do better in school – yet "Don't Say LGBTQ+" bills aim to eliminate or censor these very discussions

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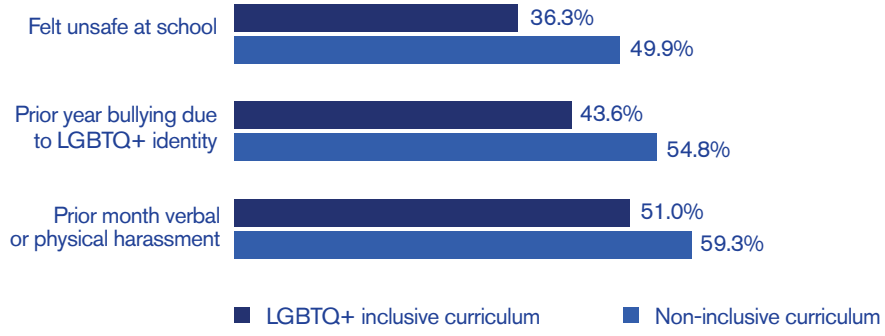
School bullying and harassment, by inclusive curriculum status



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2023: An Escalating Crisis for LGBTQ+ Equality in the States

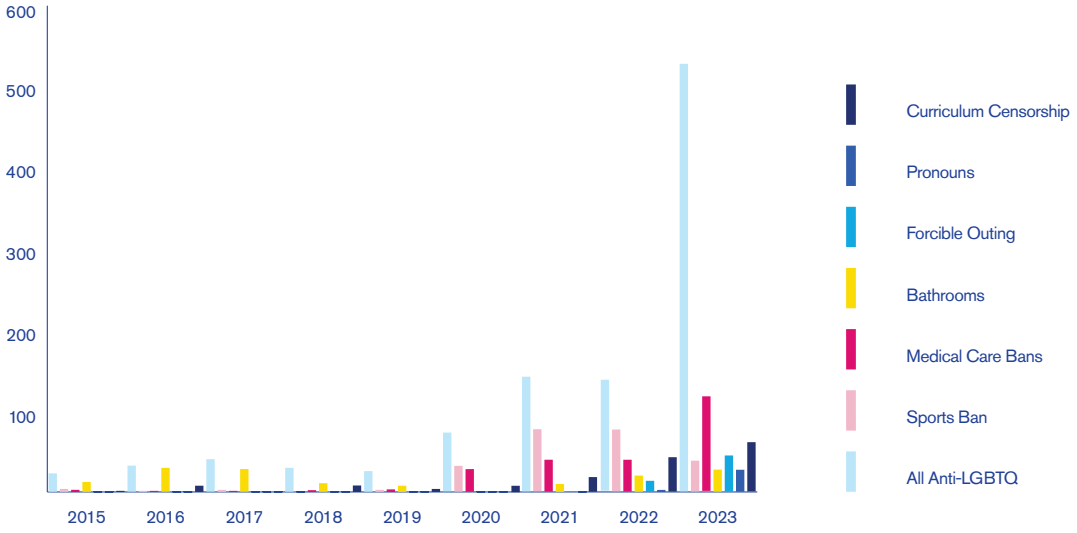
VINTAGE HOMO- AND TRANS-PHOBIA UNDERPIN A NEW ERA OF CRUELTY IN THE FIGHT FOR LGBTQ+ EQUALITY IN THE STATES

2023 is shattering previous records for anti-LGBTQ+ legislation. Since 2015 — when the *Obergefell v. Hodges* marriage equality case was in front of the United States Supreme Court — gerrymandered state legislatures have introduced increasing numbers and types of legislation that would try to stymie continued gains in lived or legal equality for LGBTQ+ people. Because legislative districts have been drawn so unfairly, too many state legislators are not held accountable to their entire district in a general election. Instead, the most competitive elections these legislators face is in their primary election, which motivates them to focus their energy to please the furthest-right extreme elements within the Republican primary electorate. Despite public opinion overall supporting LGBTQ+ equality, these legislators come back time and time again to new and innovative ways to be cruel to LGBTQ+ folks.

A NEW ERA IN THE FIGHT FOR LGBTQ+ EQUALITY IN THE STATES.

The volume of discriminatory legislation introduced in 2015 defined the beginning of a new era in the fight for LGBTQ+ equality in the states. Since 2015 the amount of legislation introduced has steadily increased, as have the numbers of discriminatory bills enacted. 115 discriminatory bills were filed across the country in 2015 — a record at the time. Starting in 2020, opponents of equality began leaning into what they saw as an area of potential opportunity — isolating transgender youth from the protection of the law, as well as from their parents, doctors, teachers, guidance counselors, classmates, coaches, and teammates as well as erasing them from the books they read and the history they learn. Efforts to attack transgender youth drove the increase in bills filed and enacted from 2020-2023, shattering previous records and harming tens of thousands of transgender young people in doing so.

Figure 1. Snapshot of Anti-LGBTQ+ Bills Introduced by Year



Of the laws enacted since 2015 that specifically target transgender people, 95% were enacted since 2020.

More than 1000 LGBTQ+ related bills have been filed in 2023, and HRC is opposing more than 525 bills in 41 states. As of June 8, 2023, a total of 77 have been enacted into law. More than 220 of the bills filed this year explicitly target transgender people.

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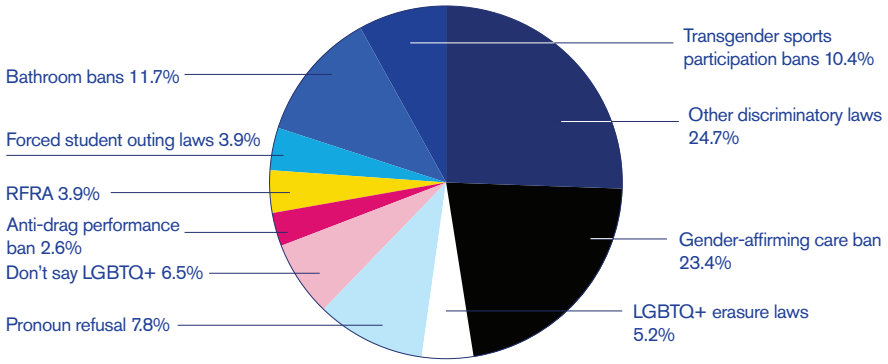
Figure 2. Type of Bills Passed in 2023



DUSTING OFF THE "SAVE OUR CHILDREN" MORAL PANIC PLAYBOOK.

Proponents of the discriminatory legislation are the same organizations that have opposed LGBTQ+ equality in the United States for the last many decade — these groups include Family Policy Council (associated with Focus on the Family), the Heritage Foundation, and the SPLC-designated anti-LGBTQ hate group the Alliance Defending Freedom. Their top-down, coordinated effort includes other groups like the American Principles Project, and their efforts are anything but clandestine. Among other things, their coalition has a website that offers model language that has been used in state legislatures across the country.

These folks have one goal: eliminate cultural and legal acceptance of LGBTQ+ people. To do this, they have revitalized the vintage homophobia that Anita Bryant made famous in her "Save Our Children" crusade in Florida many decades ago. That is, they have so sexualized LGBTQ+ identity that they argue that even acknowledging that LGBTQ+ people exist — much less showing any affirmation of LGBTQ+ identity — is inherently inappropriate and corrupting for children. They also argue that discrimination against LGBTQ+ people that would otherwise be prohibited should be allowed for people who assert a religious disagreement with the existence or acceptance of LGBTQ+ people — even though those same situations would not allow them to discriminate against a divorcee or a person of another religion.

By framing the existence of LGBTQ+ people as inherently vulgar, and suggesting that some people should have the ability to refuse to comply with the laws that govern basic civility in our public square based on a belief that LGBTQ+ people cannot or should not exist, our opponents seek to impose their worldview — to which they are, of course, entitled — upon the rest of the country and the world. To do so, they've advocated for policy proposals in state legislatures designed to isolate, alienate, and terrify LGBTQ+ people — especially transgender youth. State legislators have been all too receptive to these proposals as a result of the extreme partisan gerrymandering in state legislatures across the country.

FROM MORAL PANIC TO STATE LAW.

The proponents of the discriminatory legislation have weaponized their discriminatory ideology and distilled into discriminatory state law. Like any other kind of performance, the performance of drag can be tailored to suit many kinds of audiences — the show at the club on Saturday night will be a dramatically different set than the Sunday morning dramatic reading of a children's book at the local public library. Proponents' characterization of all drag performance as obscene is a result of a hyper-sexualization of LGBTQ+ identities. But this preoccupation

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with LGBTQ+ identity itself as obscene content is reflected in many policy proposals beyond drag. For example, the idea that the acknowledgement of the existence of LGBTQ+ people is inherently dangerous, combined with the efforts to isolate and alienate young folks from their sources of support, leads into policy proposals to ban books, censor curriculum (a la "Don't Say LGBTQ+" laws), and forbid transgender youth from being able to safely use the restroom at school; it also feeds prohibitions that require teachers to misgender and deadname students and for school personnel to forcibly "out" children to their parents — even when that would put the young person in danger. It includes sports bans that prohibit transgender kids from playing sports alongside their friends. And it absolutely includes laws that prevent doctors and parents of transgender youth from being able to access age-appropriate, best practice healthcare for a child simply because the child is transgender.

All of these policy efforts serve the true purpose of the opponents of LGBTQ+ equality: limit public acceptance and support of LGBTQ+ people and reverse legal progress and protections. Religious refusal laws continue to pass, often quietly, creating major loopholes to important and assumed protections for LGBTQ+ people and others who do not subscribe to the same religious beliefs of the entity who wishes to discriminate. Several new laws this year seek to erase legal protections for LGBTQ+ people across the state code by adopting bioessentialist and exclusionary definitions of the word "sex". These LGBTQ+ erasure laws can have major ramifications for protections for women, transgender people, and people who are lesbian, gay, bisexual or queer.

CELEBRATING THE GOOD AS WE ALSO FIGHT BACK AGAINST THE BAD.

In the midst of the most damaging and discriminatory legislative session on record, there were important victories for the LGBTQ+ community too. In Michigan, the Elliot Larsen Civil Rights Act — the state's powerful non-discrimination law — was amended to include express protections from discrimination on the basis of sexual orientation and gender identity. In Minnesota, a ban on the abusive and discredited practice of so-called "conversion therapy" was adopted. Other laws extending important protections to transgender people, including in health care, were also adopted — with more good legislation hopefully still to come this year. And, while every bad law enacted irreparably changes the course of real people's lives for the worse, about 90% of anti-LGBTQ+ bills are on track to fail to become law — an impressive rate of defeat. The work continues.

Anti-democratic Actions and Coordinated Attacks

Majorities of Americans, in every state and across every demographic, support LGBTQ+ *non*-discrimination measures. State legislators, however, have continued to increase the intensity of the anti-LGBTQ attacks in statehouses across the country. They have done so because of the increasing pressure to perform well in primaries dominated by a small group of hyperpartisan extremists, facilitated by well-funded anti-LGBTQ+ organizations who will pursue any path that reverses the pro-equality gains of recent decades — and the desperation to deliver to those audiences drove legislators around the country to flout the rules of the established democratic process.

ANTI-EQUALITY MEASURES PASSED WITH THE HELP OF ANTI-DEMOCRATIC MANEUVERS

During this legislative session, in states across the country, anti-equality elected officials subverted the democratic process to pass discriminatory legislation. Their main goal in doing so was to avoid having to own the unpopularity of such measures and the protests of the LGBTQ+ community and its allies.

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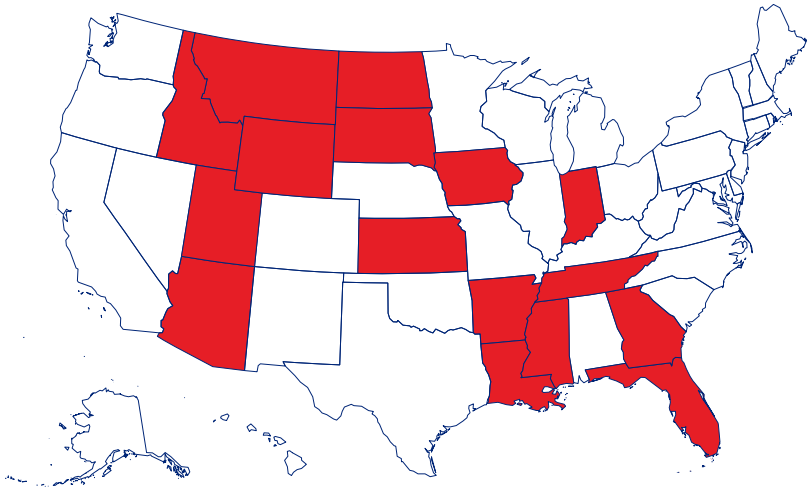
The ways that these officials violated democratic rules and norms to silence opposition included:

- The legislatures' censorship and removal of transgender legislators who spoke out against pending legislation, including State Rep. Zooey Zephyr in Montana and State Rep. Maurie Turner in Oklahoma;
- The expulsion of State Rep. Justin Jones and State Rep. Justin Pearson by the Tennessee House Speaker over their support for gun violence prevention laws and for their outspoken support for the LGBTQ+ community;
- Leadership changing procedural rules to pass bills in Kentucky in the final hours, fast-tracking legislation in Georgia, and ignoring procedural rules in Nebraska; and
- Preventing the public's right to be heard in legislatures around the country, including by removing peaceful demonstrators and violating their right to peacefully assemble in states including Texas, Oklahoma, Nebraska, and Montana.

In each of these states, supermajority Republican legislatures deployed these tactics to avoid or limit public discourse about the laws they were attempting to muscle through. The rise of these anti-democratic maneuvers poses a troubling warning for future legislative sessions. Furthermore, the lack of consequences for the politicians who violated democratic norms makes it likely that more leaders may employ such tactics in future years.

State legislatures are creatures of state constitutional law, with a complex working of formally adopted legislative rules intertwined with norms about civility, democracy, public input, and debate. These norms are generally vociferously defended — but this year they were bent past the breaking point in not only one legislature, but many.

States Where Anti-LGBTQ+ Organizations Have Supported Discriminatory Legislation That Passed This Session



ANTI- LGBTQ+ GROUPS LEADING THE ATTACK

The overwhelming volume of anti-LGBTQ+ legislation introduced in state legislatures across the country in 2023 was not a coincidence: rather, this legislation is part of a national coordinated attack by far-right entities. A coalition of groups including the Heritage Foundation, Family

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Policy Alliance and Alliance Defending Freedom (ADF)[1] drafted model legislation, recruited legislators to sponsor their policies, testified bills in committee hearings, and promised to pay for legal defense when the laws were inevitably challenged in court. These organizations use junk science and fear-mongering attacks against LGBTQ+ to peddle their policies, and try to justify discrimination in the name of religious belief.

Increasingly, these dark money groups have focused specifically on the transgender community as a legislative and political target. They support forced outing of LGBTQ+ kids, banning transgender youth from playing sports consistent with their gender identity, preventing transgender people (especially youth) from accessing best practice healthcare simply because they are transgender, discriminating in bathroom facilities, and various other legislation enshrining discrimination against transgender youth. While the Heritage Foundation, Family Policy Alliance and ADF are the leaders in this effort, they attracted like-minded allies in other far right organizations that use transgender children to score political points.[2]

Throughout this legislative session, the following groups have crisscrossed the country to testify in support of hateful and discriminatory anti-LGBTQ bills:

- American College of Pediatricians
- American Principles Project
- Gays Against Groomers
- Independent Women's Forum
- Moms for Liberty

Most states that passed anti-LGBTQ legislation in 2023 were influenced by these groups. In Texas, American Principles Project, who admitted their long-term goal was to eliminate all transition care,[3] donated t-shirts in the state capitol to drum up support for their legislation. In Kentucky, a representative from the American College of Pediatricians, a fringe group of roughly 700 doctors[4] (also designated by the Southern Poverty Law Center as an anti-LGBTQ hate group), pushed junk science to justify a ban on best practice gender-affirming care, and in Florida, prominent detransitioner Chloe Cole lobbied with the Florida affiliate of the Family Policy Alliance to push anti-LGBTQ+ and anti-abortion legislation.[5] A small group of adults who formerly identified as transgender were flown into state capitals across the country despite having no ties to the state; very often, these folks had not received the types of care that the bills even forbade.

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IMPACT OF ANTI-LGBTQ+ LEGISLATION

Across the country, thousands of LGBTQ+ people — and thousands of transgender, non-binary, and gender non-conforming (TGNC+) youth in particular — have been directly impacted by anti-LGBTQ+ legislation, losing access to life saving medical care, comprehensive and inclusive education, and activities, spaces, and facilities. Below, we estimate the number of LGBTQ+ people living in states where such bills have passed — noting that, as the impact of many of these school-based bills extend into Kindergarten (yet our population estimates start at high school), or even outside of K-12 schools altogether, many more LGBTQ+ youth and young adults are likely directly impacted by the current legislative environment.

Number of LGBTQ+ people impacted by legislative attacks

Transgender sports participation bans – 23 states

- **33.8%** of high school aged transgender youth — approximately **101,500** of the estimated 300,100 transgender youth aged 13-17[6] in the U.S. — are living in states where they are unable to simply play alongside their friends.

Gender-affirming care bans – 20 states

- **30.9%** of all transgender youth age 13-17[7] — an estimated **92,700 transgender youth** — are living in states where their access to life-saving, best practices gender affirming medical care[8] has been banned through bills and/or administrative action.
    - This number includes the 7,800 transgender youth living in Alabama, Oklahoma, and Arkansas, where court injunctions against care bans are ensuring continued access to care.
    - In some states, care has been banned not only for youth, but for young adults and adults (age 18+) as well, further increasing the number of transgender and non-binary people nationwide who have seen their access to healthcare blocked in this legislative session.
- 32 states introduced gender affirming care bans during the 2023 legislative session, meaning that at its height, **half of all transgender youth** in the U.S. were at risk of losing access to gender-affirming care.

Bathroom bans – 10 states

- **15.1%** transgender people (age 13+) — **over 247,000** of the 1.6 million transgender people in the U.S. — live in states where they are unable to use bathrooms, locker rooms, and/or other facilities in accordance with their gender identity while in K-12 (public) school buildings, if not elsewhere. This includes:
    - **11.1%** of all transgender youth age 13-17 (**33,200** transgender youth)
    - **16.0%** of all transgender adults (age 18+) nationwide (**213,800** transgender adults)

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- Over **110,000** transgender people (age 13+) live in Florida and North Dakota, states where they are also banned from using bathrooms and facilities in some public settings and buildings outside of K-12 schools

"Don't Say LGBTQ+" laws – 6 states

- **12.3%** of LGBTQ+ youth age 13-17 — over **273,600** of the more than 2.2 million LGBTQ+ high school aged youth[9]— are living in states where "Don't Say LGBTQ+" bills have passed, banning discussions of sexual orientation/gender identity, and LGBTQ+ people, in classrooms. This includes:
  - **9.9%** of transgender youth age 13-17 (**29,600** transgender youth)
  - **12.7%** of cisgender LGBQ+ youth age 13-17 (**244,000** LGBQ+ youth)

Forced Student Outing laws – 6 states

- **4.4%** TGNC+ youth age 13-17 — approximately **13,100** TGNC+ youth — live in states where forced outing bills have passed, requiring teachers, administrators, and other school staff to disclose to parents if youth adopt new chosen names and/or pronouns

"Pronoun refusal" laws – 6 states

- **8.0%** TGNC+ youth age 13-17 — approximately **24,100** TGNC+ youth — live in states with school-based pronoun bans, which prohibit school teachers and staff from using a child's chosen name and pronouns if they do not align with the child's sex assigned at birth

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Mental health impact of anti-LGBTQ+ legislation

Anti-LGBTQ+ legislation can have significant and substantial impacts on the health, well-being, and safety of the LGBTQ+ community.

INCREASED ANXIETY AS A RESULT OF LEGISLATIVE ATTACKS

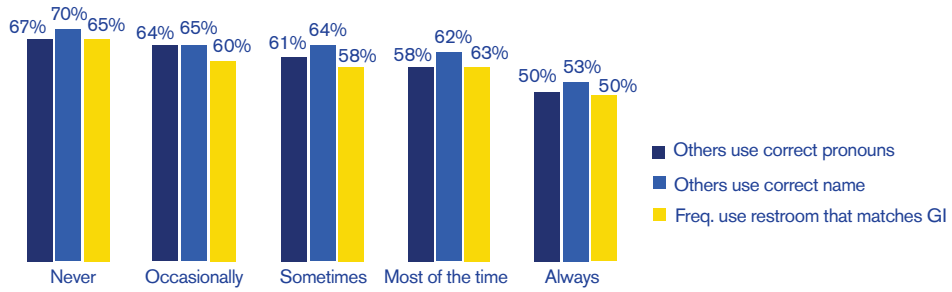
The passage of bills — and even simply their introduction — can be a substantial source of stress and anxiety for LGBTQ+ youth. For example, in 2021, when Texas first began ramping up their legislative attack against LGBTQ+ youth The Trevor Project's crisis hotline saw a 150% growth[10] in calls from youth in Texas, compared with the same period the year prior. Between 2013 and 2019, calls to the Crisis Text Line, a hotline focused on support for LGBTQ+ youth, saw a small, but significant, increase in calls from states where anti-LGBTQ+ legislation was introduced,[11] with spikes occurring in the four weeks after legislation was initially introduced. In their survey of LGBTQ+ youth conducted in 2022 – before the latest onslaught of legislative attacks — The Trevor Project found that 2 in 3 LGBTQ+ young people[12] reported their mental health was a lot worse as a result of "hearing about potential state or local laws banning people from discussing LGBTQ people at school," whereas 1 in 3 said their mental health was poor most or all of the time, as a result of anti-LGBTQ+ legislation.

These bills also strip away access to many of the supportive actions and resources that are both protective against the adverse mental health impacts of stigma, harassment, and discrimination, and which actively help LGBTQ+ youth feel safe, affirmed, and welcomed.

BLOCKED ACCESS TO SUPPORTIVE RESOURCES

Prior research has found that having one's pronouns affirmed by a single additional adult,[13] and/or a single additional context where one can use their chosen name,[14] is associated with lower risk of depression and suicidality among transgender and non-binary youth. Data from HRC and the University of Connecticut's 2022 LGBTQ+ Youth Survey[15] shows that, prior to this legislative session, TGNC+ youth who had their pronouns and chosen name used more frequently in schools, and who were able to use the restroom in accordance with their gender identity more often, were significantly less likely to be depressed (see Figure 3).[16]

Figure 3. Depression among TGNC+ youth, frequency of gender affirmation at school



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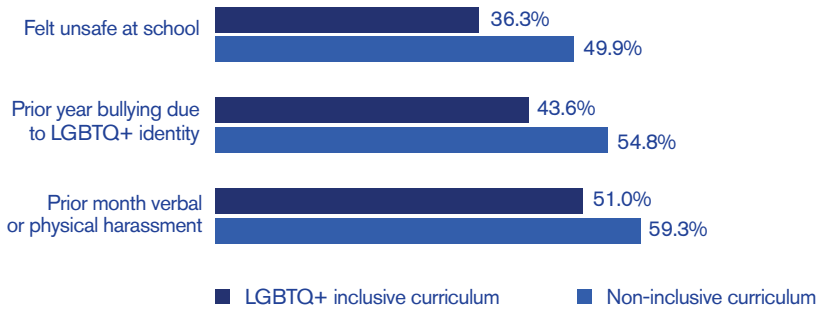
Yet, rather than supporting trans youth, state legislators in multiple states have passed bills which block TGNC+ youth from using restrooms/school facilities that match their gender identity (10 states), allow educators to refuse to affirm trans youths' pronouns and names and/or bans staff from referring to youth with chosen name and pronoun if it does not match their sex assigned at birth (6 states), and/or requires educators to out TGNC+ youth to their parents (6 states), essentially forcing TGNC+ youth back into the closet while at school, and further increasing risk for depression and suicidality in an already vulnerable population.

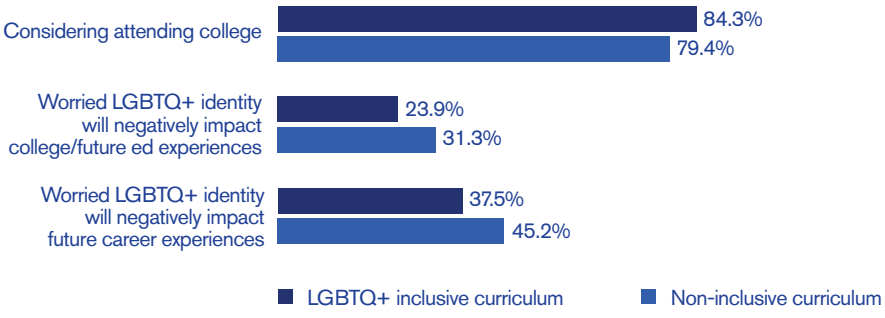
Other research has found that LGBTQ+ youth who attend schools with inclusive curricula, such as including discussions of sexual orientation and gender identity in health education, reading LGBTQ+ authors or stories in English classes, and/or teaching about LGBTQ+ people/movements in history, feel safer, are safer, and do better in school.[17] Data from HRC's 2022 Youth Study bares this out, with LGBTQ+ youth who attended schools with inclusive curriculum less likely (than those who did not) to feel unsafe at school or experience school-based bullying or harassment (Figure 4);[18] those who attended schools with inclusive curricula were also more likely to consider going to college, and were less afraid that their LGBTQ+ identity would negatively impact their future educational or employment opportunities (Figure 5).

Figure 4. School bullying and harassment, by inclusive curriculum status



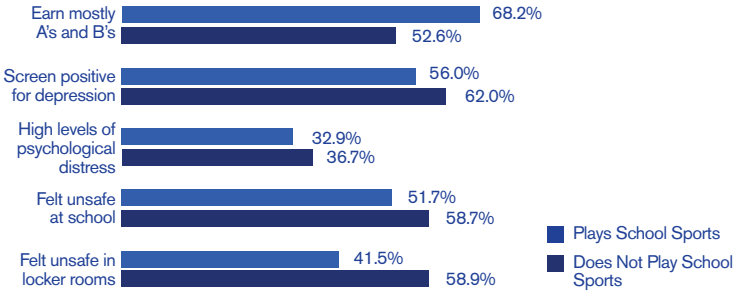
Yet since this survey was conducted, 6 states have passed or expanded "Don't Say LGBTQ+" bills which censor discussions of sexual orientation and gender identity in classrooms–increasing risk of stigmatization and harassment for LGBTQ+ youth, while denying them access to supportive and affirming education.

Figure 5. Future education and employment aspirations, by inclusive curriculum status



Similarly, there are multiple known benefits of sports participation, including lower levels of anxiety and depression,[19] higher levels of self-esteem,[20] and better academic performance.[21] Yet in the 23 states where transgender youth are banned from playing sports in accordance with their gender identity, transgender youth are denied access to these benefits as well.[22]

Figure 6. Mental health and school experiences of Transgender and Non-Binary Youth, by student athlete status



NEED TO RELOCATE OR FLEE TO SAFER AND MORE INCLUSIVE LOCATIONS

The introduction and/or passage of anti-LGBTQ+ legislation can also lead LGBTQ+ people and their families to feel unsafe and unwelcome in their hometowns, and even, in some cases, to consider leaving altogether. In a Williams Institute survey[23] of 113 LGBTQ+ adults raising kids in Florida, conducted in September 2022, three months after Florida passed their initial "Don't Say LGBTQ+" bill, over half (56%) reported they were considering moving out of Florida, and more than 1 in 6 (17%) had taken steps to do so.

In a survey of parents of TGNC+ youth (age 18 and younger) conducted by the Human Rights Campaign/University of Arizona conducted in 2022, parents — including many of those living in states where anti-LGBTQ+ legislation went on to pass in 2023 — discussed considering, or potentially even being forced to, move out of their state were legislation to pass. As one parent of a 14-year-old transgender boy in Louisiana noted:

> ***"Our son is our only child. We have little family support….We are afraid of his future living in the South and are considering moving elsewhere after he completes high school for better support of transgender individuals.***

But even parents who live in more progressive states expressed concerns about growing anti-transgender /anti-LGBTQ+ sentiment and legislation, describing an almost constant state of fear and anxiety. Concerns were not just limited to fears that legislation would pass in their own states, but also included spillover psychological impacts of legislation, and how their child could internalize it. As one parent of a 5-year-old non-binary child in Massachusetts described it,

> ***"Every anti-trans message, particularly anti-trans girls in sports message, hits close to home and makes me scared for their future. Will they be physically or emotionally harmed? Will society's lack of acceptance of their identity make them a target of hate crimes? What will acceptance look like as they grow up, go through puberty? Will they be able to play the sports they want safely? Will they be able to be themselves all the time? They already make others more comfortable than themselves when they feel social pressure to allow others to misgender them without correction. It is exhausting to constantly correct people and teach them what nonbinary means — especially when you're a 5 year old who'd already thought more about gender than most adults!***

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As the 2023 legislative session drew to a close, HRC spoke to several parents and families in states where legislation did pass, and many described similar feelings of wanting or needing to flee — or, deciding to stay and fight:

Personal Narratives About the Impact of Anti-LGBTQ+ Legislation

Below are the stories of families impacted by anti-LGBTQ+ legislation in Missouri, Florida, and Texas.

MISSOURI

Debi's non-binary teen can still access healthcare because of the legacy provision, however, the family is still leaving their home in Kansas City, Missouri. "We have been testifying against anti-trans bills for 8 years…more than half of my child's life. Yes, they can continue receiving physical healthcare for now, but the continued attacks on their very existence have taken a toll on their mental health," she said. The decision to leave isn't easy, though, and leads to conflicting emotions. "A few years ago, a GOP Representative told us that if we didn't like what they were doing and if we were good parents, we'd take our child and go. I hate feeling like we are giving in or giving them what they want. But I also have to prioritize my child's well-being over my stubborn need to make those representatives look us in the eye and openly proclaim their bigotry every session."

On the other side of the state, another family also started packing. Danielle and her husband have driven to Jefferson City to testify against bills for the last few years in support of their son. She told legislators several times that they are suburban farmers with thriving businesses and they want to continue contributing to Missouri's economy. To protect their child, though, they would give all of that up and start over somewhere new.

As they started sorting through their belongings, deciding what to keep and what to sell or donate for a move, Danielle's mother started a battery of tests for Alzheimer's and her father was diagnosed with cancer. Her son is "extremely close" with his grandpa and couldn't bear the idea of not being by his side through his upcoming treatment. She is angry at the decisions the state is forcing her to make, saying that "it's unfair that Missouri is making us choose between doing what two different generations of my family need to survive."

For now, they will be staying. "We've established an entire supportive community and shouldn't have to leave where our son is thriving. He's happy, has a perfect first job, and has an adorable girlfriend. I shouldn't have to consider taking him away from everyone who loves him, especially when other family members need us, to get him healthcare." Her son is willingly putting his own future on hold in the hope that his supportive grandfather will have a longer future because of his support. That is loving, heartbreaking, and unfair. That is the impact of laws that legislators will never see.

FLORIDA

Julie and Theresa are a married couple in central Florida who have just welcomed their first child. They are now leaving due to fear about how all of these laws will impact their family. Julie is an elementary school teacher who worries about losing her job as an out lesbian educator or potentially facing violence if confronted in a restroom. "I don't look particularly femme. That's never been a problem before, and wearing more masculine clothes at work has actually

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been nice because I don't have to worry about ruining them when I get on the floor to play with my students," she jokes. "But now I'm nervous. It's one thing to not be able to talk about my wife, but what if someone tries to get physical thinking I'm a guy in the wrong bathroom? I have a family to think about. And how could I ever look into the eyes of one of my kids and not call them the pronoun that I know they need to hear? It would tear me apart to hurt them so much."

Theresa would find her job just as difficult. As a nurse, she knows how frightening it can be for a trans person to go to the hospital, wondering if they will be disrespected or even turned away for care. "There aren't laws saying I can't take care of my trans patients anymore, but this is Florida, so it's probably just a matter of time. I do worry that because hate and bigotry are being openly promoted and celebrated that I could still lose my job for showing basic kindness and being an ally to trans people."

The couple are now both applying for jobs in every state that is considered "blue" and are hopeful they will find work because of teaching and nursing shortages in so many areas. But they are also concerned that offers will come from different states, potentially splitting up the family they are trying so hard to keep safely together.

By contrast, Lou knows that her transgender teenager is facing certain difficulties, but her family is not ready to leave the state. Her child, M, just completed their junior year in a public high school. For the past three years, M has used the restroom and locker room that aligns with their gender and gender expression, but with the passage of HB 1521, school officials notified the family that M will have access to only one unisex restroom on the high school campus. They have already lost access to participate in sports, now will be restricted on where they can relieve themself, and the GSA at the school is likely disbanding because of the Don't Say Gay law. M is hoping to complete their senior year online to avoid campus altogether. "What reason is there even to go to school?" they ask.

M's mom has the answer: college. "Our student's future beyond high school — and our family's finances — are hugely impacted by the passing of these draconian laws. Our rising senior has a GPA and SAT scores that would qualify them for any public university in Florida, and the state-funded Bright Futures Scholarship program would likely cover most, if not all, of the cost of their college education. But they aren't safe in Florida, so we are looking at out-of-state opportunities that could cost hundreds of thousands of dollars."

She ends with a note of optimism, saying, "Our child is strong, resilient, creative, and beautiful. I know their future is bright…as soon as we can get them out of this godforsaken state."

TEXAS

This year SB 14, a bill that bans medically necessary, age-appropriate, life-saving gender-affirming healthcare, was passed. [It now sits on the Governor's desk to be officially signed into law.] In a twisted irony, an amendment was added to the bill to create an exemption for youth already receiving hormonal treatment, but the amendment had cruel restrictions. Only youth who had received at least 12 mental health counseling sessions or six months of psychological therapy and had started hormone therapy before June 1st were eligible. However, they were not eligible to continue that care indefinitely. They were eligible to be "weaned" off the care rather than to have it taken away immediately.

The draconian nature of SB 14 has driven some families to make the decision to flee the state. One of those families is from Houston, where they have had some struggles with individual teachers in their transgender child's school but where they also had access to high-quality

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healthcare at Texas Children's Hospital. Unfortunately, with the new ban on gender-affirming healthcare coupled with a privacy breach of medical records from the hospital's gender clinic leaked to conservative media outlets, they no longer feel safe. They are now considering moving to the Washington DC area or Colorado.

Another family has taken even more drastic steps to find a sense of peace and safety. Lauren Rodriguez and her son Greyson are leaving the United States completely. Lauren sold their home and has been paring down and packing up a lifetime of memories into a few boxes for a planned move to New Zealand. Greyson has already moved there to start his college education. He says that he felt an immediate sense of relief and lightness on his shoulders upon stepping off the plane — completely alone in a new country — because he knew that transgender people are welcomed and protected there. "I feel just so much better, happier, safer. I didn't realize how uncomfortable I felt in Texas until I got here."

There are families who are staying behind, either because of the support within their local community or because of a lack of means to move. Within this group, there are still those who are hoping to move to one of the relatively liberal bubbles where elected officials have indicated their cities will be as much of a sanctuary as is possible given statewide laws. Megan L. is part of this second group. Her family lives about 45 minutes outside of Austin, where her husband works. The family cannot afford a move out of Texas, but they are hoping to sell their home and make enough of a profit to afford a smaller home within the city where there is a supportive school district and to put some money into a savings account for future trips out-of-state for gender-affirming healthcare.

"I'm a Texan through and through. I really love this state. We've talked about leaving, but it could take a long time for my husband to find a new job in a safe state…and those states are so expensive. I hope a fresh start in a new school where no one knows my daughter is trans will be enough to keep her safe. We'll figure out getting to doctors somewhere else when the time comes," Megan said. "We might be making a big mistake staying here. All I can do right now is pray."

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[1]Promise to America's Children. (2023, January). About Us. Retrieved June 2, 2023, from https://promisetoamericaschildren.org/about-us/

[2]Nagourney, A., & Peters, J. W. (2023, April 17). How a Campaign Against Transgender Rights Mobilized Conservatives. The New York Times. https://www.nytimes.com/2023/04/16/us/politics/transgender-conservative-campaign.html

[3]Astor, M. (2023, January 30). G.O.P. State Lawmakers Push a Growing Wave of Anti-Transgender Bills. *The New York Times*. https://www.nytimes.com/2023/01/25/us/politics/transgender-laws-republicans.html

[4]Mehrotra, D., & Cameron, D. (2023, May 2). ***An anti-trans doctor group leaked 10,000 confidential files.*** Wired. Retrieved June 2, 2023, from https://www.wired.com/story/american-college-pediatricians-google-drive-leak/

[5]Kim Kendall (@KimKend24) on Twitter, March 28, 2023 https://twitter.com/KimKend24/status/1640732147148374016

[6] Herman, J. L., Flores, A. R., & O'Neill, K. K. (2022, June). *How Many Adults and Youth Identify as Transgender in the United States?* Williams Institute. Retrieved June 2, 2023, from https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

[7]Estimates of the number of transgender people impacted by legislation are modeled after estimates run by The Williams Institute (e.g. Elana Redfield, Kerith J. Conron, Will Tentindo, & Erica Browning, The Williams Institute, Prohibiting Gender-Affirming Medical Care for Youth (March 2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf).

To derive these counts, we tallied Williams Institute estimates of the total number of transgender youth and adults, and of the number of LGBTQ+ youth and adults, living in states **where legislation has passed, as an estimate of the number of people 'at risk' of being impacted by such legislation** (meaning, for example, this reflects the total number of transgender youth who are in states where gender affirming care is no longer accessible, not the number of transgender youth currently receiving care).

As Williams Institute estimates of the LGBTQ+ adult and youth population are derived from 2015 and 2017 data, and the percentage of adults and youth in the United States openly identifying as LGBTQ+ has steadily increased since then, it is likely that these estimates are an undercount.

[8]Human Rights Campaign. (2023, March 22). *Get the Facts on Gender-Affirming Care*. Human Rights Campaign. Retrieved June, 2023, from https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care

[9]Estimates of the number of LGBTQ+ youth in each state are derived from summing Williams Institute estimates of the number of transgender youth, with estimates of the number of cisgender LGBQ+ youth, to derive a total

[10]Weaver, J. (2021, September 27). *New Data Illuminates Mental Health Concerns Among Texas' Transgender Youth Amid Record Number of Anti-Trans Bills*. The Trevor Project. Retrieved June 2, 2023, from https://www.thetrevorproject.org/blog/new-data-illuminates-mental-health-concerns-among-texas-transgender-youth-amid-record-number-of-anti-trans-bills/

[11]Parris, D., Fulks, E., & Kelley, C. (2021, July 6). *Anti-LGBTQ Policy Proposals Can Harm Youth Mental Health*. Child Trends. Retrieved June 2, 2023, from https://www.childtrends.org/publications/anti-lgbtq-policy-proposals-can-harm-youth-mental-health

[12]The Trevor Project. (2023). *2023 U.S. National Survey on the Mental Health of LGBTQ Young People*. The Trevor Project. Retrieved June 2, 2023, from https://www.thetrevorproject.org/survey-2023/#anti-lgbtq-policies

[13]The Trevor Project. (2021). *The Trevor Project National Survey on LGBTQ Youth Mental Health 2021*. The Trevor Project. Retrieved June 2, 2023, from https://www.thetrevorproject.org/survey-2021/?section=FindingSupport

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[14]Russell, S. T., Pollit, A. M., & Grossman, A. H. (2018, October). Chosen Name Use is Linked to Reduced Depressive Symptoms, Suicidal Ideation and Behavior among Transgender Youth. *Journal of Adolescent Health*, 63(4), 503-505. 10.1016/j.jadohealth.2018.02.003

[15]Data comes from approximately 13,000 LGBTQ+ youth (age 13-18) in all 50 U.S. States, plus Washington, DC, surveyed as part of the 2022 LGBTQ+ Youth Study, conducted by HRC/University of Connecticut. Data was collected between January 31, and October 23, 2022.

[16]Depression is based on the PHQ-2, a 2-question screening tool which assesses frequency, over prior two weeks, of being "bothered by the following problems:" "little interest or pleasure in doing things" AND "feeling down, depressed, or hopeless" Those who score above a specified threshold are considered to have screened positive for depression.

[17]GLSEN. (2022, October). *The 2021 National School Climate Survey*. https://www.glsen.org/sites/default/files/2022-10/NSCS-2021-Full-Report.pdf

[18]**Inclusive curriculum** defined as receiving either LGBTQ-inclusive sex education and/or history ("Have any of your history classes ever had a lesson, unit, or chapter on LGBTQ+ history?")

Feeling unsafe defined as reporting "never" or "rarely" (vs. "sometimes", "usually", or "always") feeling safe in at least one of the following settings "while at school":classrooms; bathrooms; locker rooms; hallways and stairwells; school library; cafeteria; school grounds; getting to /from school; and/or on the school bus;

Prior year bullying due to LGBTQ+ identity, defined as being bullied at school "sometimes", "often", or "very often" due to their sexual orientation, gender/gender identity, and/or gender expression, in the 12 months prior to the survey

Prior month harassment defined as reporting that other students "called me names", "made fun of me", "picked on me," and/or "hit/pushed me" at school at least once in the 30 days prior to the survey

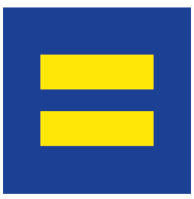
[19]Panza, M. J., Graupensperger, S., Agans, J. P., Dore, I., Vella, S. A., & Evans, M. B. (2020, May). Adolescent Sport Participation and Symptoms of Anxiety and Depression: A Systematic Review and Meta-Analysis. *Journal of Sports and Exercise Psychology*. https://doi.org/10.1123/jsep.2019-0235

[20]Zuckerman, S. L., Tang, A. R., Richard, K. E., Grisham, C. J., Kuhn, A. W., Bonfield, C. M., & Yengo-Kahn, A. M. (2021, September). The behavioral, psychological, and social impacts of team sports: a systematic review and meta-analysis. *The Physician and Sports Medicine*, 39(3), 246-261. 10.1080/00913847.2020.1850152

[21]Rankin, S., Merson, D., Garvey, J. C., Sorgen, C. H., Menon, I., Loya, K., & Oseguera, L. (2016). The Influence of Climate on the Academic and Athletic Success of Student-Athletes: Results from a Multi-Institutional National Study. *The Journal of Higher Education*, 87(5), 701-730. https://doi.org/10.1080/00221546.2016.11777419

[22]Goldberg, S. K. (2021, February 8). *Fair Play: The Importance of Sports Participation for Transgender Youth.* Center for American Progress. Retrieved June 2, 2023, from https://www.americanprogress.org/article/fair-play/

[23]Goldberg, A. E. (2023, January). *Impact of HB 1557 (Florida's Don't Say Gay Bill) on LGBTQ+ Parents in Florida*. Williams Institute. Retrieved June 2, 2023, from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Dont-Say-Gay-Impact-Jan-2023.pdf



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www.publichealth.lacounty.gov

May 17, 2023

TO: Planning, Priorities and Allocation Committee

FROM: Michael Green, Ph.D., MHSA
Chief of Planning, Development and Research

SUBJECT: RYAN WHITE HIV/AIDS PROGRAM PART A and MAI FISCAL YEAR 2023 RECOMMENDED ALLOCATIONS

The Los Angeles County Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) has drafted fiscal year (FY) 2023 recommended allocations for Ryan White HIV/AIDS Program Part A and MAI for your review and approval. Every year, DHSP and the Commission must submit an allocation table and letter from the Commission to HRSA that reflects any changes from what was submitted with the application. The FY 2023 recommended allocation table references the FY 2023 allocations that were agreed upon by the Commission in 2022, prior to the HRSA Part A non-competitive continuation application submission, as well as the recommended FY 2023 allocations based on programmatic changes discussed since the application submission. Some contextual factors include:

1. In FY 2023 Early Intervention Services (EIS) is recommended to support the Linkage and Re-engagement Program (LRP) and a new partnership with DPH Clinic Services. The partnership with DPH Clinic Services will support HIV testing in DPH clinics for clients receiving STD services to identify positive cases and make recommendations for PrEP for high-risk individuals.
2. In FY 2023 an allocation for Emergency Financial Assistance (EFA) has been recommended. This program was previously supported in FY 2021 using HRSA EHE and moved to Part A in FY 2022. Support for this program under Part A will allow more eligible LAC RWHAP clients to receive financial assistance.
3. Projected FY 2022 Part A expenditures show that expenditures for contracted services in Outpatient Ambulatory Medical Services and Mental Health Services were much lower than the approved FY 2022 allocations. Including EIS and EFA will offset that underspending and assist DHSP in maximizing the FY 2023 Part A award.

Because we recommend including EIS and EFA, the allocation percentages were revised for the remaining service categories under HRSA Part A.

DHSP is requesting your approval on the FY 2023 Recommended Allocation Table. If you have any questions or need additional information, please contact me at mgreen@ph.lacounty.gov or Victor Scott at vscott@ph.lacounty.gov. Thank you.

APPROVED by COH 6/8/23

	Part A Award	MAI Award	Part A/MAI Totals
Total Award	**$ 42,984,882**	**$ 3,675,690**	**$ 46,660,572**
Admin Ceiling	$ 4,298,488	$ 367,569	**$ 4,666,057**
CQM	$ 859,698	$ -	**$ 859,698**
Direct Services	$ 37,826,696	$ 3,308,121	**$ 41,134,817**

	Service Category	FY 2023 Approved Part A Allocations (approved 1/13/22)	FY 2023 Part A Recommendation	FY 2023 Part A %	FY 2023 Approved MAI Allocations (approved 1/13/22)	FY 2023 MAI Recommendation	FY 2023 MAI %	Total FY 2023 Part A/MAI Recommended $	Total FY 2023 Part A/MAI %	Notes
ORE SERVICES (68.94%) C	Outpatient/Ambulatory Health Services	25.51%	$ 7,033,345	18.59%	0.00%	$ -	0.00%	**$ 7,033,345**	**17.10%**	Reduction in Part A allocation to account for addition of EIS, EFA and Outreach allocations and estimated YR 33 AOM expenditures. ***APPROVED by COH 6/8/23***
	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	AIDS Pharmaceutical Assistance (local)	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Oral Health	17.60%	$ 6,658,822	17.60%	0.00%	$ -	0.00%	**$ 6,658,822**	**16.19%**	No change.
	Early Intervention Services	0.00%	$ 1,947,583	5.15%	0.00%	$ -	0.00%	**$ 1,947,583**	**4.73%**	Allocation includes new DPH Clinic Health Services program. Funding will help support a status-neutral approach using Part A funds. ***APPROVED by COH 6/8/23***
	Health Insurance Premium & Cost Sharing Assistance	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Home Health Care	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Home and Community Based Health Services	6.78%	$ 2,565,974	6.78%	0.00%	$ -	0.00%	**$ 2,565,974**	**6.24%**	No change.
	Hospice Services	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Mental Health Services	4.07%	$ 1,290,874	3.41%	0.00%	$ -	0.00%	**$ 1,290,874**	**3.14%**	Reduction in Part A allocation due to estimated YR 33 expenditures. Spanish Mental Health Telehealth and other mental health assesments will be supported using EHE funds. ***APPROVED by COH 6/8/23***
	Medical Nutritional Therapy	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Medical Case Management (MCC)	28.88%	$ 8,862,606	23.43%	0.00%	$ -	0.00%	**$ 8,862,606**	**21.55%**	Reduction in Part A allocation by to account addition of EIS, Outreach and allocations and estimated YR 33 MCC expenditures. ***APPROVED by COH 6/8/23***
	Substance Abuse Services Outpatient	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Case Management (Non-Medical) Benefits Specialty	2.44%	$ 923,917	2.44%	0.00%	$ -	0.00%	**$ 923,917**	**2.25%**	No change.
	Case Management (Non-Medical) TCM - Jails	0.00%	$ -	0.00%	12.61%	$ 417,154	12.61%	**$ 417,154**	**1.01%**	No change.

SUPPORT SERVICES (31.06%)	Child Care Services	0.95%	$ 360,299	0.95%	0.00%	$ -	0.00%	**$ 360,299**	**0.88%**	No change.
	Emergency Financial Assistance	0.00%	$ 1,569,808	4.15%	0.00%	$ -	0.00%	**$ 1,569,808**	**3.82%**	EFA allocation added. EFA was previously funded under HRSA EHE but now funded with Part A to ensure RWHAP target populations are reached with the program. ***APPROVED by COH 6/8/23***
	Food Bank/Home-delivered Meals	8.95%	$ 3,386,813	8.95%	0.00%	$ -	0.00%	**$ 3,386,813**	**8.23%**	No change.
	Health Education/Risk Reduction	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Housing Services RCFCI	0.58%	$ 220,719	0.58%	0.00%	$ -	0.00%	**$ 220,719**	**0.54%**	No change.
	Housing Services TRCF	0.38%	$ 145,065	0.38%	0.00%	$ -	0.00%	**$ 145,065**	**0.35%**	No change.
	Housing Services /Rental Subsidies with CM	0.00%	$ -	0.00%	87.39%	$ 2,890,967	87.39%	**$ 2,890,967**	**7.03%**	Permanent Supportive Housing/ Rental Subsidies costs beyond allocation to be supported using MAI carryover or other funding sources. ***APPROVED by COH 6/8/23***
	Legal Services	1.00%	$ 379,213	1.00%	0.00%	$ -	0.00%	**$ 379,213**	**0.92%**	No change.
	Linguistic Services	0.65%	$ 246,819	0.65%	0.00%	$ -	0.00%	**$ 246,819**	**0.60%**	No change.
	Medical Transportation	2.17%	$ 721,771	1.91%	0.00%	$ -	0.00%	**$ 721,771**	**1.75%**	Part A allocation reduced due to estimated YR 33. ***APPROVED by COH 6/8/23***
	Outreach Services	0.00%	$ 1,513,068	4.00%	0.00%	$ -	0.00%	**$ 1,513,068**	**3.68%**	Funds will support Linkage and Reengagement Program and Partner Services Program. ***APPROVED by COH 6/8/23***
	Psychosocial Support Services	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	New Buddy Program is supported using EHE funds. ***APPROVED by COH 6/8/23***
	Referral	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Rehabilitation	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Respite Care	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Substance Abuse Residential	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Treatment Adherence Counseling	0.00%	$ -	0.00%	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Overall Total		**$ 37,826,696**			**$ 3,308,121**		**$ 41,134,817**		
	Admin		**$ 4,298,488**			**$ 367,569**		**$ 4,666,057**		
	CQM		**$ 859,698**			**$ -**		**$ 859,698**		
			$ 42,984,882			**$ 3,675,690**		**$ 46,660,572**		

Identifying People Living with Diagnosed HIV in Medical Care but Who Are Not Virally Suppressed: Results from Health Resources and Services Administration-HIV/AIDS Bureau's Updated Approach

Wendy Garland, MPH
Chief Epidemiologist
Program Monitoring & Evaluation
Division of HIV and STD Programs

Los Angeles County Commission on HIV
June 8, 2023

Presentation Overview

- Follow up to presentation at annual meeting on updated approach to estimate unmet need

- One of three presentations to discuss estimates
  - Late diagnoses (April 2023)
  - Unmet need for medical care, or not in care (May 2023)
  - **In care but not virally suppressed (June 2023)**

- Define unmet need measures and populations, present results and discuss how to use in our work

What is Unmet Need?

- Defined by HRSA HIV/AIDS Bureau as:

  " the need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary [HIV] health care."
- Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
- New and expanded methodology released 2021 and implemented in 2022

1."HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

Evolving Definition of Unmet Need

2005

- Focus on people aware of their HIV/AIDS diagnosis but not in regular HIV medical care
- People living with diagnosed HIV and AIDS with no evidence of care (at least one **viral load [VL]** or **CD4 test** or **ART prescription**) in past 12 months

2017

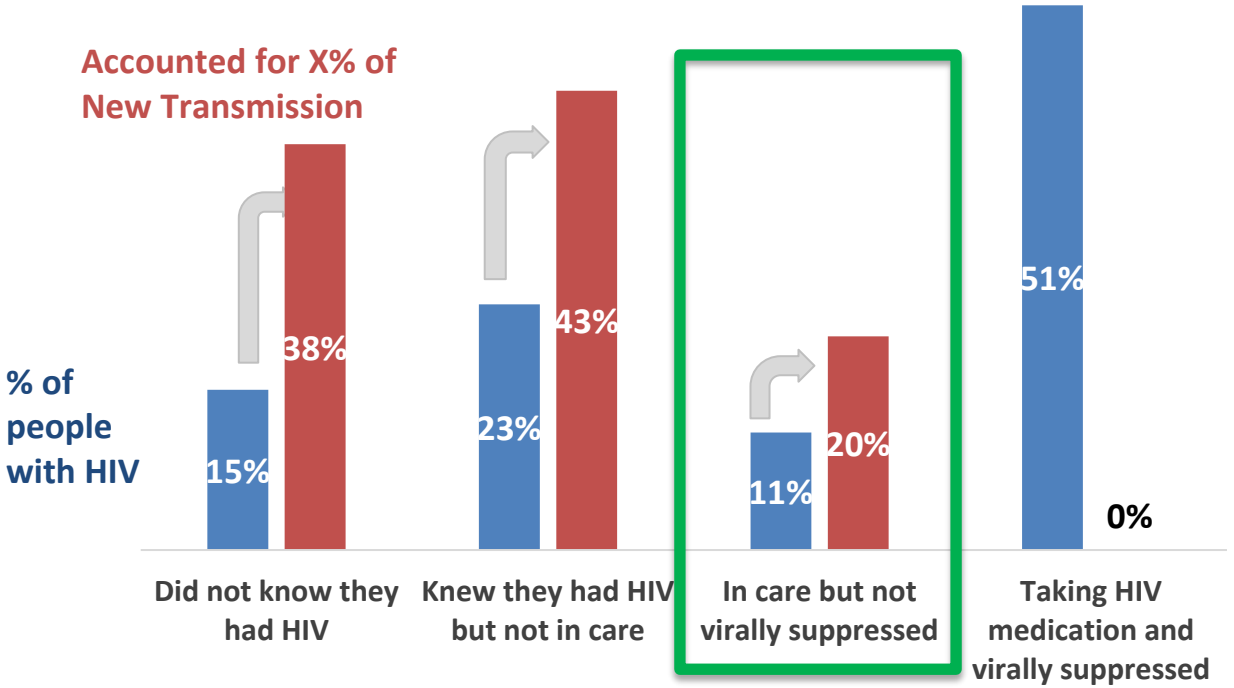
- Unmet need definition updated to align with HIV Care Continuum definitions
- People living with diagnosed HIV and AIDS with no evidence of care (2 or more **medical visits** or **VL** or **CD4 tests** at least 90 days apart) in past 12 months

2021

- Revised and expanded unmet need definitions and added RWP population
- People living with **diagnosed HIV** with no evidence of care (at least one **VL or CD4 test**) in the past 12 months
- Adds two new indicators:
  - Persons diagnosed with HIV in the past 12 months with **LATE DIAGNOSIS (Stage 3 [AIDS]** diagnosis or an **AIDS-defining condition** ≤ 3 month after HIV diagnosis**)**
  - Persons living with diagnosed HIV **IN MEDICAL CARE** (at least one VL or CD4 test) who were **NOT VIRALLY SUPPRESSED** in the past 12 months

Unmet need estimates attempt to measure the gaps between the HIV care continuum

- To reduce HIV transmission

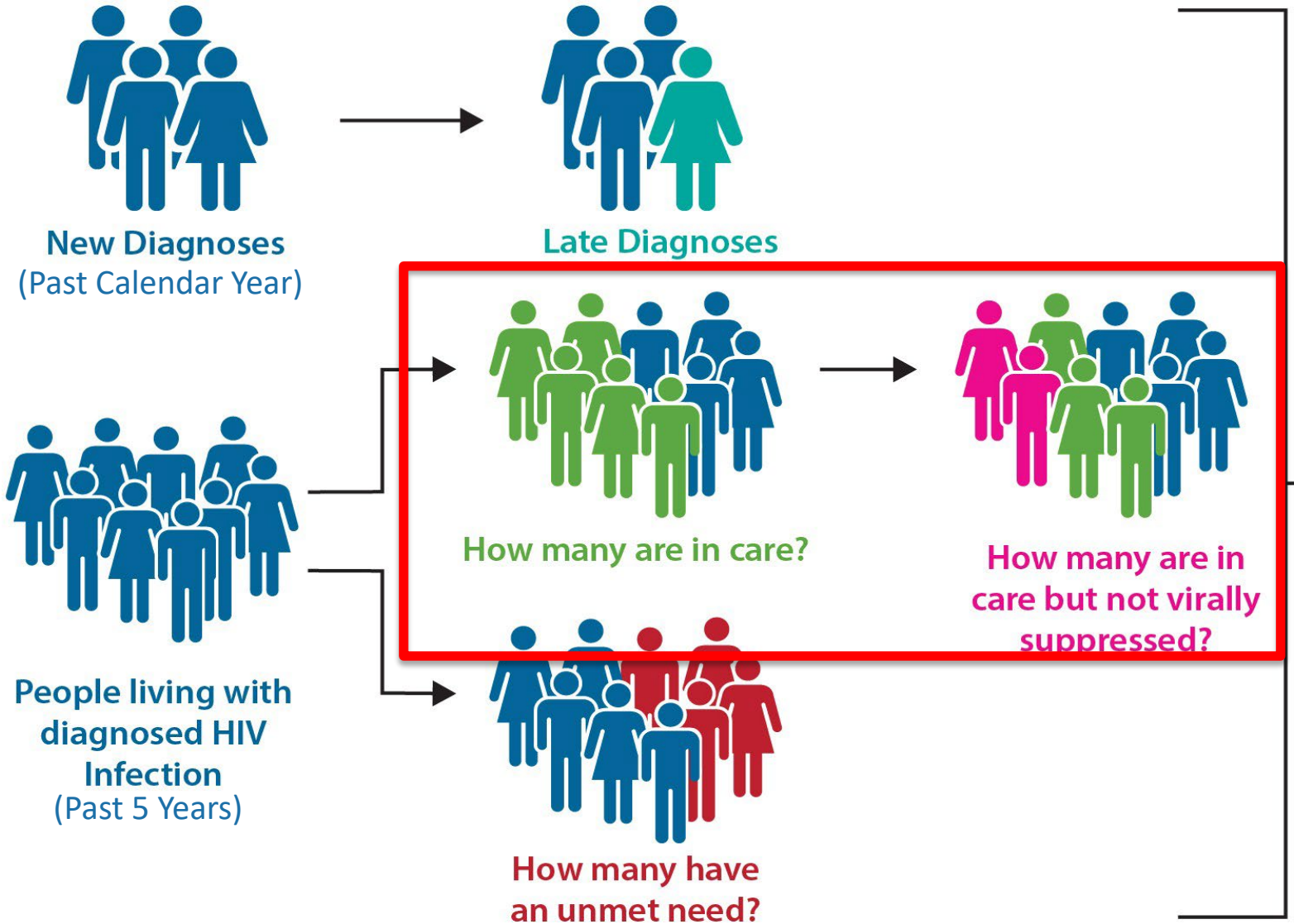


HIV Transmissions in the United States, 2016[1]

- To improve health outcomes among PLWDH
  - Start ART early in infection
  - Reduce HIV comorbidities, coinfections and complications
  - Slow disease progression
  - Extend life expectancy
  - Reduce HIV-related mortality

1. Li Z, Purcell DW, Sansom SL, Hayes D, Hall HI. *Vital Signs:* HIV Transmission Along the Continuum of Care — United States, 2016. MMWR Morb Mortal Wkly Rep 2019;68:267–272. DOI: http://dx.doi.org/10.15585/mmwr.mm6811e1 .
2. National HIV/AIDS Strategy for the United States (2022-2025). https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf

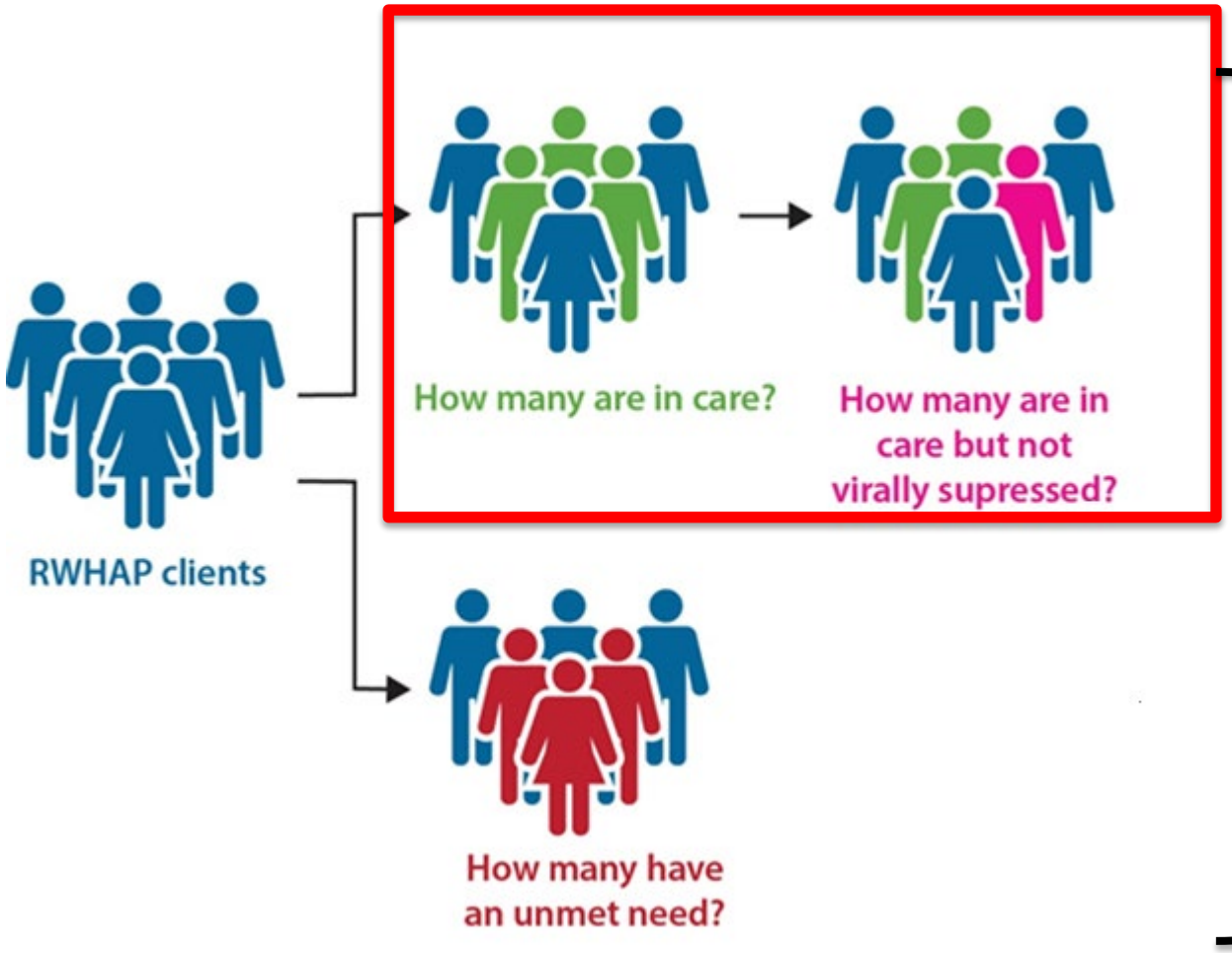
LAC Populations for Estimates of Unmet Need



What do the data look like for three priority populations (chosen by jurisdiction)?

1. Hollywood-Wilshire HD
2. Central HD
3. Long Beach HD

RWP Populations for Estimates of Unmet Need



1. Hollywood-Wilshire HD
2. Central HD
3. Long Beach HD

What do the data look like for three priority populations (chosen by jurisdiction)?

Approaches to Identify Disparities and Gaps - Examples

Across Group Comparison*

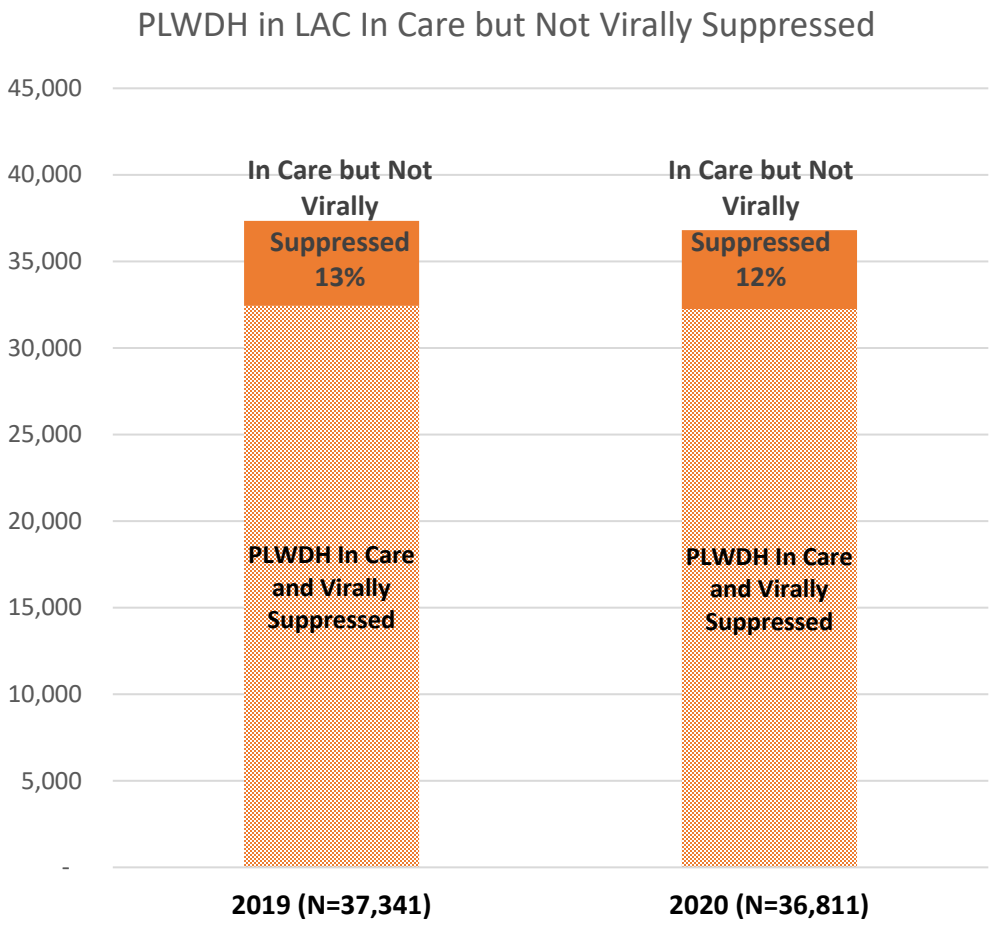
- Helpful for describing a population
  - Latino males made up 24% of LAC residents in 2020
- Identify disparities across populations
  - Latino males made up 53% of LAC residents newly diagnosed HIV in 2020
  - Proportional difference between residents who were Latino males (24%) compared to new diagnoses who were Latino males (53%)

Within Group Comparisons*

- Helpful to understand how specific groups are impacted compared to each other
  - Linkage to care among 170 newly diagnosed Hollywood-Wilshire HD residents (85%) compared to 126 newly diagnosed among Central HD residents (67%) compared to 92 newly diagnosed among Long Beach HD residents (80%)

*Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.

Considerations when thinking about this data



- These data represent the characteristics of:
  - LAC residents living with confirmed HIV diagnoses in 2020 reported to DHSP
  - RWP clients who accessed services in 2020
- These data do not reflect
  - Why PLWDH may or may not access HIV care services
- Unmet need is estimated using HIV surveillance and program data – both may be incomplete due to reporting delay. For example, changes in unmet need from 2019 to 2020 may be due to
  - Decreased laboratory access or availability due to COVID-19
  - Fewer people seeking care services

Unmet Need Estimates: In Care but Not Virally Suppressed among PLWDH and RWP Clients in LAC, 2020

Context for Unmet Need for Adherence Support

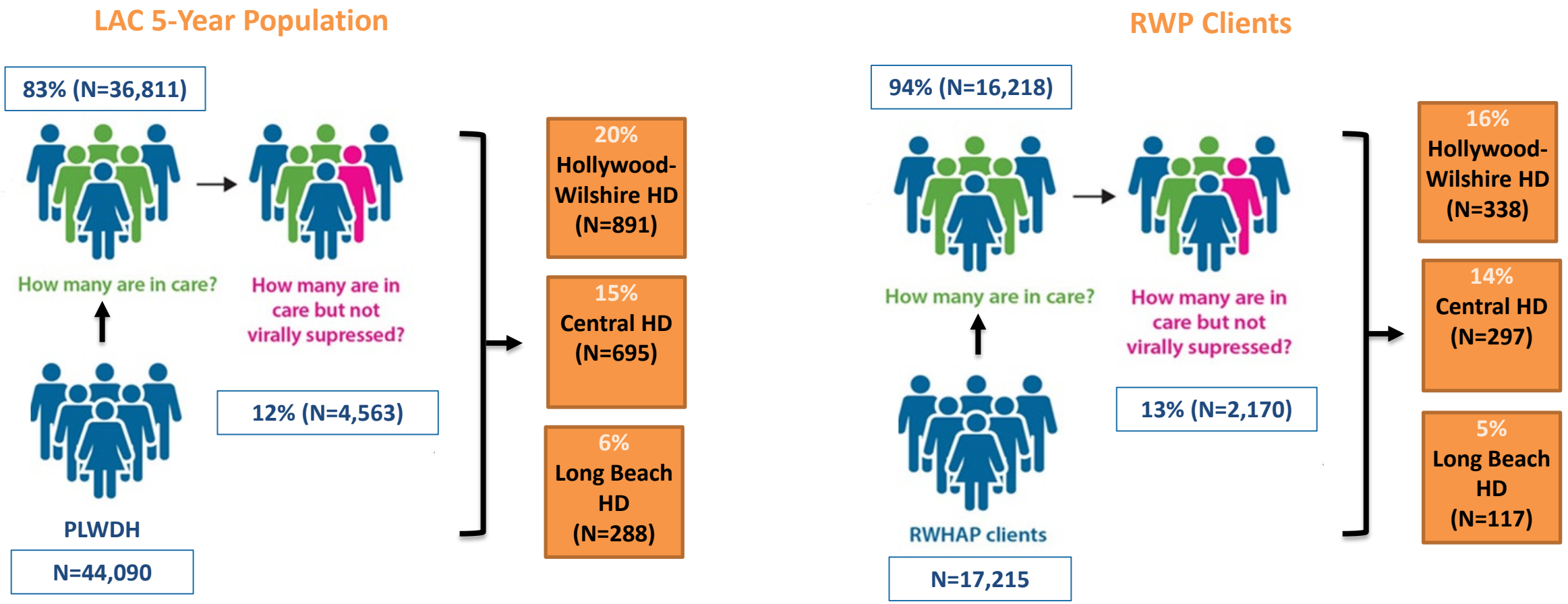
- EHE Goal: Increase percentage of PLWDH with viral suppression to 95% by 2025
  - 61% among all PLWDH in LAC regardless of care status[1]
  - 92% among PLWDH **in care** in LAC[1]

- Among a representative sample of PLWDH in LAC, 79% were prescribed ART[1]
  - Of those on ART, 46% reported missing at least one dose in the past 30 days
  - The main reason for missed ART doses was forgetting to take their medicine

- Limitations to ART prescription and adherence data
  - Only reported for a limited number of RWP services

1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.

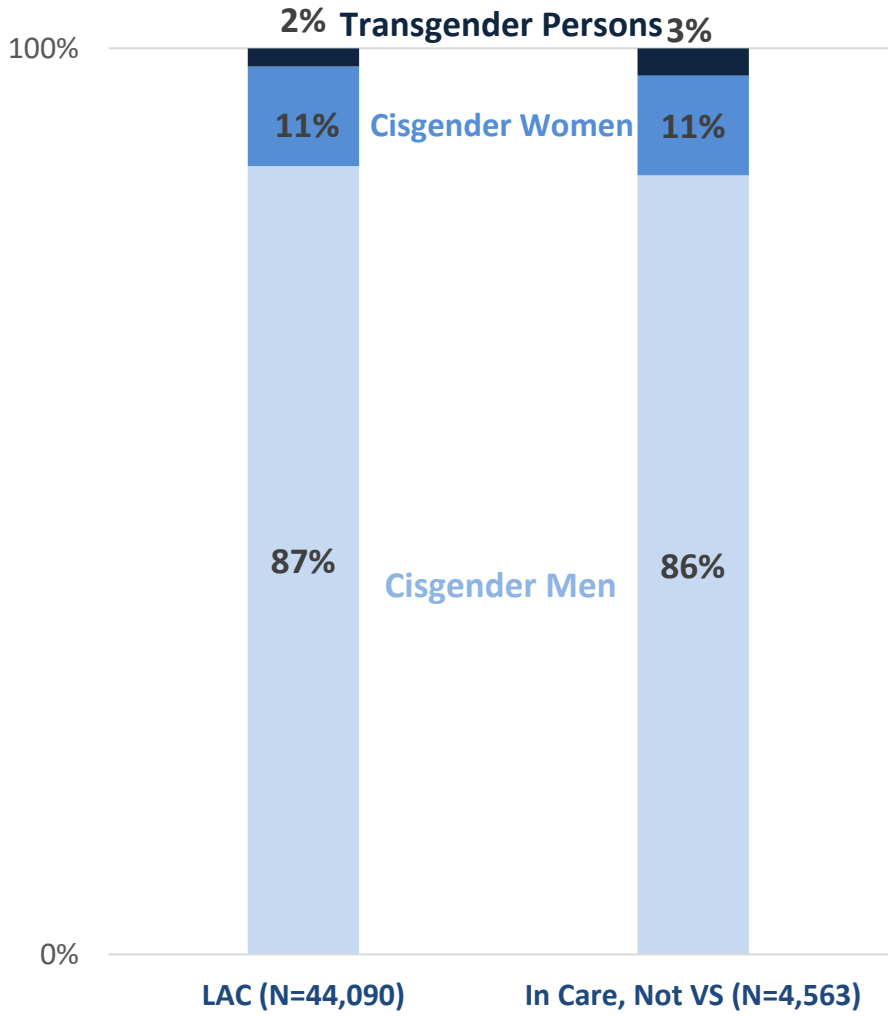
Unmet ART Adherence Need among LAC PLWDH and RWP Clients, 2020



- Unmet need for ART adherence support was comparable between LAC and RWP
- In LAC and in the RWP, unmet adherence need was highest among residents of Hollywood-Wilshire health district

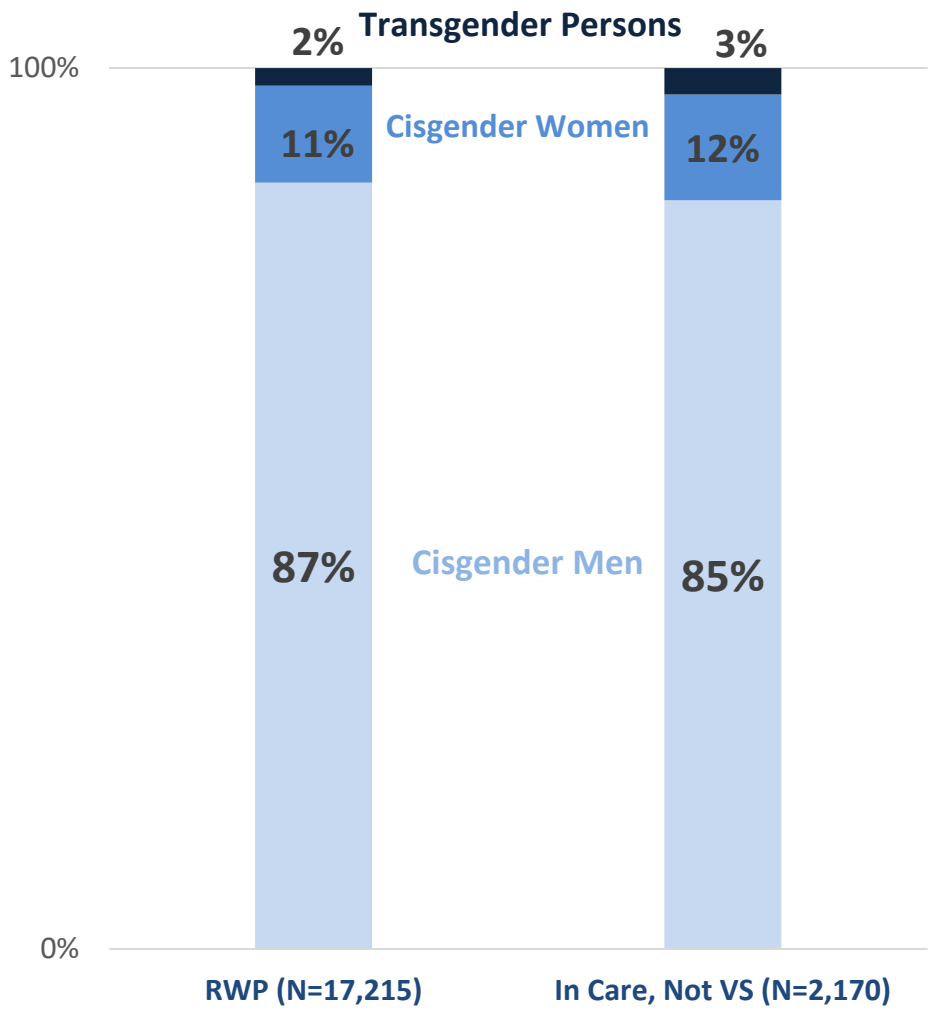
Unmet Need for ART Adherence Support by Gender Identity, 2020

LAC PLWDH



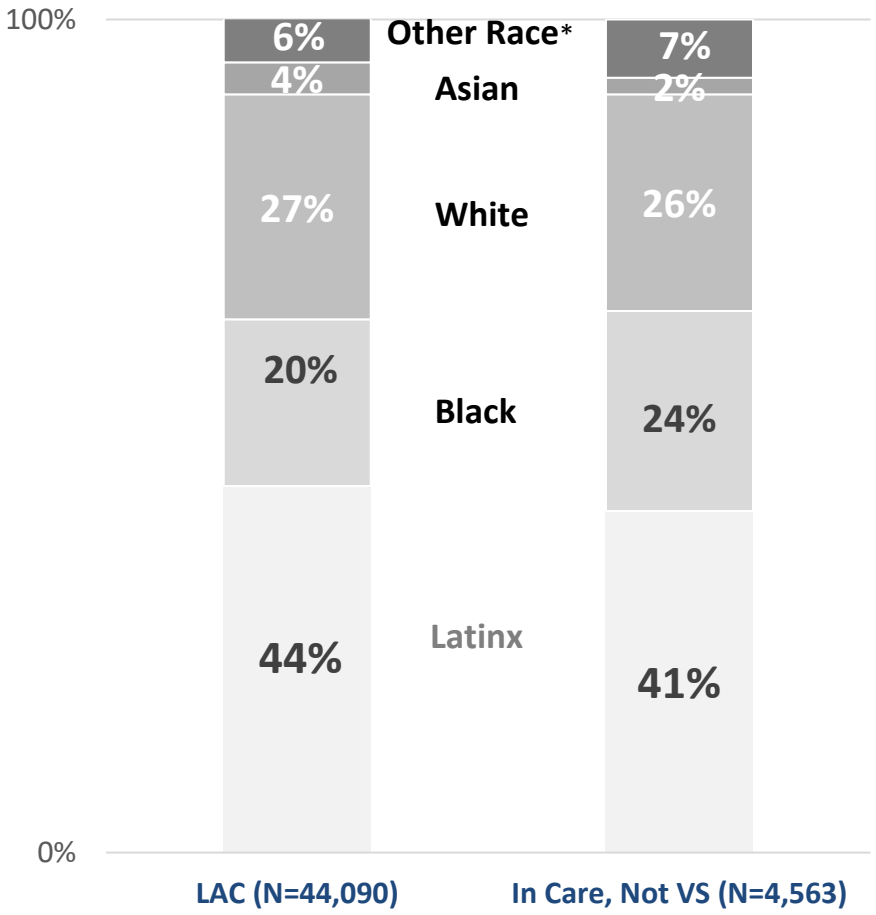
- The largest percent of PLWDH and RWP clients were cisgender men
- Cisgender men represented the majority of individuals in care without VS

RWP CLIENTS



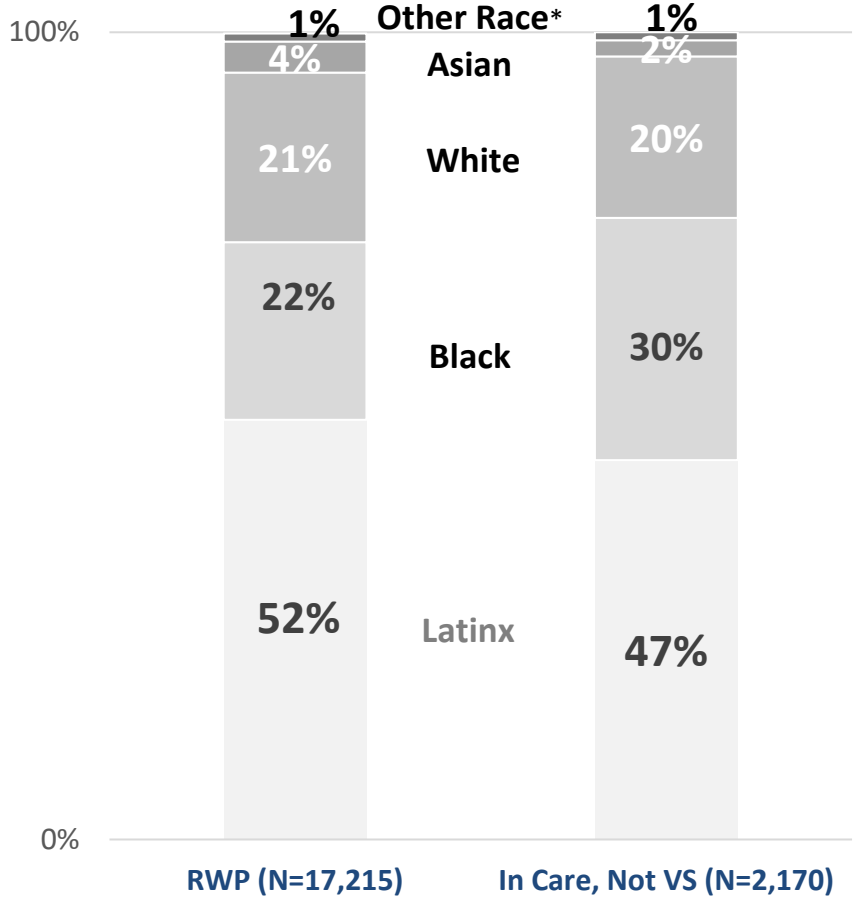
Unmet Need for ART Adherence Support by Racial/Ethnic Group, 2020

LAC PLWDH



- A higher percent of RWP clients were Latinx vs. LAC
- Fewer RWP clients were of other racial/ethnic groups compared to LAC
- Unmet need for adherence support was disproportionately higher among LAC and RWP clients who were Black race/ethnicity compared to their population size

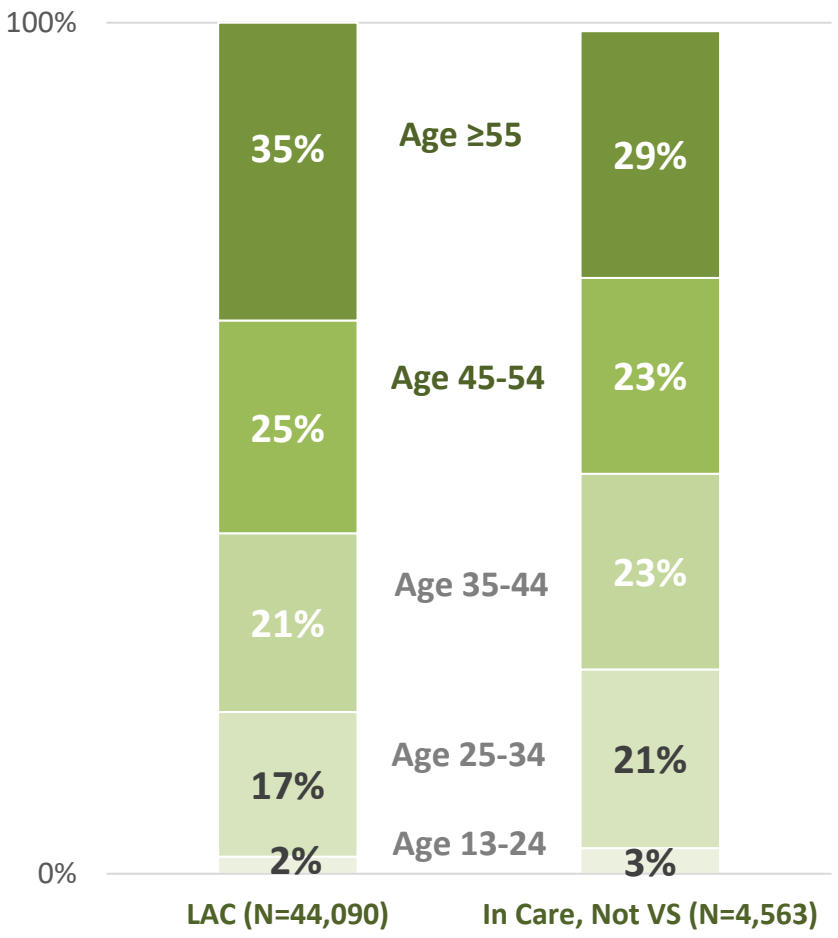
RWP CLIENTS



*Persons of other racial/ethnic groups include: Multiple race, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander, race/ethnicity not reported.

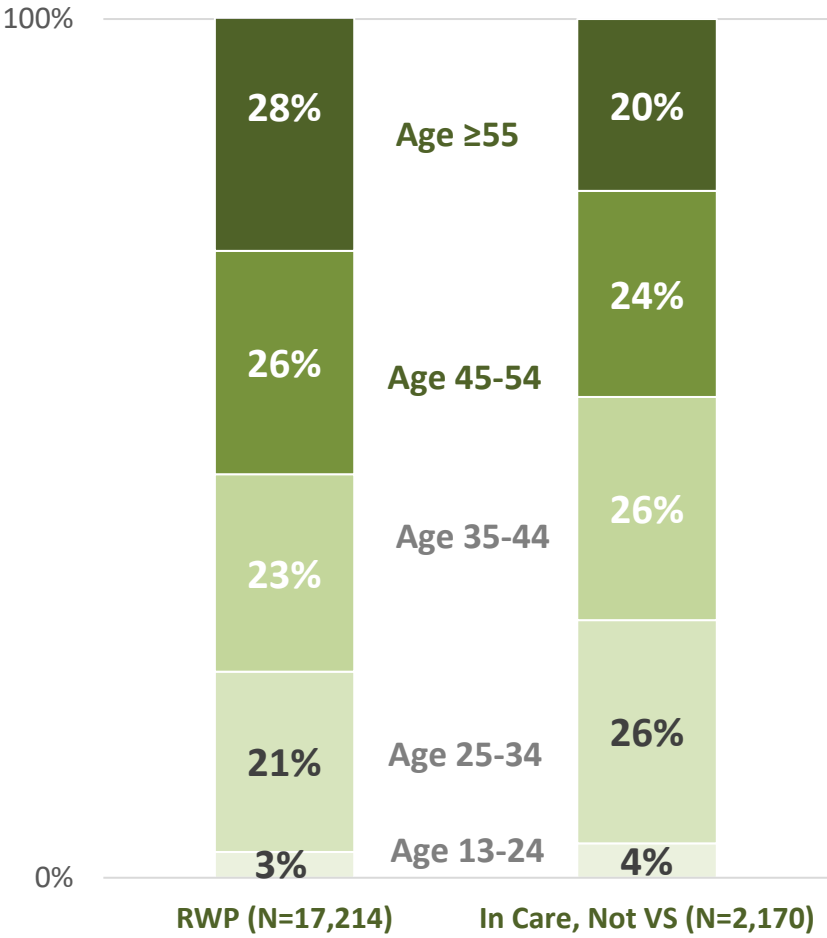
Unmet Need for ART Adherence Support by Age Group, 2020

LAC PLWDH



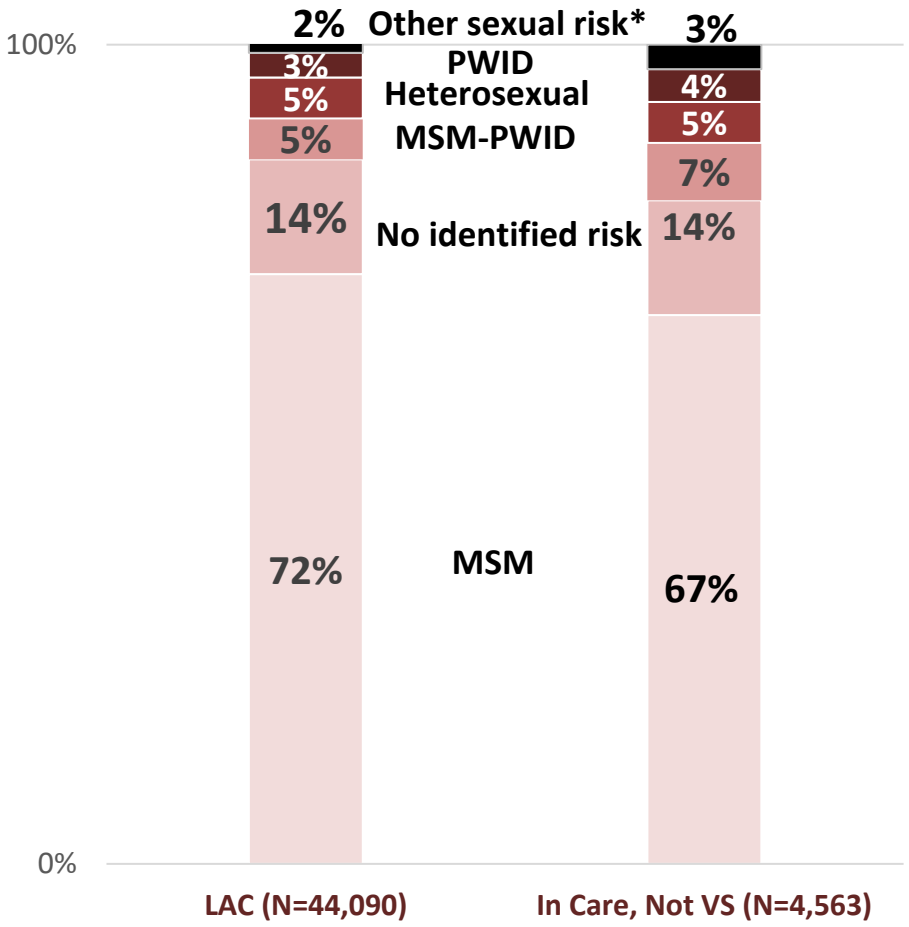
- The majority LAC PLWDH and RWP clients were ≥ age 45
- Among LAC PLWDH, 52% of LAC PLWDH ≥ age 45 had unmet adherence need compared to 44% of RWP clients
- While 40% of PLWDH in LAC were <age 45 they represented 49% of those with unmet adherence need
- Similarly, clients <age 45 represented 47% of RWP clients but 56% of unmet need

RWP CLIENTS



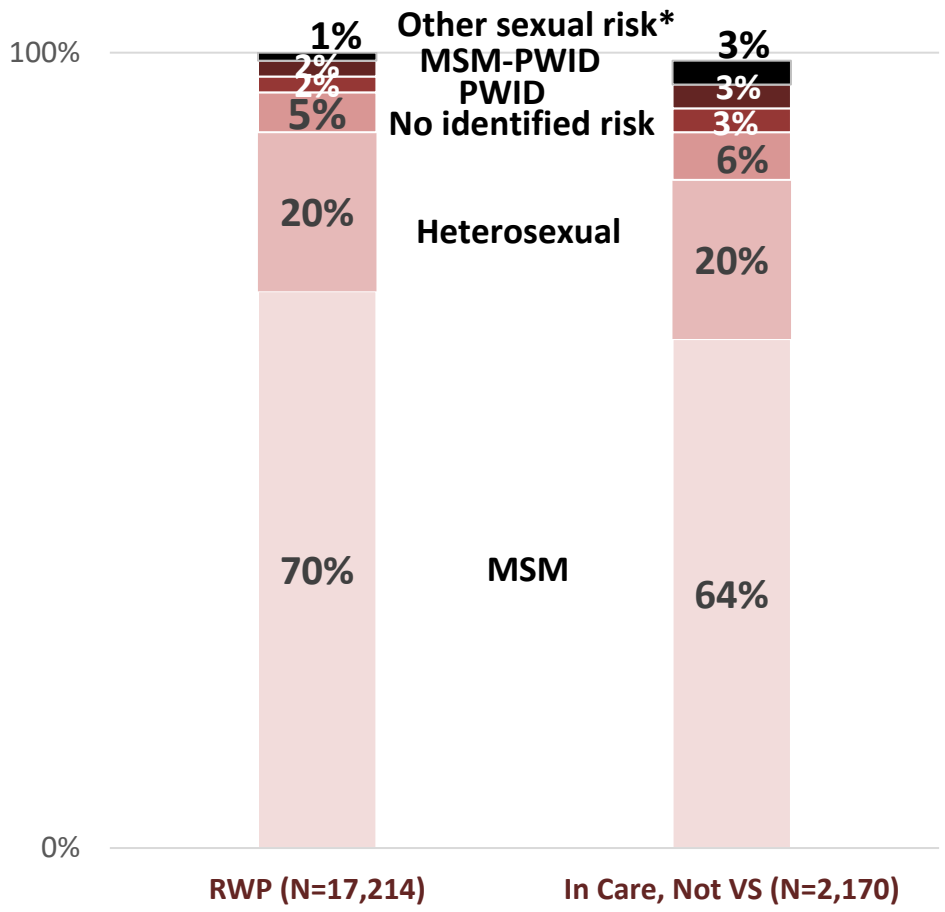
Unmet Need for ART Adherence Support by Risk Category, 2020

LAC PLWDH



- The majority of LAC PLWDH and RWP clients were MSM
- Relative to population size, MSM represented a lower percent of LAC PLWDH and RWP clients with unmet adherence need

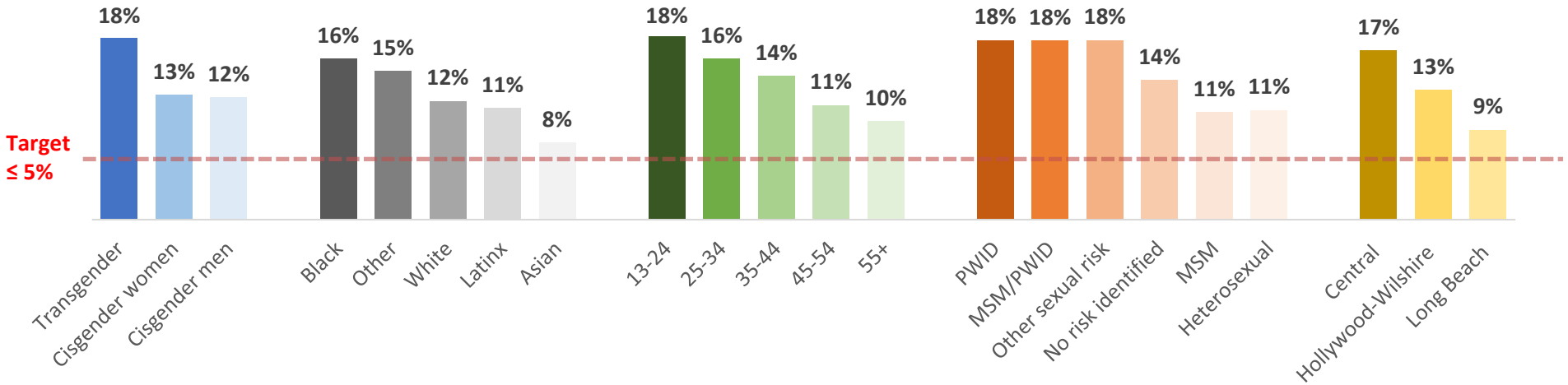
RWP CLIENTS

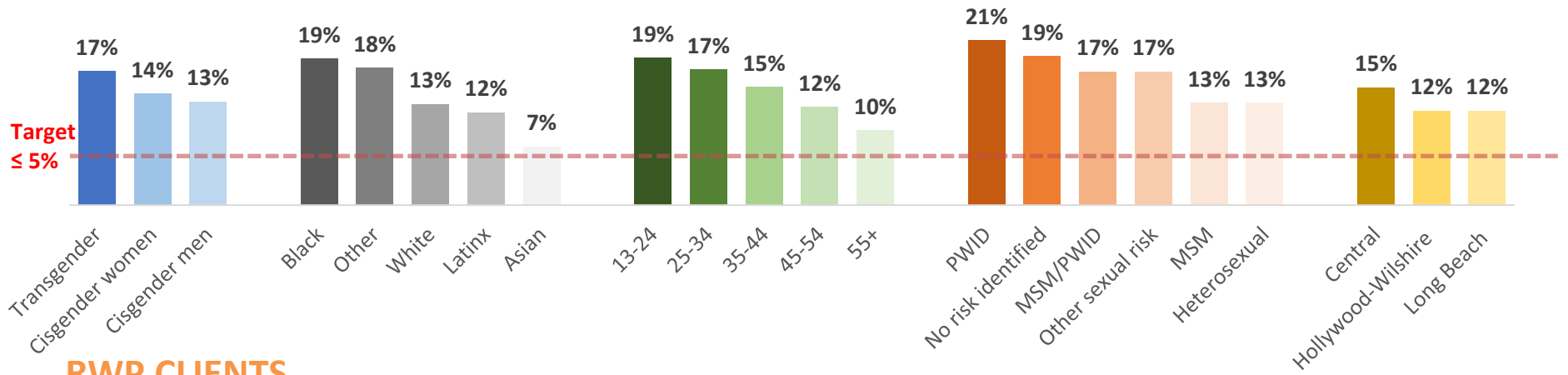


Definitions: MSM: Men who have sex with men; PWID: People who inject drugs

*Other sexual risk include: sexual contact among transgender individuals, sexual contact and PWID among trans individuals.

LAC PLWDH





RWP CLIENTS

Unmet need for adherence support within groups was similar for LAC and RWP

Neither population met the EHE goal of ≤5% unsuppressed viral load

Trans persons, those of Black or other racial/ethnic groups, younger persons, PWID and those residing in Central HD had the highest levels of unmet adherence need

Los Angeles County PLWDH Population-Level Unmet Need Estimates within Categories of Age, Gender, Race/Ethnicity, Transmission/Risk Categories and Health District, 2020.

Key Takeaways

Population-level (LAC)

Largest burden of unmet adherence need (in care, not VS)	• Cisgender men • Latinx PLWDH • ≥ age 55 • MSM • Hollywood-Wilshire HD
Unequal % of PLWDH vs unmet adherence need	• Black PLWDH • < age 45 • Central HD
Highest % of unmet adherence need within population	• Transgender persons • Black PLWDH • Age 13-24 • PWID • Central HD

Program-level (RWP)

Largest burden of unmet adherence need (in care, not VS)	• Cisgender men • Latinx clients • Aged 25-44 • MSM • Hollywood-Wilshire HD
Unequal % of RWP clients vs unmet adherence need	• Black clients • Under 45 years of age • Central HD
Highest % of unmet adherence need within population	• Transgender clients • Black clients • Aged 13-24 • PWID • Central HD

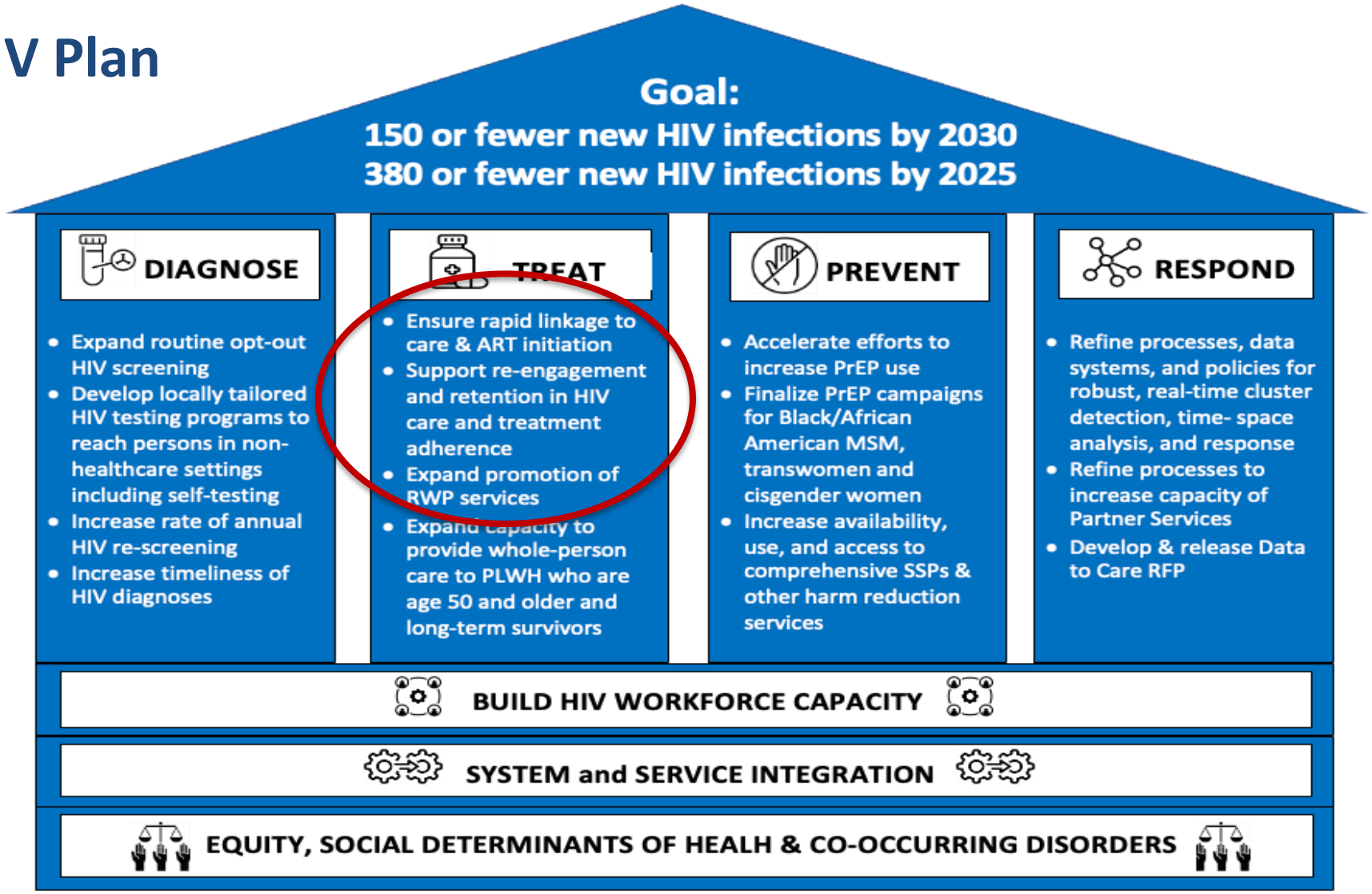
Questions

Discussion – using estimates of unmet need for ART adherence support for planning

LAC Comprehensive HIV Plan Snapshot

Priority Populations

- Latinx MSM
- Black MSM
- Transgender persons
- Cisgender women of color
- PWID
- Persons < age of 30
- PLWH ≥age 50



Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2022- 2026), December 2022: 1-136.

What are strategies to improve ART adherence?

- Identify and address barriers to ART adherence at the patient-level[1]
  - Behavioral health – stigma, mental health issues (depression, anxiety), substance use
  - Client-centered supportive services (housing, poverty, benefits, transportation)
  - Adherence tools – pill boxes, apps, reminders
  - Incentives or directly administered therapy
- Provider-level
  - EMR reminders to clients for medications and refills; flag patients with unsuppressed VL for follow-up
  - Medication side effects
- Health-department-level -Directly administered therapy?
- Novel approaches – incentives, long-acting injectable ART
- Focus on those populations that account for a large proportion of PLWDH with unsuppressed viral load in LAC
  - Black sub-populations, women and transgender persons, persons aged 30-49, PWID and those residing in the Central HD

1.Thompson, et al. https://www.acpjournals.org/doi/full/10.7326/0003-4819-156-11-201206050-00419
2.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.

How can our services improve viral suppression and reduce unmet need?

- Expanding access to RWP wraparound services
- Facilitate ART access and adherence
  - Rapid ART and same-day appointments
  - Peer-support?
  - Update Medical Care Coordination adherence intervention
  - Provider detailing?
  - U=U social marketing?
- Expand access for HIV medications
  - Uninterrupted coverage
  - Mobile or street-based clinics that dispense ART
  - Pharmacy collaboration
- Linguistically and culturally appropriate services

Next Steps for Unmet Need Estimates

- Further analyses are needed to
  - Identify predictors of unmet need among LAC residents
  - Include housing status

- Summary report completed mid-2023

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Janet Cuanas, MPP

Virginia Hu, MPH

Michael Green, PhD, MHSA

References and Resources

- Webinar video and slides: Enhanced Unmet Need Estimates and Analyses: Using Data for Local Planning https://targethiv.org/library/enhanced-unmet-need-estimates-and-analyses-using-data-local-planning

- Webinar video and slides: https://targethiv.org/library/updated-framework-estimating-unmet-need-hiv-primary-medical-care

- Methodology for Estimating Unmet Need: Instruction Manual https://targethiv.org/library/methodology-estimating-unmet-need-instruction-manual

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PP&A Stakeholder Engagement and PSRA Timeline – DRAFT

Month	Key Activities
June - July	• Develop CAB Questionnaire and Discussion Prompts • Identify 6-8 HIV and non-HIV related CABs to engage • Engage with various County Commissions to identify opportunities for partnership to extend sphere of influence • Review recommendations from the Prevention Planning Workgroup*
July - Oct	• Disseminate CAB Questionnaire and participate in CAB discussions • Analyze CAB questionnaire and findings from discussions • Identify specific areas of focus for collaboration with various County Commission and develop a shared messaging/goals • Review and determine paradigms and operating values for PSRA • Begin in-depth data review of first key area (Housing, STIs, Mental Health, Substance Use Disorder)
Nov – Dec	• Identify locations for regional townhalls (SPA, health district) • Determine audience for townhalls (if beyond priority populations, such as SSP providers or behavioral/mental health). • Secure locations for regional townhalls and begin promotion • In-depth data review of second key area (Housing, STIs, Mental Health, Substance Use Disorder)
Jan – April	• Host regional townhalls • In-depth data review of third key area (Housing, STIs, Mental Health, Substance Use Disorder) • Identify any additional data needs to inform the PSRA process
May – July	• Analyze data from regional townhalls • In-depth data review of fourth key area (Housing, STIs, Mental Health, Substance Use Disorder) • Rank RW service categories
Aug - Oct	• Review any additional data that would inform the PSRA process • Re-evaluate priority rankings and compare with data from engagement activities. Re-prioritize as needed. • Determine allocations by service category • Submit priorities and allocations to DHSP
Nov ‘24 – Feb ‘24	• Develop Directives

***ongoing**

Town Hall Meetings: A RWHAP Needs Assessment Tool

Town hall meetings provide a valuable forum for information as part of Ryan White HIV/AIDS Program (RWHAP) Part A needs assessment activities that aim to better understand the service needs of people with HIV within an EMA or TGA. This overview describes town hall meetings, their goals, advantages, limitations, composition and logistics, and key elements to pay attention to in planning and conducting them – including tips for conducting remote or virtual town hall meetings.

What is a Town Hall Meeting?

In the context of a Ryan White HIV/AIDS Program (RWHAP), a town hall meeting – sometimes called a "community forum" – is a gathering designed to obtain community input on topics related to HIV services. These are public meetings, but they typically hope to engage people with HIV and other key stakeholders in the care and service system for people with HIV. Usually the main focus is to obtain diverse input about service needs, barriers, and gaps; satisfaction with current services; and trends and concerns. Ideally, these are more than input sessions where the topics are determined solely by each person who makes a presentation. If appropriately planned, they can provide opportunities for the Planning Council to request input on specific issues and organize discussion among community members and with the sponsoring organization. Often the facilitators are Planning Council or committee leaders from the PC/PB committee responsible for the meeting.

Typically, town hall meetings have more participants than focus groups. Town halls generally aim for at least 15 participants and up to 40 or more, and are normally held in a community facility. However, in the event of a public health emergency, such as COVID-19, they can also be held online, ideally using an easily accessed electronic platform so people can connect via smartphone, tablet, or computer. If your Planning Council has learned to successfully run meetings remotely, including Consumer Committee meetings, many of the same sound practices and strategies apply, as well as the connectivity challenges that may limit or prevent participation by some consumers.[1]

Use of Town Hall Meetings in RWHAP Needs Assessment

Planning councils/planning bodies (PC/PB) can use town hall meetings to:

- Obtain information about current service needs and barriers for people with HIV (PWH), in any year when the PC/PB is not conducting a PWH survey or other in-depth PWH-focused needs assessment effort
- Ask people with HIV to indicate their most important service needs, as input to the PC/PB's priority-setting process
- Learn about geographic similarities and differences in needs, barriers, and priorities by holding several town halls in different parts of the jurisdiction and then comparing/contrasting the results
- Learn about subpopulation differences by bringing together diverse people with HIV or holding several town halls focusing on particular groups
- Supplement needs assessment findings by obtaining updated information just before the priority setting and resource allocation (PSRA) process begins
- Gather information to strengthen the Part A application, particularly to understand recent trends or emerging issues
- Better understand the impact of COVID-19 on people with HIV, especially Ryan White HIV/AIDS Program clients (for this purpose the town hall meeting would be implemented remotely).[2]

Town hall meetings can also be used to hear from service providers instead of, or in addition to, people with HIV.

BENEFITS/ADVANTAGES OF TOWN HALL MEETINGS:

- Can be arranged relatively quickly
- Can be adjusted to work for groups of varying size
- Are relatively low-cost: Often a provider facility can be used for the meeting at no cost. The main costs are a simple meal or refreshments and sometimes transportation
- Can be adapted for remote implementation using an electronic platform

Relation to Legislative Requirements

Town hall meetings address the legislative requirement for planning councils to obtain "input on community needs and priorities" *[Section 2602(b)(4)(C)(iii) and (G)]*.

For a RWHAP Part A TGA with no planning council, town hall meetings help to meet the legislative requirement "to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds" *[Section 2609(d)(1)(A)]*.

Keys to a Successful Town Hall

1. **Effective recruitment**, to ensure good turnout and diverse participation. The goal is to bring together a diverse group of 15 or more people – in most cases people with HIV – to provide their views on services and needs. The focus should be on engaging people whose voices would not otherwise be heard, such as individuals who are not PC/PB members or regular participants in consumer committees or caucuses. This begins with choosing a location that is both accessible and comfortable for the population of focus – or an online platform accessible through a smart phone as well as tablet or computer – and then doing systematic outreach. For recruitment, you can partner with community-based HIV and other human service providers, faith-based institutions, and community leaders to inform people with HIV of the importance of participation in such events. Let people know that they do not need to share their names or HIV status to attend. If you include providers or have a separate town hall for providers, encourage participation by frontline staff who work with people with HIV including RWHAP consumers, and by service providers that are not RWHAP-funded.

REMOTE MEETING TIPS:

- Recruit pre-existing groups that have been meeting remotely, and therefore are likely to have connectivity – for example, a support group that is meeting remotely during the COVID-19 epidemic, a people with HIV group, or a service provider's Community Advisory Board (CAB)
- Use an electronic platform that can be accessed even by people with limited connectivity – via telephone, smartphone, tablet, or computer

2. **A plan for gathering needed information.** A successful town hall meeting needs to be well planned, publicized, and facilitated. Rather than providing only an open forum, it uses a carefully developed set of topics or questions to obtain information the Planning Council needs for decision-making. It also gives participants time to raise their own issues of concern. A presentation period gives participants a voice in planning by providing time for them to offer input about services and needs and share their ideas or concerns. Ground rules may require people to sign up before speaking and keep to a time limit such as 3-5 minutes. Often the meeting includes several different components, such as presentations from community members, facilitated discussion about topics important to the Planning Council, and community input on service priorities.

REMOTE MEETING TIPS:

- If you are good with technology and have a powerful platform, consider creating virtual small groups – divide participants into separate "rooms" for discussion of different topics, and have them "report out" to the full group.
- Be prepared to inform participants at the start of the town hall that you will be recording the session, and give anyone uncomfortable with that time to disconnect.

3. **A well-defined agenda and process** for gathering information, managing discussion, keeping everyone engaged, and doing it all in a reasonable time period. The appropriate length depends on many factors; evening and online meetings may need to be shorter than sessions held during the day. A typical length is 1½ to 2 hours (up to 3 hours if you use "topic tables," described below). This is based on the expectation that the meeting is likely to start 15 minutes late, and you will probably include a 15-minute break, so the actual presentation and discussion time is 1 to 1½ hours. Planning a town hall meeting is similar to developing the questions or "script" for a focus group, but implementing it can be more challenging. The group is larger and more diverse and the process is more complicated, so the role of facilitators is more demanding. You may have several PC members – often committee co-chairs – share facilitation. It is important to set and enforce ground rules. Be sure to use plain language and avoid jargon and unfamiliar terminology. Doing a "dry run" with facilitators and staff can be very helpful. Planning Council Support staff can play a key role in logistics and time management as well as taking notes and managing technology.

REMOTE MEETING TIPS:

- Send out the agenda when you recruit; an interesting multi-part agenda with identified focus issues can increase participation. It also gives participants at-a-glance information about when topics that may be important to them will be covered.
- Use a brief PowerPoint or share the agenda on-screen during the town hall, to help keep the meeting on track and participants engaged.
- Post and discuss ground rules that address how to be called upon or recognized to speak, the importance of hearing from everyone, how to avoid domination of discussion by a few people, and use of the chat room.

Steps in Planning and Conducting a Town Hall Meeting

Here is a step-by-step process for planning and implementing a town hall meeting or series of meetings. These steps were developed primarily for a face-to-face meeting, but can be refined to implement a virtual meeting, without a physical location.

1. **Decide how you want to structure and focus your meeting(s). For example:**
   - **Number of meetings:** Do you need separate sessions in each of several geographic locations/jurisdictions, or meetings focusing on different key target populations? Should there be a session conducted in a language other than English?
   - **Activities:** What activities do you want to include? For example:
     - Individual presentations by consumers and/or providers or other interested residents
     - A group discussion of key issues (with main topics usually pre-determined)
     - Topic tables or small groups to allow for discussion of multiple topics, with someone from each group presenting a summary of the discussion after returning to the full group
     - Community assessment of needs, where participants identify their top 3-5 service needs
   - **Content focus:** What kinds of information does your Planning Council most need to inform decision-making? You will probably want to choose a small number of key issues or topics to address (e.g., key barriers to care, service gaps for particular populations, promising service strategies) – topics on which the Planning Council needs additional or more current information. You should also allow some time for participants to raise and discuss other concerns or issues.
   - **Food and transportation:** For in-person town halls, consider what refreshments are appropriate. You will probably need to provide some refreshments or a boxed lunch for participants, depending on the timing of the town hall. To get people to attend, you may need to provide bus passes or other transportation assistance.
   - **Recruitment:** Once you have identified key focus populations and meeting location(s), decide how best to recruit participants. Planning Council and consumer committee members might play a key role, using their personal and organizational contacts. The recipient can often help by asking subrecipients to recruit some of their clients.

2. **Agree on meeting components and procedures, lay out your plans, and develop a time-phased agenda.** Include a brief description of each town hall component on your recruitment flyer, email, or social media post, and post it on your website. Plan each component; for example:
   - **Presentations:** Identify a set of issues important to the Planning Council, agreeing on them early so they are included in invitations and all outreach/recruitment efforts. Encourage (but do not require) presentations on those topics. Let presenters know they have 3-5 minutes to speak.
   - **Open Discussion:** Set aside about 30-45 minutes after the presentations for open discussion and reaction to the presentations. If meeting remotely, use technology that allows people to raise their hands, and keep a running list. If time is short, allow or encourage discussion in the chat room, with someone monitoring it and sharing key points. Focus discussion on your key issues or questions, but let facilitators use their judgment in adding topics that arise during the presentations.
   - **Small Groups (Topic Tables):** Topic tables can be used instead of full-group discussion if the group is large and/or you have many topics to cover. Identify those topics – for example, if the meeting focus is barriers to care and how to overcome them, small groups might focus on barriers for specific subpopulations of people with HIV. In a town hall meeting held remotely, put participants in different "rooms" for discussion. Always have someone facilitate each small group and someone else take notes, and ask each group to provide a 2-3 minute report back to the full group.
   - **Service Needs:** Consider asking participants to identify their top service needs. Explain that the Planning Council prioritizes services for funding each year, and provide or show a prioritized list of Part A-fundable service categories from the prior year. Have available a handout briefly describing each service category.[3] Ask participants to identify and explain their top service needs.

3. **Set the date and time and choose your location.** Identify bus lines and other public transportation access points, and include that in your outreach communications. Indicate whether parking is available, the availability of bus passes or reimbursement for transportation. If the meeting is remote, choose an appropriate platform and provide specific instructions for connecting.

4. **Recruit participants.** Be sure the invitation lists each component of the town hall meeting. Ask people to RSVP, but be prepared for people to arrive without letting you know ahead of time. Encourage RSVPs by announcing those who RSVP ahead of time will speak first, so they are assured a spot on the agenda; those who sign up at the door are not. Ask presenters for a name (or nickname), contact information, affiliation and role (i.e., staff, volunteer, Board, person with HIV, or RWHAP client) and the topic they want to focus on.

5. **Use the RSVP and topic information to make a preliminary list of presenters.** Either assign time slots in order of the RSVP or prepare a logical order of presentations – for example, put all the speakers focusing on barriers facing a particular subpopulation together.

6. **Welcome participants.**
   - **Ask participants to register as they arrive,** providing contact information if they want to receive a summary of the meeting. You may want to allow people to attend without giving their full name or contact information. If the meeting is remote, ask everyone to give at least a first name in the Chat Room.
   - **Have a sign-up sheet at the door or direct online participants to the chat room to add last-minute presenters** – ask for name, affiliation, and topic. Let people speak in the order in which they sign up. If only a few people sign up at the last minute, fit them into the schedule based on the topics they want to address.
   - **Be sure the Planning Council is well represented.** Often the Chair or a Co-Chair welcomes participants, and Consumer and/or Needs Assessment Committee Chairs share facilitation responsibilities.

7. **Run the meeting.**
   - **Set the stage.** Welcome participants, describe the way the meeting will inform decision- making by the Planning Council, present ground rules, and review the agenda. Remind presenters of the amount of time they have, and explain that you will be using a timer and will let them know when their time is ending. Thank people for their time.
   - **Receive presentations.** Explain the process and indicate your plans for handling questions from non-presenters – whether they can be asked after the presentation or must wait for general discussion. Enforce presentation time limits as planned – be firm but polite. Give not more than 30 seconds additional time beyond the time limit, being sure to treat everyone equally. Thank each presenter and invite them to leave any desired written materials with a specified person. Allow other participants to speak or ask questions if there is time.

- **Provide time for open discussion if possible.** You may want a different facilitator for this section of the meeting. The facilitator should be prepared to raise questions if the audience is initially quiet. Be sure to direct questions to presenters and encourage them to respond and to ask their own questions of other participants and the PC/PB committee managing the meeting.
- **If you are planning small group discussions, explain how they work and summarize guidelines.** "Count off" the group or let participants pick a table based on their interests, announce starting and ending times, and monitor the process.
- **If asking participants about their most important service needs is part of the schedule, leave at least 20 minutes for this discussion.**
- **When the meeting time is up, thank the group and promise to share a summary and the service priorities.**

8. **After the meeting ends, hold a quick debrief.** Include facilitators, the responsible committee, and planning council support staff, and be sure to clarify follow-up assignments and time deadlines for aggregating priorities and summarizing presentations and discussion. If you are planning additional town halls, be sure to refine processes for improving upcoming meetings, based on your experience with the first one.

9. **Have the appropriate committee review the findings from the town hall, and determine how best to share them with the full Planning Council.** You may want to report first to the Consumer Committee and Executive Committee, then at a Planning Council meeting, and/or make this information a part of your PSRA data presentation. Be sure you share findings with participants and the community as promised.

References

1 See JSI Planning CHATT's "Remote Meetings: Tips for PC/PBs," on the Planning CHATT website.

2 For more ideas on Rapid Needs Assessment, see EGMC's new "Quick Guide to Rapid Needs Assessment at a Time of Social Distancing: Ideas for Planning Councils," on the EGMC website, www.egmc-dc.com.

3 Quick Reference Handout #3 in Module 2 of the PC/PB Training Guide briefly describes all service categories; it is available online on the Planning CHATT webpage, at https://targethiv.org/sites/default/files/supporting-files/PlanningCHATT-Module2-QRH2.3.pdf.

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