LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE MEETING

Tuesday, February 20, 2024
1:00pm - 3:00pm (PST)

Vermont Corridor
510 S. Vermont Ave. Terrace Conference Room TK02
****Valet Parking: 523 Shatto Place, LA 90020****

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting to access the Terrace Conference Room (9th Floor) where our meetings are held.

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http://tinyurl.com/2p94xtdr

To Join by Telephone: +1-213-306-3056 United States Toll (Los Angeles)
Password: PLANNING **Access Code:** 2531 902 3051

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together.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, FEBRUARY 20, 2024 | 1:00 PM – 3:00 PM

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

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
http://tinyurl.com/2p94xtdr
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2531 902 3051

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Felipe Gonzalez Co-Chair	Al Ballesteros, MBA	Lilieth Conolly
Michael Green, PhD	Ish Herrera	William King, MD, JD	Miguel Martinez, MPH, MSW
Derek Murray, MPH, MPA	Dechélle Richardson (Alternate)	Daryl Russ	Harold Glenn San Agustin, MD
LaShonda Spencer, MD	Lambert Talley (Alternate)	Jonathan Weedman	
QUORUM: 8			

AGENDA POSTED: February 14, 2024.

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

ATTENTION: Any person who seeks support or endorsement from the Commission on any official

action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

7. Executive Director/Staff Report 1:15 PM – 1:20 PM
    a. 2023 Annual Report
    b. PP&A Committee Role and Priority Setting & Resource Allocation (PSRA) Overview

8. Co-Chair Report 1:20 PM – 1:35 PM
    a. New Member Introduction
    b. Commissioner Duty Statement
    c. Integrating Caucus' Recommendations into PP&A Work & Follow-Up and Accountability Measures

9. Division of HIV and STD Programs (DHSP) Report 1:35 PM – 1:50 PM
    a. Program Year (PY) 33 Expenditure Report
    b. 2024 Solicitation Priorities

V. DISCUSSION ITEMS 1:50 PM—2:50 PM

10. Review Draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework

VI. NEXT STEPS 2:50 PM – 2:55 PM

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting
    a. Prevention Focused Planning

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the meeting of February 20, 2024.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.

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
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/7/24

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
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
CAMPBELL *	**Danielle**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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**	Invisible Men	No Ryan White or prevention contracts
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated consumer	No Ryan White or prevention contracts
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	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
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
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROBINSON	**Mallery**	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
RUSSEL	**Daryl**	Unaffiliated consumer	No Ryan White or prevention contracts

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
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
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
September 19, 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	Derek Murray	P
Al Ballesteros, MBA, Co-Chair	P	Jesus "Chuy" Orozco	P
Lilieth Conolly	P	Dechelle Richardson	P
Felipe Gonzalez	P	Reverend Redeem Robinson	LOA
Michael Green, PhD, MHSA	EA	Harold Glenn San Agustin, MD	P
Ismael "Ish" Herrera	EA	LaShonda Spencer, MD	P
William King, MD, JD	P	Lambert Talley	P
Miguel Martinez, MPH, MSW	P	Jonathan Weedman	P
Anthony M. Mills, MD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon			
DHSP STAFF			
Sona Oksuzyan, MD, MPH			

*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 1:05pm.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, Dr. Mills, K. Donnelly, J. Weedman, M. Martinez, Dr. King, L. Conolly, F. Gonzalez, D. Murray, C. Orozco, D. Richardson, Dr. San Agustin, Dr. Spencer, L. Talley

3. **Approval of Agenda**
   MOTION #1: Approve the Agenda Order **(✓Passed by consensus.)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(✓Passed by consensus.)**

II. PUBLIC COMMENT

5. **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

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

   J. Weedman shared that the 5th Supervisorial District will be hosting a World AIDS Day breakfast event and invited the committee members to attend. More information to follow as the event approaches.

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **Bylaws Review Taskforce Updates**
      - C. Barrit, Commission on HIV (COH) Executive Director, reported that the Bylaws Review Taskforce (BRT) continues to make progress on review and update of the bylaws document. The BRT will meet Sept. 21st and plan to review the remaining portion of the document. Commission staff continue to work with County Counsel (CoCo) to ensure any suggested changes are within County guidelines and federal requirements.

   b. **Los Angeles Homeless Services Authority (LAHSA) Data Request Update**
      - C. Barrit noted that the first data request that was received in August was incomplete and Commission staff requested additional filters be added to the data. The updated data was received two weeks ago, and Commission staff are working on preliminary analysis. Initial analyses will be shared with the committee at a future Planning, Priorities, and Allocations (PP&A) Committee meeting.

   c. **RWP FY 2024 Non-Competing Progress Report Deadline**
      - C. Barrit reminded the committee that approximately two and a half years ago the Ryan White Program (RWP) changed from an annual application to a three-year funding cycle and noted this cycle aligns with the committees planning process. She noted the next Non-Competing Progress Report for the upcoming 2024 fiscal year is due on October 2nd to the

Health Resources and Services Administration (HRSA) and explained that the portion of the report that the Planning Council (PC) was responsible for was the Letter of Assurance that outlines responses to five questions from HRSA as related to planning processes, priority setting and resource allocation, training for members and the assessment of the administrative mechanism. The Letter of Assurance has been signed by Commission co-chairs and was submitted to the Division of HIV and STD Programs (DHSP). See meeting packet for more details.

8. Co-Chair Report

a. New Member Welcome

- K. Donnelly welcomed new PP&A committee members, Dr. Harold Glen San Agustin, and Lambert Talley. He noted new member Ismael "Ish" Herrera was absent due to illness.

b. Sexual Health and Older Adults September 22 Event

- K. Donnelly reminded Commissioners of the upcoming Sexual Health and Wellness for Older Adults event organized by the Aging Caucus. The event is geared toward providers to better serve their older patients, but all are welcome to attend. The event will be held on Friday, September 22 from 10am to 2pm at the Vermont Corridor. Approximately 90 have RSVPed for the event. See meeting packet for event flyer.

9. Division of HIV and STD Programs (DHSP) Report

a. Fiscal Year 2022 Expenditures and Utilization Report

- DHSP staff, Sona Oksuzyan, provided a report on Mental Health and Substance Abuse Residential Services utilization for fiscal year 2022. See meeting packet for more details.
- It was noted that there has been a decline in Mental Health services within the RWP in program year 32 despite recent data showing the need for more mental health services for people living with HIV. It was noted that more data was needed to better understand the trend downward, but some possible explanations include lack of providers, Medi-Cal expansion, coverage by RWP Parts C & D over RWP Part A, and the Department of Health Services and/or other programs covering costs.
- Wendy Garland, DHSP staff, reminded the committee that the numbers only reflect RWP clients and that most services are covered by Medi-Cal, noting that the numbers indicate utilizing the RWP as the payor of last resort. She noted that currently, the RWP covers the same mental health services that are also covered by Medi-Cal and if the committee wants to see different populations served, then the Commission on HIV (COH) will need to identify and cover mental health services that are not covered by Medi-Cal. For example, W. Garland noted psychotherapy is not covered by Medi-Cal. W. Garland also noted that DHSP is currently working to identify other ways that mental health services can be provided acknowledging the need for services and noted that there was also a shortage of providers.
- A. Ballesteros commented that a key challenge faced providers with Ryan White funded mental health services is the fee for service model. A fee for service model hampers the

ability of providers to hire a full-time mental health professional. DHSP needs to allow for a line-item budget for mental health services and staff similar to Part C grants. He explained most agencies cannot afford to hire a mental health provider under the fee for service structure noting that billing is not enough to cover salary and benefits and would result in the agency running in a deficit. He suggested that this may be another reason why mental health services utilization is low under RWP Part A and asked that DHSP consider switching to a line-item budget. He noted mental health providers were previously structured as line-items and it would help increase capacity and access.

- Dr. San Agustin recommended getting feedback from clients as to why people are no longer seeking mental health services to help identify both positive factors that keep patients engaged in care and negative factors that contribute to stopping care.
- F. Gonzalez noted that more needs to be done to support the mental health needs of women of color.
- C. Orozco commented that the ability to fund permanent supportive housing for HOPWA clients is due to the increased need for mental health services.
- D. Murray recommended identifying what is covered under Medi-Cal and what is not to increase services within the RWP. C. Barrit noted that the committee can identify new services to support that are not supported by Medi-Cal and coordinate with the Standards and Best Practices Committee to then develop service standards for service delivery.
- L. Talley commented that, based on his experience, a lot of clients are unaware of the mental health services that are available to them and that more needs to be done to increase awareness.
- L. Conolly noted that more providers need to be trained in offering compassionate care, particularly for women who are often needing mental health support beyond HIV, such as dealing with raising children as a single provider.
- M. Martinez noted many communities of color utilize a paraprofessional model to provide needed support and escalate to licensed professionals based on acuity and asked if the service standards allow for this type of model. It was noted that RWP regulations specifically state licensed mental health professionals.
- Carlos Vega-Matos reported that though telehealth is offered many young individuals cannot access this service due to incompatibility with software and lack of privacy within their living situations to engage in services. He recommended access to technology be tracked in the future.
- A. Ballesteros recommended the committee request that DHSP pilot the transition of mental health services as a line-item budget vs a fee for service model, explore ancillary services, such as the use of paraprofessionals, that can help support/round out mental health services, and identifying factors that contribute to drop off in mental healthcare.
- M. Martinez recommended requesting a presentation from the Department of Mental Health (DMH) on mental health services for people living with HIV and other priority populations.
- D. Murray requested information on what services are being provided in residential

substance use facilities as well as what specific substances clients being treated for. A. Ballesteros added that, based on the report, the average daily rate for services is approximately $70/day and requested a report back from DHSP on what services are provided. He noted this rate is much lower than the average daily rate for services under the Substance Abuse Prevention and Control (SAPC) program. W. Garland indicated that she will check the SAPC rate and specific services provided under residential substance use.

- Dr. Spencer suggested comparing mental health services utilization data with under Part C and D providers.

b. Programmatic and Fiscal Updates

- No report was provided.

V. DISCUSSION

10. Prevention Planning Workgroup (PPW) August 23 Meeting Recap & Status Neutral Recommendations

- Dr. King and M. Martinez, Prevention Planning Workgroup (PPW) co-chairs, reported that the PPW continue to make progress on Prevention Standards recommendations and provided a presentation on proposed status neutral recommendations and integration of prevention within the PP&A Committee. See meeting packet for details.
- Recommendations included adding medical home within Quality Care and community engagement and outreach into the graphic. It was noted that many patients seek HIV and STI services outside of their primary care providers but that securing a medical home is important for clients that do not have one.
- D. Murray asked if integrating prevention into the committee and commission would require revisions to the bylaws or any other formal process. C. Barrit noted current bylaws already articulate the charge of the PP&A Committee and the COH as an integrated planning body. However, she recommended developing a written status neutral priority setting and resource allocation process to ensure a strong prevention component to the Committee's deliberations and decision making.
- A recommendation was made to continue the PPW as a committee to ensure prevention discussions and priorities continue. M. Martinez commented that continuing as a committee will continue to have prevention separated from care and would undermine the goal of the status neutral framework.

11. Review Community Listening Sessions Questionnaire Feedback

- L. Martinez, Commission staff, reported that minor changes to the Community Listening Sessions Questionnaires were made based on feedback received. She noted the review was another opportunity for committee members to provide any additional feedback before the questionnaires are finalized.
- A recommendation was made to add an option to decline to respond to sexual orientation and gender identity questions in addition to adding a column in the client/consumer questionnaire

table regarding being unaware but needing services. See meeting packet for more details.

12. Recap Department of Health Services (DHS) HIV Cascade Data Presentation

- K. Donnelly postponed the discussion to the next PP&A Committee meeting due to time constraints.

13. Recap Cities/Health Districts Harm Reduction Report

- K. Donnelly postponed the discussion to the next PP&A Committee meeting due to time constraints.

VI. NEXT STEPS

- **Task/Assignments Recap**
  - **a.** Review FY 33 RWP Expenditures
  - **b.** Review and Analyze LAHSA Data
  - **c.** Recap HIV & STDs Surveillance and Data Challenges for LA County Native American Communities

- **Agenda Development for the Next Meeting**
  - **a.** Continue RWP Utilization Reports
  - **b.** Review FY33 RWP Expenditures
  - **c.** LAHSA Data Review

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

- **Adjournment for the Meeting of September 19, 2023.**
  The meeting was adjourned by K. Donnelly at 3:58pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
October 17, 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	Derek Murray	EA
Al Ballesteros, MBA, Co-Chair	P	Jesus "Chuy" Orozco	EA
Lilieth Conolly	P	Dechelle Richardson	EA
Felipe Gonzalez	P	Reverend Redeem Robinson	LOA
Michael Green, PhD, MHSA	EA	Harold Glenn San Agustin, MD	P
Ismael "Ishh" Herrera	P	LaShonda Spencer, MD	P*
William King, MD, JD	EA	Lambert Talley	P
Miguel Martinez, MPH, MSW	P	Jonathan Weedman	EA
Anthony M. Mills, MD	A		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Lizette Martinez			
DHSP STAFF			
Sona Oksuzyan, MD; 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 1:10pm.

2. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, K. Donnelly, M. Martinez, L. Conolly, F. Gonzalez, Dr. San Agustin, I. Herrera, L. Talley

3. **Approval of Agenda**
   MOTION #1: Approve the Agenda Order **(No vote held; quorum was not reached.)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(No vote held; quorum was not reached.)**

II. PUBLIC COMMENT

5. **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

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

   There was no new business.

IV. REPORTS

7. **Execute Director/Staff Report**

   a. **Commission on HIV Annual Conference**
   - C. Barrit, Commission on HIV (COH) Executive Director, shared a brief reminder of the upcoming COH Annual Conference on Thursday, Nov.9th at the Vermont Corridor. She asked committee members to promote the event and noted the agenda would be posted as the event date nears. See meeting packet for details.

   b. **Bylaws Review Taskforce Updates**
   - C. Barrit reported that the Bylaws Review Taskforce (BRT) needs a new co-chair with the departure of co-chair, Everardo Alvizo. She noted that the BRT is schedule to meet on Oct. 18th and will continue its review and update of the bylaws document. The BRT plans to have a revised document for the Operations Committee to review by the end of the year.

   c. **CDC/HRSA Integrated HIV Plan Feedback Meeting**
   - C. Barrit reminded the committee that the Health Resources and Services Administration (HRSA) had provided written feedback to the Integrated HIV Plan in May and a follow up meeting with the Planning Council (the Commission on HIV) and the Division of HIV and STD Programs (DHSP) on Sept. 18th. The meeting consisted of a review of the written feedback and highlighted two areas of improvement: community engagement and data sharing. C. Barrit noted that the COH has already started taking steps to address the areas of improvement and will continue to find opportunities for engagement and data sharing.

See meeting packet for details.

8. Co-Chair Report

a. Debrief Prevention Planning Workgroup September 27 Meeting

- K. Donnelly reported that the Prevention Planning Workgroup (PPW) last met on September 27th and noted that the group has completed a lot of work and is ready to sunset with the intent of incorporating prevention and suggested recommendations into the Planning, Priorities and Allocations (PP&A) Committee. PPW and PP&A co-chairs are meeting on Oct. 19th to further discuss opportunities for prevention integration within PP&A. The next PPW meeting will be held virtually on Wednesday, October 25th from 4pm-5:30pm.

b. November and December Meeting Schedule

- K. Donnelly noted that the November PP&A lands on the week of Thanksgiving on Tuesday, Nov. 21st. He recommended postponing the November PP&A meeting to Dec. 14th from 2:30-4:30pm at the Vermont Corridor. He noted the Consumer Caucus is holding a retreat on Dec. 14th from 11am-2pm and the rescheduled PP&A meeting would follow the retreat. He also announced that the December PP&A meeting is cancelled.

c. 2024 Co-Chair Nominations

- K. Donnelly announced an open call for PP&A co-chair nominations for the 2024 year. He noted nominations would remain open until January 2024 and reminded the group that self-nomination was allowed. The committee will vote during the January PP&A meeting.
- Felipe Gonzalez was nominated but did not accept nor decline the nomination.

d. 2024 Committee Priorities and Workplan Planning

- K. Donnelly reported that the committee will need to develop their workplan for next year. He noted that the next Ryan White Program (RWP) funding cycle will be in 2024 and that the 2023 workplan included the priority setting and resource allocation (PSRA) process which was postponed to 2024 to sync with the RWP 3-year funding cycle and grant application. He provided a brief overview of the workplan and asked the group if there were any additional recommendations and requested prevention integration be added to the 2024 workplan. See meeting packet for details.
- M. Martinez recommended incorporating prevention in the priority setting and resource allocation process. K. Donnelly commented that priority setting, and resource allocation are two separate processes, but that priority setting does have an opportunity to include status neutral approaches. He noted that resource allocation is limited to RWP funds.
- C. Barrit commented that she will be sharing a summary of suggestions for incorporating status neutral into the PSRA process at an upcoming PP&A meeting.
- M. Martinez requested more information on prevention funding streams and service categories provided from DHSP to help inform the PSRA process. Additionally, he asked if

DHSP would be receptive to prevention related recommendations. He noted this would help inform status neutral strategies and planning.

- A. Ballesteros agreed and suggested requesting a report from DHSP outlining Ending the HIV Epidemic funding and service categories similar to RWP funding and service categories.
- It was noted that DHSP had previously provided the committee with a funding stream table highlighting the programs funding sources and the activities supported by each grant. The table will be reviewed again at an upcoming committee meeting.

9. Division of HIV and STD Programs (DHSP) Report

a. Fiscal Year 2022 Utilization Report - Housing, Emergency Financial Assistance and Nutrition Services

- DHSP staff, Dr. Sona Oksuzyan, provided a report on Housing, Emergency Financial Assistance and Nutrition service utilization for fiscal year 2022. See meeting packet for more details.
- For Housing Services, it was noted that, on average, clients remained housed for the majority of the year.
- More clarification on what each housing service covers was requested noting that the amount of spending on these services seemed very high given the small number of people that utilized the services.
    - Housing for Health (H4H) services are used to find permanent supportive housing for PLWH. H4H includes a bundle of services including permanent supportive housing, rental subsidies, or a bed. This service is covered for two years with an option to extend for an additional year.
    - Residential Care Facilities for Chronically Ill (RCFCI) is for PLWH who are sick and require nurses to care for them within the facility. It pays for an individual's bed and the care/management of their condition.
    - Transitional Residential Care Facilities (TRCF) pays for an individual's bed and the care/management of their condition.
- Carlos Vega-Matos commented that RCFCIs are regulated by the State of California that require specific staffing patterns of nurses, must provide meals, and are explicitly for clients who fall below the Karnofsky Scale of human functioning (inability to carry out basic daily functions of living). He added that TRCFs were created approximately 8-10 years ago to create a space for patients that did not need as intense of services as RCFCIs. TRCFs do not require the same staffing patterns as RCFCIs, patients must meet specific cognitive function, and clients are linked to needed services outside of the TRCF. TRCFs are limited to two years with the possibility of one year extension but are meant to be temporary.
- Dr. San Agustin commented that the 1.6% housing services utilization among RWP clients seems alarmingly low and asked how many RWP clients were eligible for these services. It was noted that the report focused on service utilization and not eligibility.
- It was noted that approximately 6-8% of RWP clients have unmet housing needs and the

current housing services serves about a quarter to a third of these clients.

- A. Ballesteros commented that he recalled the decision to increase allocation to housing services was intended to help the general population of RWP clients with unmet housing needs and not intended to be limited for the three specific categories. M. Martinez recalled that discussions were to increase access for all RWP clients with unmet housing needs but, at that time, only the three types of services (H4H, RCFCIs and TRCFs) were available at the time. He noted that current discussions should include efforts to expand housing services to all RWP clients who are eligible for Medical Care Coordination (MCC) and other services.
- L. Conolly asked for clarification on the amount of funds allocated to the Emergency Financial Assistance (EFA) service category. It was noted that EFA began in 2021 and was originally funded through Ending the HIV Epidemic (EHE) at $1.5 million and transitioned to the RWP in program year 32 with an allocation amount remaining at approximately $1.6 million.
- Dr. San Agustin noted that for all services, RWP clients experienced better health outcomes when accessing needed services vs not accessing services. He asked if there was a reason behind this trend. Dr. Oksuzyan noted that clients who accessed the supportive services were initially accessing medical care and were referred to services which showed regular engagement in care. M. Martinez commented that these services are challenging to navigate, and data reflect better outcomes for those who have learned how to navigate these systems. L. Conolly added that in addition to the challenge of navigating systems, available services are often not shared with consumers and that providers determine who is eligible for a program/service based on their biases/perception.
- M. Martinez requested that a meeting should be dedicated to looking at housing and looking at priority populations as the committee prepares for the priority setting and resource allocation process.
- A. Ballesteros commented that previous discussions on reallocation of RWP savings and how to identify people that were not reflected in the data but in need of services such as young people who were both HIV+ and HIV-. Discussions focused on reviewing MCC funds and identifying ways to find housing services for individuals that were on PrEP or PEP and were homeless as well as transgender populations.
- Additional discussions centered identifying individuals within the RWP care continuum that were healthy in terms of HIV but were at risk of losing their housing and offering some form of ongoing assistance to prevent them from entering into homelessness instead of waiting for them to get sick or become unhoused. A. Ballesteros noted that the group envisioned a program beyond EFA that would provide permanent, ongoing support for the PLWH who struggle to pay for housing and prevent homelessness. He noted the group did not identify ways to overcoming existing barriers, particularly how to pay landlords.
- C. Barrit commented that the discussions mentioned took place before the COVID-19 pandemic and before the EFA program was established. She noted that when the program around H4H was presented and the Memorandum of Understanding (MOU) was being worked out between DHSP and the Department of Health Services (DHS) that Minority

AIDS Initiative (MAI) funding would look at the flexible subsidy pool, Brilliant Corners housing (how many people are going to those housing units), and how many people are going into the intensive case management component of the housing program. She noted it would be useful to get the flexible subsidy data from the H4H program, if available, as she noted this funding is intended to prevent individuals from falling off current housing. DHSP noted that they would look to identify any missing data. C. Barrit also requested information on whether individuals who participate in any form of permanent supportive housing if the RWP pays for housing services in perpetuity or do they transfer the funding support to the H4H program. She noted the vision of utilizing MAI funding was to serve as a resource for individuals to enter into the program and into the housing pipeline.

- L. Talley recommended establishing partnerships with the Los Angeles Housing Services Authority (LAHSA) and Children of the Night to open up opportunities to youth and young adults.
- M. Martinez noted that there are new, innovative models being used to support housing individuals who are experiencing homelessness that are cheaper and that the Commission should be looking at these models. He also noted movements toward guaranteed basic income as another model to reference when the committee works towards the intention of creating housing stability for unhoused PLWH. He added that many are being funded by government entities and suggested inviting these agencies to present at a meeting so the committee.
- A. Ballesteros added that there should be a program to help young individuals who pay for a room in a shared living space for a year or two instead of the more expensive traditional models.

b. Programmatic and Fiscal Updates

- V. Scott provided a review of the Ryan White Program Year 33 Expenditures. The total RWP Part A award is approximately $42.9 million, Part B award is approximately $5.4 million, Minority AIDS Initiative (MAI) award of $1.7 million and an MAI carryover from RWP Year 32 of $685,000. See meeting packet for more details.
- DHSP is in the process of reviewing and analyzing current expenditures to date to identify opportunities to shift and adjust funding based on underspending and potential carryover, if and where needed. Potential spending plans and estimated carryover will be sent to HRSA in December.
- Spending for all awards is on trend with program year 32 expenditures but noted underspending in Mental Health and Childcare services. He noted there are currently no funded agencies for childcare services.
- DHSP is seeing less expenditures in Ambulatory/Outpatient Medical due to the DHS pull out of the RWP funding streams and Medi-Cal expansion.
- C. Barrit asked if there is potential to fund the new Spanish Mental Health program using RWP Part A funds that is currently funded by Ending the HIV Epidemic (EHE) funds. V. Scott noted there was potential to shift funding if needed but that would not be determined until federal funding for EHE is allocated in the next year.

V. DISCUSSION

10. Prevention Integration and Status Neutral Planning

- M. Martinez opened the discussion on prevention integration and status neutral planning by posing the question of how the group can incorporate prevention into the structure of PP&A agendas, discussions and the PSRA process.
- K. Donnelly noted siloed funding for prevention and care continue to be a barrier.
- M. Martinez asked the group if there were any trainings or capacity building needs that would need to be addressed to help inform status neutral programming and prevention integration moving forward.
- A. Ballesteros asked if the group had a solid understanding of how prevention work is operationalized within agencies and how well recommendations are implemented. It was noted that the services standards set by the COH's Standards and Best Practices Committee are included in DHSP Requests for Proposals (RFPs) and are operationalized to loosely guide the implementation of services. It is the responsibility of the funder, DHSP, to monitor implementation.
- A. Ballesteros expressed concern about the ability of providers to link non-HIV+ clients to needed services. F. Gonzalez noted that navigators and coordinators need to learn about services/programs that are available to all populations and not just programs for individuals diagnosed with HIV. A. Ballesteros noted that in the current system, HIV- individuals will not be treated the same way as HIV+ individuals due to the lack of resources for this group.
- M. Martinez recommended framing strategies around priority populations and using diverse funding streams that target priority populations to create innovative approaches that address all the health needs of an individual regardless of HIV status.
- A. Ballesteros recommended increasing funding to agencies specifically for capacity building for providers around both HIV+ and HIV- services. Dr. San Agustin added that many providers continue to lack knowledge around some HIV/STI prevention services and that they also need assistance beyond increasing knowledge but also in implementing strategies/activities.
- There was an additional recommendation to engage priority populations outside of the COH and in spaces where they feel safe and heard. There was a push to engage with agencies currently doing innovative work by commissioners engaging in their spaces rather than inviting them into the COH.

VI. NEXT STEPS

11. Task/Assignments Recap

a. Follow Up on Housing Questions Based on the Utilization Report
b. Review DHSP Funding Table
c. Review and Analyze LAHSA Data

12. Agenda Development for the Next Meeting

a. Review Updated Priority Setting and Resource Allocation Document

b. Fiscal Year 2022 RWP Utilization Report - General and Specialty Oral Health Services
c. LAHSA Data Review

VII. ANNOUNCEMENTS

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

K. Donnelly announced the following events and encouraged commissioners to participate:

- *Taste of Soul – Saturday, Oct. 21st in Inglewood. The Black Caucus will have a booth as well as committee member, Dr. William King.*
- *The Transgender Health Summit – Thursday, Nov. 2nd at The Village at Ed Gould Plaza*
- *Commission on HIV Annual Conference – Thursday, Nov. 9th at the Vermont Corridor*

VIII. ADJOURNMENT

14. Adjournment for the Meeting of October 17, 2023.

The meeting was adjourned by K. Donnelly at 4:00pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
December 14, 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	Derek Murray	A
Al Ballesteros, MBA, Co-Chair	A	Jesus "Chuy" Orozco	A
Lilieth Conolly	EA	Dechelle Richardson	A
Felipe Gonzalez	P	Reverend Redeem Robinson	A
Michael Green, PhD, MHSA	A	Harold Glenn San Agustin, MD	EA
Ismael "Ishh" Herrera	P	LaShonda Spencer, MD	EA
William King, MD, JD	EA	Lambert Talley	P – AB2449
Miguel Martinez, MPH, MSW	EA	Jonathan Weedman	P
Anthony M. Mills, MD	EA		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Lizette Martinez			
DHSP STAFF			
Wendy Garland, Sona Oksuzyan, MD; Victor Scott, Pamela Ogata			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
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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 2:35pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): K. Donnelly, F. Gonzalez, I. Herrera, J. Weedman, L. Talley (AB449)

3. Approval of Agenda

MOTION #1: Approve the Agenda Order **(No vote held; quorum was not reached.)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(No vote held; quorum was not reached.)**

II. PUBLIC COMMENT

5. **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

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

   There was no committee new business.

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **Recap Commission on HIV Annual Conference**
      - C. Barrit, Commission on HIV (COH) Executive Director, provided a brief recap of the Commission on HIV (COH) Annual Conference. C. Barrit shared highlights from the Commission Annual Conference. She noted that a report containing the attendee evaluation results and a summary of the feedback collected during the group activities were shared with the Executive and Operations Committee meetings on December 12, 2023. The noted action items will be incorporated into Commission and Committee workplans for the 2024 calendar year. C. Barrit also shared that overall feedback received in the evaluations was positive and that many attendees appreciated the opportunity to interact with one another.

   b. **Bylaws Review Taskforce Updates**
      - C. Barrit reported that the Bylaws Review Taskforce (BRT) completed their review of the bylaws and have drafted proposed changes. The document will be presented at the Operations Committee and Executive Committee for review and approval and will be posted for a public comment period. The document will then by reviewed and voted on by the full Commission body after the public comment period ends. Once approved by the full Commission body, Commission staff will work with County Counsel to determine which items on the updated By-laws will require an ordinance change and initiate that process.

8. **Co-Chair Report**
   a. **2024 Co-Chair Nominations**

- K. Donnelly announced open nominations for the 2024 Planning, Priorities, and Allocations (PP&A) Committee. To date, K. Donnelly and F. Gonzalez have been nominated and have accepted nomination. Co-chair elections will take place at the January PP&A Committee meeting.

b. January PP&A Meeting

- K. Donnelly reported that the January PP&A Committee meeting needed to be rescheduled. The reschedule meeting date and time is Tuesday, January 23rd from 1pm-4pm at the Vermont Corridor.

c. Approval of Los Angeles County HIV &STI Status Neutral Service Delivery Framework - MOTION #3

- K. Donnelly announced that vote for approval of the Los Angeles County HIV &STI Status Neutral Service Delivery Framework would be postponed to the January meeting due to lack of quorum.

d. Prevention Planning Workgroup Co-Chair Recognition

- Noting that Prevention Planning Workgroup (PPW) Co-chairs were not present, K. Donnelly postponed the Prevention Planning Workgroup Co-Chair Recognition to the January PP&A Committee meeting.

e. Current Allocations and Priorities, Draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework and 2024 Draft Workplan

- K. Donnelly announced that the current RWP approved allocations and priorities, draft status neutral priority setting and resource (PSRA) framework and 2024 draft workplan are in the December meeting packet and asked committee members to review the documents ahead of the January PP&A Committee meeting.
- C. Barrit clarified that the draft PSRA framework is still being revised and is not included in the meeting packet.
- Commission staff will also send the documents to the committee after the new year holiday in preparation for the January PP&A Committee meeting.

9. Division of HIV and STD Programs (DHSP) Report

a. Fiscal Year 2022 Utilization Report – General and Specialty Oral Health Services

- DHSP staff, Dr. Sona Oksuzyan, provided a report on General and Specialty Oral Health service utilization for fiscal year 2022. See meeting packet for more details.
- It was noted that expenditures for Oral Health Services and Oral Specialty Care cover staff time and resources and not the cost of the procedure.
- Additionally, it was noted that Ryan White Program (RWP) clients accessing specialty oral

care services that are invasive must be virally suppressed in order receive services.

- C. Barrit asked if AOM, MCC, and MH services for RWP clients stopped at DHS sites as indicated on page 15 of the report. DHSP staff, Wendy Garland, clarified that these services did not stop at the DHS sites but rather DHS stopped billing the RWP for these services.

b. Programmatic and Fiscal Updates

- V. Scott provided a review of the Ryan White Program Year 33 Expenditures. The total RWP Part A award is approximately $42.9 million, Part B award is approximately $5.4 million, Minority AIDS Initiative (MAI) award of $3.67 million, and an MAI carryover from RWP Year 32 of $685,000. See meeting packet for more details.
- The current estimated MAI carryover from RWP Year 33 to 34 is $1.6 million which includes approximately $375,000 from Part A, $543,000 and the $685,000 of MAI carryover funds from Program Year 32. V. Scott noted that this number may change as the program year closes at the end of February and expenditures are finalized in May. He also noted that the $685,000 of MAI carryover from fiscal year 32 must be spent by the end of program year 33.

V. DISCUSSION

10. Los Angeles Homeless Services Authority (LAHSA) Data Report

- L. Martinez, Commission staff, provided a brief report on a data request that was sent to the Los Angeles Homeless Services Authority (LAHSA) regarding the number of unhoused people living with HIV (PLWH) in Los Angeles County. LAHSA staff were not available to provide a presentation to the PP&A Committee and provided raw data to Commission staff. The request took approximately five months to complete and required follow-up from Commission staff due to initial data being incomplete. LAHSA staff noted delays were due to competing priorities/reports and staffing shortages. The report was developed through analysis by COH staff and includes data from years 2021 to 2023 (through July). See meeting packet for details.
- Important to note, the total of PLWH per year includes duplicated counts of PLWH and not the number of unique clients. The LAHSA service system includes a variety of housing services and individuals are counted by each service they may receive throughout a given calendar year. For example, one client may access five different LAHSA services in year 2022. This one person living with HIV will be counted once for each service received for a total of five PLWH reported.
- It was noted that very few PLWH exit the LAHSA service system into permanent housing situations and that more needs to be done to ensure more people transition to permanent housing situations.
- C. Barrit noted the report was challenging to navigate and took COH staff time to translate the data into a format that was clear for the committee and shows the data challenges with LAHSA. She added that there have been recent articles in the Los Angeles Times around LAHSA's data reliability and accuracy.
- C. Barrit commented that the responses to the questions also showed lack of provider knowledge and training and the need to educate housing providers on available resources for

PLWH.

- L. Talley suggested holding a conference with housing providers and other organizations including faith-based organizations to education them on resources and services that are available to PLWH through the RWP. He noted these organizations can help those in need access services.
- J. Weedman commented that he would like to see more outreach and engagement within the community groups and organizations to ensure information and messaging is being reached beyond the Commission on HIV and to the people they serve and who may need services.
- Daryl Russell commented that it is unacceptable for people in such a large city to be unable to access needed services.

VI. NEXT STEPS

11. Task/Assignments Recap

a. Deferred items from the December meeting will be added to the January agenda

b. Complete status neutral priority setting and resource (PSRA) framework and share ahead of January meeting

12. Agenda Development for the Next Meeting

a. 2024 Co-chair Elections

b. Fiscal Year 2022 RWP Utilization Report - Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

VII. ANNOUNCEMENTS

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

- *There were no announcements.*

VIII. ADJOURNMENT

14. Adjournment for the Meeting of December 14, 2023.

The meeting was adjourned by K. Donnelly at 4:00pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

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
January 24, 2024

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Derek Murray	P
Al Ballesteros, MBA, Co-Chair	A	Jesus "Chuy" Orozco	A
Lilieth Conolly	P – AB2449	Dechelle Richardson	P
Felipe Gonzalez	P	Reverend Redeem Robinson	A
Joseph Green (ex-officio)	P	Harold Glenn San Agustin, MD	EA
Michael Green, PhD, MHSA	P	LaShonda Spencer, MD	EA
Ismael "Ishh" Herrera	EA	Lambert Talley	P – AB2449
William King, MD, JD	EA	Jonathan Weedman	P
Miguel Martinez, MPH, MSW	P		
COMMISSION STAFF AND CONSULTANTS			
Dawn McClendon, Lizette Martinez, Jose Rangel-Garibay			
DHSP STAFF			
Wendy Garland, Sona Oksuzyan, MD; 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

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:02pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): L. Connolly (AB2449), M. Green, F. Gonzalez, M. Martinez, D. Murray, D. Richardson, L. Talley (AB2449), J. Weedman, K. Donnelly

3. Approval of Agenda

MOTION #1: Approve the Agenda Order **(No vote held; quorum was not reached.)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(No vote held; quorum was not reached.)**

II. PUBLIC COMMENT

5. **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

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

   K. Donnelly

IV. REPORTS

7. **Execute Director/Staff Report**
   a. **Bylaws Review Taskforce Updates**
      - L. Martinez, Commission on HIV (COH) staff commented that the Bylaws Review Taskforce completed their review of current COH bylaws and proposed changes. Proposed changes were based on feedback and findings from the Health Services and Resources Administration (HRSA). A summary of proposed changes can be found in the January COH meeting packet (here). The proposed changes will be reviewed and voted for approval at the Operations and Executive Committees on January 25th and will be presented to the full body at the February COH meeting for approval. There will also be a 30-day public comment period before moving to the Board of Supervisors for final approval.

   b. **Draft Comprehensive HIV Plan Progress Report**
      - L. Martinez provided an overview of the draft Comprehensive HIV Plan Progress Report. See meeting packet for more details.
        - Commissioners requested:
          - Additional detail be added to the progress report including outcomes, where feasible.
          - Inclusion of more Ryan White Program (RWP) services
          - Inclusion of work being done by other partners
        - Bamby Salcedo, President of the TransLatin@ Coalition, suggested creating a team of commissioners to regularly attend Board of Supervisor (BOS) meetings to

advocate for additional HIV and STI funding resources. She also suggested speaking with Mario Perez, Director of the Division of HIV and STD Programs (DHSP) within the Department of Public Health (DPH), to request an analysis of DPH funds to request additional funding for DHSP.

8. Co-Chair Report

a. 2024 Co-Chair Elections

- K. Donnelly and F. Gonzalez were elected as co-chairs for the 2024 year.

b. Prevention Planning Workgroup Co-Chair Recognition

- K. Donnelly recognized M. Martinez and W. King for their leadership and dedication on the Prevention Planning Workgroup. M. Martinez and W. King received a certificate of appreciation.
- K. Donnelly also announced that Dr. Mills has resigned from the COH and wished him well on his future endeavors.
    a. Bamby Salcedo asked if the COH was actively recruiting new members.
    b. F. Gonzalez noted there was a lack of transgender representation and voice within the COH and encouraged Bamby to apply. Bamby noted that it may be hard for transgender people to attend but will make an effort to have representation from the TransLatin@ Coalition.
    c. M. Martinez noted that DHSP funded providers are required to attend COH meetings as stated in their contracts but only a handful of agencies regularly attend meetings. He asked how agencies are being held accountable and noted reports submitted to DHSP include a section to indicate who attended COH meetings.

c. Approval of Los Angeles County HIV &STI Status Neutral Service Delivery Framework - MOTION #3 (No vote held; quorum was not reached.)

- K. Donnelly requested the Los Angeles County HIV &STI Status Neutral Service Delivery Framework be forwarded to the Executive Committee for approval.

d. 2024 Draft Workplan

- K. Donnelly provided a brief overview of the 2024 draft workplan. The workplan will focus on the priority setting and resource allocation (PSRA) process for the upcoming Health Resources and Services Administration (HRSA) funding cycling and community listening sessions to help inform the PSRA process. See meeting packet for more details.
- K. Donnelly reminded the group that the workplan is a living document and if anyone had any suggestions to submit them in writing to COH staff.
- F. Gonzalez commented that there was an infographic of the previous version of the PSRA processes and requested a similar infographic be development to align with the proposed

framework to serve as a quick reference for commissioners.

9. Division of HIV and STD Programs (DHSP) Report

a. Fiscal Year 2022 Utilization Report – Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

- DHSP staff, Wendy Garland, provided a report on Benefits Specialty, Transitional CM- Jails, Home-Based Case Management (HBCM) service utilization for fiscal year 2022. See meeting packet for more details.
    - Home-Based Case Management (HBCM)
        - D. Murray asked if individuals who receive subsidized housing were eligible for HBCM services and how housing stability was assessed under this service. W. Garland indicated that individuals should qualify, if eligible, regardless of whether or not they receive subsidies and stated that reassessments are not standardized but unique to each agency.
        - W. Garland clarified that HCBM services are temporary and for individuals who have functional status issues such as a disability or temporary recovery after a hip surgery and are on bed rest.
        - W. King asked if individuals receiving home health services supplied by the County of Los Angeles can also receive HBCM from RWP. W. Garland indicated that they would not be eligible as the RWP is the payor of last resort.
        - W. King noted underutilization of HBCM among Black/African American populations and asked if there was any explanation as to why. W. Garland added that lack of utilization is unknown but potential reason could be lack of knowledge among providers and RWP clients.
        - D. Murray commented that more outreach is needed among providers to increase awareness of HBCM and other services so that providers can share information with their clients.
    - Benefits Specialty (BS) and Transitional Case Management (TCM) - Jails
        - BS services focus on addressing gaps and access to public benefits and programs outside of the RWP.
        - D. Murray commented that BS services work well for individuals who are housed but those who are unhoused may need additional support such as assistance with document readiness (e.g., obtaining identification cards).
        - M. Martinez noted that remediation support around denial of benefits was surprisingly low and asked how many people seek assistance with remediation. He also asked how many of the 11 contracted agencies serve people outside of their agency.
        - B. Salcedo asked what benefits are available to undocumented individuals and how the program is promoted. W. Garland stated that more

information is need with how information is being shared with both providers and clients and stronger efforts to promote all RWP services are needed.

- W. Garland commented that achieving higher rates of viral suppressions by those receiving BS services should not be determined as a causation noting that the two time points are too far apart.
- W. Garland noted that TCM jail services sunset September 2023 and are no longer provided by DHSP. Services will be provided within the jails by the Department of Health Services (DHS). She noted jail-based services have historically been challenging to implement due to jails restricting access to providers implementing services. The COVID pandemic exacerbated restrictions further and the hope is the new jail-based system will better serve clients given they will be embedded within the jails. DHSP will be assisting with follow up on individuals who are lost to care post release via the linkage and reengagement program (LRP).
- D. Murray noted a there was a high number of RWP clients entering the jail system (5%).
- B. Salcedo and L. Talley expressed concerns that DHSP will no longer be providing services within the jail system. W. Garland noted that DHSP no longer provides services due to challenges with implementation and inability to expend funding, but that DHS will be providing services within the jail system.
- TCM allocations will need to be reallocated to one or more service categories.
- DHSP will be using Minority AIDS Initiative (MAI) funding to hire a Correctional Services Coordinator and 6 Medical Case Workers to replace the TCM program and focus on post-release linkage activities (while still offering pre-release interventions). This new program will leverage client information currently accessible within DHSP and coordinate external services with CHS and other partners like the Office of Diversion and Re-entry (ODR). Separately but in coordination with re-entry navigation, the Linkage and Re-Engagement Program (LRP) will continue to focus on priority populations given the long-term case management needs of the pregnant/postpartum/potentially pregnant. DHSP will utilize their Rapid & Ready Navigation Team (EHE contractors providing linkage support to the community currently) to temporarily provide support to fill in any gaps while the long-term DHS plan gets solidified. DHSP is beginning the hiring process and anticipates the program to be fully hired within a few months.

- The utilization report for the LRP was postponed and will be presented at a full Commission on HIV (COH) meeting. DHSP staff noted that the program has been restructured and all commissioners would benefit from hearing the report.

b. Programmatic and Fiscal Updates

- There were no programmatic or fiscal updates.

V. DISCUSSION

10. DHSP Data Presentation Feedback

- Commissioners noted that the revised utilization report format easier to follow than previous reports. They appreciated the concise format and highlighting key details needed to assist in the priority setting process.

11. Review Draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework, Current Allocations and Priorities, and Prevention Planning Workgroup Recommendations

- K. Donnelly held this item for review during the February PP&A meeting due to time constraints.
- Commissioners were asked to review the materials ahead of the February meeting and submit any feedback or questions to Commission staff. Staff will gather feedback and present comments at the next meeting.

VI. NEXT STEPS

12. Task/Assignments Recap

a. Deferred items from the January meeting will be added to the February agenda.
b. Review the draft status neutral priority setting and resource (PSRA) framework and provide feedback to staff ahead of the February meeting.

13. Agenda Development for the Next Meeting

a. Review Draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework, Current Allocations and Priorities, and Prevention Planning Workgroup Recommendations
b. RWP Fiscal Year 2023 Updates

VII. ANNOUNCEMENTS

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

- *D. Murray announced that the City of West Hollywood is currently working to create a fixed harm reduction site within the city that will offer harm reduction services such as needle exchange, test strips, etc. More information will follow as the project progresses.*

VIII. ADJOURNMENT

15. Adjournment for the Meeting of January 23, 2024.

The meeting was adjourned by K. Donnelly at 3:56pm.

SAMHSA
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

January 30, 2024

Dear Colleague:

On behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), I want to alert you to increased rates of syphilis and other sexually transmitted infections (STIs) and provide guidance on the use of grant funds and SAMHSA's programmatic work to address this public health concern.

Syphilis and congenital syphilis along with substance use disorder, mental illness, and other STIs such as HIV, gonorrhea, and chlamydia represents a syndemic. Syndemics happen when two or more health conditions cluster and interact within a population because of social and structural factors and inequities, leading to an excess burden of disease and continuing health disparities. Addressing the syphilis syndemic requires collaboration between substance use preventionists, substance use disorder treatment providers, sexual health service providers, and supportive services providers (e.g., housing).

Screening, testing, and treating for STIs is part of SAMHSA's whole person approach to behavioral health treatment and substance use prevention. The U.S. Preventive Services Task Force recommends providers screen early for syphilis in all pregnant women as well as screen asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection. Data from the Centers for Disease Control and Prevention (CDC) show a 74% increase in syphilis diagnoses from 2017-2021, including 2,800 congenital, or mother-to-child, syphilis cases in 2021 leading to 220 infant deaths. STIs overall have increased by 7% from 2020, with more than 2.5 million cases reported in the United States during 2021. Substance use, particularly methamphetamine use, appears to be highly correlated with rising rates of syphilis and other STIs. Among pregnant women with syphilis, substance use is nearly twice as high among those with a congenital syphilis outcome than those without transmission. Disparities also exist in syphilis rates across racial and ethnic groups. For example, among American Indian and Alaska Native (AI/AN) persons, the rate of new syphilis cases of nearly four times the rate of white persons in 2020. Syphilis is also increasing among gay, bisexual, and other men who have sex with men. However, we know that actions can be taken to reverse these trends and prevent transmission of syphilis and other STIs in these and other populations.

Unless expressly stated in the Notice of Funding Opportunity (NOFO) through which a grant is funded, SAMHSA grant recipients are not permitted to directly use SAMHSA funds for syphilis treatment. However, SAMHSA grant recipients may use their grant funds to address the syphilis syndemic by providing syphilis and other STI screening, testing, and referral to treatment in conjunction with SAMHSA supported work. Additional allowable activities include, but are not limited to, training for staff, case management for people who test positive for STIs, service navigation for people served by SAMHSA funds to syphilis or other STI prevention resources

and mental health support, and the development of memoranda of understanding (MOUs) or other agreements with STI treatment providers.

Additionally, some current SAMHSA grant programs include required or allowable activities that address the syphilis syndemic. Those grant programs are listed below, with additional information provided in Appendix 1.

1. The SAMHSA Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).
2. Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS (Short title: MAI – High Risk Populations: fiscal year (FY) 2023 grant cohort only, TI-23-008.
3. Minority HIV/AIDS Fund (MHAF): Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project (Short Title: Portable Clinical Care Pilot Project)**:** TI-23-024.
4. Minority AIDS Initiative: The Substance Use and Human Immunodeficiency Virus Prevention Navigator Program for Racial/Ethnic Minorities (Short Title: Prevention Navigator): FY 2023 grant cohort only, SP-23-005.
5. Services Program for Residential Treatment for Pregnant and Postpartum Women (Short Title: PPW): FY 2023 grant cohort only, TI-23-002.
6. Building Communities of Recovery (Short Title: BCOR): FY 2022 and FY 2023 grant cohorts only, TI-22-014.
7. Recovery Community Services Program (Short Title: RCSP): FY 2023 cohort only, TI-23-018.
8. Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (Short Title: MAT-PDOA): FY 2021 (TI-21-006), FY 2022 (TI-22-013), and FY 2023 (TI-23-001) grant cohorts.
9. Grants for the Benefit of Homeless Individuals (Short Title: GBHI): FY 2023 grant cohort only, TI-23-005.
10. Targeted Capacity Expansion: Special Projects (Short Title: TCE – Special Projects): FY 2022 and FY 2023 grant cohorts, TI-22-002.

Note that this list does not include any future grant programs; for grant programs FY 2024 and later, please refer to the grant NOFO and/or contact your Government Project Officer if you have additional questions about how SAMHSA-supported programs can help to address the syphilis syndemic.

SAMHSA also oversees Opioid Treatment Programs (OTPs), which play an important role in addressing the syphilis syndemic. In addition to providing medications for opioid use disorder and other treatment and support services to address substance use and substance use disorders, OTPs are required by 42 Code of Federal Regulations (CFR) Part 8 Rules to "establish the risk of undiagnosed conditions such as Hepatitis C, the human immunodeficiency virus (HIV), sexually transmitted infections (STIs)." These requirements are important for assessing and providing whole-person care.

The rising rates of syphilis and other STIs in the United States, particularly among people who use substances, necessitate action across the healthcare field. For a list of resources to assist

clinicians in addressing the syphilis syndemic, see this link. By assessing the whole person needs of individuals with behavioral health conditions, we can make progress together. Thank you for your partnership in this effort. Please contact your Government Project Officer if you have any questions about your award or need additional information about STI prevention and substance use and how SAMHSA funding can be used to address the syphilis syndemic.

Sincerely,

/Miriam E. Delphin-Rittmon/

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use

Appendix 1: SAMHSA grant programs that include required or allowable activities that address the syphilis syndemic are listed below.

1. The SAMHSA Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Provides funding as a "payment of last resort" in very limited circumstances for syphilis screening, testing, prevention education, and medical treatment. Those three limited circumstances are:
    I. For **pregnant people in SUBG-funded SUD treatment programs** and for people in SUD treatment with dependent children. Allowable services include providing an array of primary medical care for women and primary pediatric care for their children, including syphilis screening, testing, prevention education, and medical treatment for syphilis and congenital syphilis.
    II. For **persons with HIV in SUBG-funded SUD treatment programs** in CDC designated states. The SUBG requires the delivery of a defined array of HIV Early Intervention Services (EIS) in states with a prevalence of 10 or more cases of AIDS per 100,000 persons. The provision of EIS and post-test counseling includes screening and testing individuals with HIV and are engaged in SUD treatment for syphilis and referral to treatment.
    III. SUBG funds may also be used to address syphilis if a SUBG grant recipient has been **approved by their assigned Center for Substance Abuse Treatment (CSAT) State Project Officer (SPO) to use grant funds for approved elements of a Syringe Service Program (SSP)**, with the important exception that SUBG grant funds may not be used for distribution of needles or syringes for purposes of injection drug use of illegal substances. In the circumstances in which SUBG funds have been approved by the CSAT SPO to fund approved elements of a Syringe Services Program, these approved elements may include screening and testing for HIV, HCV, TB, and STIs, including syphilis.
        Note: Aside from these three limited circumstances, the SUBG does not allow the use of general block grant funds for routine testing for infectious diseases for individuals who are engaged in SUD treatment. If you are a SUBG grant recipient and have additional questions, please reach out to your CSAT SPO directly.

2. Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS (Short title: MAI – High Risk Populations:), TI-23-008: Recipients awarded from this NOFO in FY 2023 may use no more than 5 percent of the total award for staff training and screening and testing participants for HIV and other STIs, including test kits and required supplies, and referral to treatment services as appropriate.

3. Minority HIV/AIDS Fund (MHAF): Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project (Short Title: Portable Clinical Care Pilot Project)**:** TI-23-024.
    I. Recipients awarded from this NOFO are required to provide the following activities:
        i. Screen clients and their drug-using and/or sexual partners on-site for HIV, viral hepatitis, STIs, mpox, and tuberculosis.
        ii. Provide case management and referral/linkage to treatment as necessary based on the client's individual needs. Case management includes a comprehensive assessment of the client's needs and the development of an individualized

service plan, including infectious disease prevention and/or treatment services, as well as helping clients with funding for treatment, including HCV treatment, as necessary.

iii. Test participants for STIs (gonorrhea, chlamydia, and syphilis) and provide treatment on-site as needed.

II. As stated in the NOFO, no more than 15 percent of the total grant award may be used for the purchase of, among other expenses, STI screening, testing, and treatment medications (chlamydia, gonorrhea, and syphilis).

4. Minority AIDS Initiative: The Substance Use and Human Immunodeficiency Virus Prevention Navigator Program for Racial/Ethnic Minorities (Short Title: Prevention Navigator): SP-23-005: Recipients awarded from this NOFO in FY 2023 may provide and/or refer individuals to supportive services that address social determinants of health and childhood adverse experiences to prevent the onset of mental health (MH)/SUD and reduce risk for HIV/viral hepatitis and STIs, including syphilis.

5. Services Program for Residential Treatment for Pregnant and Postpartum Women (Short Title: PPW): TI-23-002**:** Recipients awarded from this NOFO in FY 2023 are required to provide required supplemental services for women, including counseling on risk and testing for HIV, Hepatitis C, and other communicable diseases, including syphilis.

6. Building Communities of Recovery (Short Title: BCOR). TI-22-014: Recipients awarded from this NOFO in FY 2022 and FY 2023 are allowed to provide education, screening, care coordination, risk reduction interventions, testing, and counseling for HIV/AIDS, hepatitis, and other infectious diseases, including syphilis, for individuals with SUD.

7. Recovery Community Services Program (Short Title: RCSP): TI-23-018: Recipients awarded from this NOFO in FY 2023 are allowed to provide HIV/AIDS, viral hepatitis, and other infectious diseases education, including syphilis, screening, case management, and/or risk reduction interventions for individuals with Substance Use Disorder (SUD) or co-occurring substance use and mental disorders (COD), including those in recovery.

8. Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (Short Title: MAT-PDOA): FY21 (TI-21-006), FY22 (TI-22-013), and FY23 (TI-23-001) grant cohorts: Recipients awarded from the NOFOs in FY 2021, FY 2022, and FY 2023 are allowed to provide education, screening, including screening and confirmatory laboratory testing, care coordination, risk reduction interventions, and counseling for HIV, hepatitis C, and other infectious diseases for people with Opioid Use Disorder (OUD) who are receiving Medication for Opioid Use Disorder (MOUD), including syphilis.

9. Grants for the Benefit of Homeless Individuals (Short Title: GBHI), TI-23-005: Recipients awarded in FY 2023 are allowed to provide training, screening, including laboratory screening and confirmatory testing, counseling, and treatment linkage as appropriate for Hepatitis C and other sexually transmitted infections, including syphilis.

10. Targeted Capacity Expansion: Special Projects (Short Title: TCE – Special Projects): FY22 and FY23 grant cohorts only, TI-22-002: Recipients awarded from the NOFO in FY 2022 and FY 2023 are allowed to provide education, screening, care coordination, risk reduction interventions, testing, and counseling for HIV/AIDS, hepatitis, and other infectious diseases, such as syphilis, for people with SUD who are receiving MOUD.

Planning, Priorities, & Allocations Committee

- Recommends priorities and allocations
  - Ensures that the priorities are consistent with needs and with the service delivery system
- Identifies and recommends solutions for service gaps
  - Conducts data collection and needs assessment activities
  - Develops strategies to identify, document and address “unmet need”
  - Gathers expressed need data from consumers
  - Reports consumer and service needs, gaps and priorities to the Commission
- Conducts strategic planning activities for the Commission

Planning, Priorities, & Allocations Committee

- Collaborates with DHSP to ensure the effective integration and implementation of the HIV/AIDS continuum of care
  - Recommends service system and delivery improvements to the grantee (DHSP) to ensure that the needs of people living with HIV are adequately met
- Reviews fiscal reporting data for Ryan White Part A and B and CDC expenditures by funding source and/or service category
  - Making recommendations to the Commission on the monitoring and reporting of unspent funds
- Evaluates and designs systems to ensure that other sources of service funding are sufficiently accessed
- Identify, access and expand other financial resources to meet Los Angeles County's HIV service needs

Service Ranking & Priority Setting

The process of deciding which HIV/AIDS services are the most important in providing a comprehensive system of care for all PLWH in an Eligible Metropolitan Area (in our case, LA County).

- Must address needs of *all* PLWH regardless of:
  - Who they are
  - Where they live in the County
  - Stage of disease
  - Whether they currently receive services
- Priorities should be set without regard to the availability of funds (RWHAP Part A or other funds)

What are the Ryan White Service Categories?

These are the services ranked by the Commission during the PSRA process.

Fall under two categories:

- Core Medical Services
- Support Services

HRSA requires that 75% of funds be allocated to core medical services, but waiver requests are permitted.

Core Medical Services

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support Services

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Legal Services
7. Linguistic Services
8. Medical Transportation
9. Non-Medical Case Management Services
10. Other Professional Services
11. Outreach Services
12. Permanency Planning
13. Psychosocial Support
14. Referral for Healthcare and Support Services
15. Rehabilitation
16. Respite Care
17. Substance Abuse (residential)

Resource Allocation

Process of determining how much **RWHAP Part A** & **Minority AIDS Initiative (MAI)** program funding will be allocated to each service category

- Commission instructs DHSP on how to distribute the funds in contracting for service categories
- Some lower-ranked service categories may receive larger allocations than higher-ranked service categories due to cost per client and services available through other funding streams

Directives

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

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

Reallocation

Process of moving program funds across service categories after the initial allocations are made.

This may occur:

- Right after grant award (partial and final award), since the award is usually higher or lower than the amount requested in the application
- During the program year, when funds are underspent in one category and demand is greater in another

PSRA Tips

- There is no one “right” way to set priorities and allocate resources.
- An evolving process influenced by status-neutral approaches and ever-changing healthcare landscape like Medi-Cal expansion
- Process must be documented in writing and used to guide deliberations and decision-making.
  - A grievance can be filed if the planning council deviates from its established process.
- Agree on the PSRA process, its desired outcomes, and responsibilities for carrying out the process.

Steps in the Priority Setting and Resource Allocations Process

1. Review core medical and support service categories, including HRSA service definitions
2. Review data/information from DHSP
3. Agree on how decisions will be made; what values will be used to drive decisions.

Steps in the Priority Setting and Resource Allocations Process

4 Rank services by priority

5 Allocate funding sources to service categories by percentage

Ranking DOES NOT equal level of allocation by percentage

Steps in the Priority Setting and Resource Allocations Process

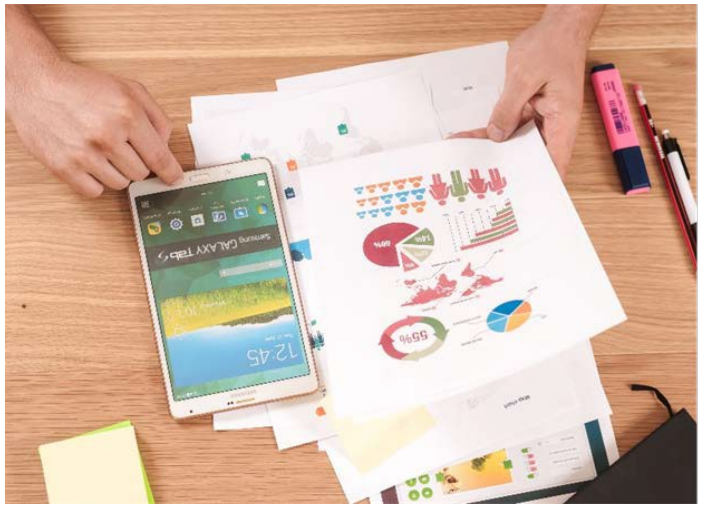
6 Provide instructions to DHSP on how best to meet the priorities (Directives)

7 Reallocation of funds across service categories, as needed

Directives are informed by COH Committees, Caucuses, Task Forces, data, PLWH and provider input.

Data to Support Decision-Making

- Needs assessment findings
- Cost-effectiveness data
- Actual service cost and utilization data
- Priorities of PLWH who will use services
- The amount of funds provided by other sources
- Use of RWHAP Part A, B and MAI funds to work with other services providers



LOS ANGELES COUNTY
COMMISSION ON HIV

Steps in the Priority Setting and Resource Allocation Process
Ryan White Program Year – March 1 to February 28

1. Review core medical and support service categories, including HRSA service definitions

2. Review data/information from DHSP & COH Caucuses

3. Agree on how decisions will be made; what values will be used to drive the decision-making process

4. Rank services by priority
   Ranking DOES NOT equal level of allocation by percentage

5. Allocate funding sources to service categories by percentage
   Ryan White Program Part A and Minority AIDS Initiative (MAI)

6. Draft Directives: Provide instructions to DHSP on how best to meet the priorities
   Informed by COH Committees, Caucuses, Task Forces, data, PLWH & provider input

7. Reallocation of funds across service categories, as needed throughout funding cycle

LOS ANGELES COUNTY
COMMISSION ON HIV

Ryan White Program Service Categories

Core Medical Services

- AIDS Drug Assistance Program (ADAP) Treatments
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services (aka Home-based Case Management)
- Home Health Care
- Hospice Services
- Medical Case Management, including Treatment Adherence Services (aka Medical Care Coordination)
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care

Supportive Services

- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management Services
- Other Professional Services
  - Legal Services
  - Permanency Planning
- Outreach Services
- Permanency Planning
- Psychosocial Support
- Referral for Healthcare and Support Services
- Rehabilitation
- Respite Care
- Substance Abuse (Residential)

Click here for more information on allowable use of funds.

LOS ANGELES COUNTY
COMMISSION ON HIV

Ryan White Program Parts

Program Part	Recipient	Funding Purpose
Part A and Minority AIDS Initiative Funds* **(Locally managed by DHSP)**	**Eligible Metropolitan Areas (EMAs) & Transitional Grant Areas (TGAs)**	• **Provide medical (core) and support services to cities/counties most severely affected by HIV** • **Minority AIDS Initiative – Help RWHAP recipients improve access to HIV care and health outcomes for minorities**
Part B	All 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and six U.S. territories; states distribute money to counties	• Improve the quality of and access to HIV health care and support in the U.S. • Provide medications to low-income people with HIV through AIDS Drug Assistance Program (ADAP)
Part C	Local community-based groups (e.g., FQHCs, clinics, CBOs, FBOs, etc.)	• Provide outpatient ambulatory health service s and support for people with HIV • Help for community-based groups to strengthen their capacity to deliver high-quality HIV care
Part D	Local community-based organizations	• Provide medical care for low-income women, infants, children and youth with HIV • Offer support services for people with HIV and their family members
Part F	• AETCs & SPNS • Dental Programs	• AIDS Education and Training Center (AETC) Program – Provide training and technical assistance to providers treating patients with or at risk for HIV • Special Projects of National Significance (SPNS) – Develop innovative models of HIV care and treatment to respond to RWHAP client needs • Dental Programs – Provide oral health care for people with HIV and education about HIV for dental care providers

** Indicates RWP Parts that are allocated by the Commission on HIV/Planning Council.*

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 9003.0 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la .info

DUTY STATEMENT, COMMISSIONER (subject to change)

POLICY:

1) Candidates for membership on the Commission on HIV must complete a membership application and are evaluated/scored by the Commission's Operations Committee, consistent with Policy/ Procedure #09.4205 *(Commission Membership Evaluation and Nomination Process).* The Operations Committee recommends candidates for membership to the Commission, which, in turn nominates them to the Board of Supervisors by a majority vote. The Board of Supervisors is responsible for appointing members to the Commission.

DUTIES AND RESPONSIBILITIES: In order to be an effective, active member of the Commission on HIV, an individual must meet the following demands of Commission membership:

1. Representation/Accountability:

- Possess a thorough knowledge of HIV/AIDS/STI issues and affected communities, and the organization or constituency the member represents;
- Continually and consistently convey two-way information and communication between the organization/constituency the member represents and the Commission;
- Provide the perspective of the organization/constituency the member represents and the Commission to other, relevant organizations regardless of the member's personal viewpoint;
- Participate and cast votes in a manner that is best for the entire County, regardless of the personal opinions of the member personal or the interests/opinions of the organization/constituency the member represents.

2. Commitment/Participation:

a) Commitment to fill a full two-year Commission term.

b) A pledge to:

- respect the views of other members and stakeholders, regardless of race, ethnicity, sexual orientation, HIV status or other factors;
- comply with "Robert's Rules of Order, Newly Revised", the Ralph M. Brown Act, the Commission's Code of Conduct and applicable HIPAA rules and requirements;
- consider the views of others with an open mind;
- actively and regularly participate in the ongoing decision-making processes; and
- support and promote decisions resolved and made by the Commission when representing the Commission.

c) A commitment to devote a minimum of ten hours per month to Commission/committee attendance, preparation and other work as required by your Commission membership.

d) Each year of the two-year term, the Commissioner is expected to attend* and participate in, at a minimum, these activities:

- Two all-day Commission orientation meetings *(firstyear only)* and assorted orientations and trainings of shorter length throughout the year;
- One to two half-day County commission orientations *(alternate years);*
- One half- to full-day Commission meeting monthly;
- One two- to three-hour committee meeting once a month;
- All relevant priority- and allocation-setting meetings;
- One all-day Commission Annual Meeting in the Fall;
- Assorted voluntary workgroups, task forces and special meetings as required due to committee assignment and for other Commission business.

***Stipulation:** Failure to attend the required meetings may result in a Commissioner's removal from the body.*

3. Knowledge/Skills:

a) A commitment to constantly develop, build, enhance and expand knowledge about the following topics:

- general information about HIV/STIs and its impact on the local community;
- a comprehensive HIV/STI continuum of care/prevention services, low-income support services, and health and human service delivery;
- the Commission's annual HIV service priorities, allocations and plans;
- the Ryan White Program, County health service and Medicaid information and other information related to funding and service support.

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 33 AND PART B YR 33 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by January 30, 2024

1	2	3	4	5	6	7	8	9	10
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 4,447,245	$ -	$ 4,447,245	$ 5,879,947	$ -	$ 5,879,947	$ -	$ -	$ 4,447,245
MEDICAL CASE MGMT (Medical Care Coordination)	$ 7,588,707	$ -	$ 7,588,707	$ 10,060,657	$ -	$ 10,060,657	$ -	$ -	$ 7,588,707
ORAL HEALTH CARE	$ 5,254,982	$ -	$ 5,254,982	$ 7,421,917	$ -	$ 7,421,917	$ -	$ -	$ 5,254,982
MENTAL HEALTH	$ 84,485	$ -	$ 84,485	$ 208,964	$ -	$ 208,964	$ -	$ -	$ 84,485
EARLY INTERVENTION SERVICES	$ 1,817,513	$ -	$ 1,817,513	$ 2,295,962	$ -	$ 2,295,962	$ -	$ -	$ 1,817,513
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,174,566	$ -	$ 2,174,566	$ 2,697,882	$ -	$ 2,697,882	$ -	$ -	$ 2,174,566
CHILD CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 1,129,501	$ -	$ 1,129,501	$ 1,425,340	$ -	$ 1,425,340	$ -	$ -	$ 1,129,501
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 318,984	$ 318,984	$ -	$ 318,984	$ 318,984	$ -	$ -	$ 318,984
HOUSING-RCFCI, TRCF	$ 344,080	$ -	$ 344,080	$ 353,500	$ -	$ 353,500	$ 2,990,264	$ 4,239,220	$ 3,334,344
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,765,535	$ 1,765,535	$ -	$ 3,426,176	$ 3,426,176	$ -	$ -	$ 1,765,535

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 33 AND PART B YR 33 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by January 30, 2024

SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	$ 670,000	$ 670,000	$ 670,000
MEDICAL TRANSPORTATION	$ 368,940	$ -	$ 368,940	$ 460,539	$ -	$ 460,539	$ -	$ -	$ 368,940
LANGUAGE SERVICES	$ 3,300	$ -	$ 3,300	$ 5,198	$ -	$ 5,198	$ -	$ -	$ 3,300
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 2,877,861	$ -	$ 2,877,861	$ 3,741,136	$ -	$ 3,741,136	$ -	$ -	$ 2,877,861
EMERGENCY FINANCIAL ASSISTANCE	$ 1,972,778	$ -	$ 1,972,778	$ 2,045,472	$ -	$ 2,045,472	$ -	$ -	$ 1,972,778
LEGAL	$ 323,213	$ -	$ 323,213	$ 537,628	$ -	$ 537,628	$ -	$ -	$ 323,213
OUTREACH/REFERRAL	$ 524,013	$ -	$ 524,013	$ 619,663	$ -	$ 619,663	$ -	$ -	$ 524,013
SUB-TOTAL DIRECT SERVICES	$ 28,911,184	$ 2,084,519	$ 30,995,703	$ 37,753,805	$ 3,745,160	$ 41,498,965	$ 3,660,264	$ 4,909,220	$ 34,655,967
YR 33 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 4,214,223	$ 271,066	$ 4,485,289	$ 4,298,488	$ 367,569	$ 4,666,057	$ 294,163	$ 537,589	$ 4,779,452
YR 33 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 510,029	$ -	$ 510,029	$ 713,795	$ -	$ 713,795	$ -	$ -	$ 510,029
TOTAL EXPENDITURES	$ 33,635,436	$ 2,355,585	$ 35,991,021	$ 42,766,088	$ 4,112,729	$ 46,878,817	$ 3,954,427	$ 5,446,809	$ 39,945,448
TOTAL GRANT AWARD				**$ 42,984,882**	**$ 3,675,690**	**$ 46,660,572**		**$ 5,446,809**	
VARIANCE				$ (218,794)	437,039			0	
MAI Carryover from YR 32 to YR 33	$ 685,010								
Estimated MAI Carryover from YR 33 to YR 34	$ 466,765								

EHE Funded Ryan White Program Services

EHE Program	Ryan White Service Category	Total	Description
Rapid and Ready Program	Outreach/Referral	$370,578	Navigators assist in securing medical and other appointments for clients. Serves as an advocate for client/patient access to departmental and community resources. Assists clients, patients, family members, and caregivers in obtaining and completing application forms for benefits and services. Accompanies clients to medical and other social services appointments to provide support. Takes medical, mental health, family, social, and employment histories and assists clients and patients in completing necessary forms. Assists in program implementation by monitoring the completion of questionnaires, conducting interviews, and collecting basic data. Provides client transportation when necessary.
Rapid and Ready Program	Transportation	$27,958	Rideshare will be utilized to provide reliable transportation to medical and supportive services appointments for Rapid and Ready Linkage to Care HIV clients.
Spanish Language Mental Health Telehealth	Mental Health	$251,698	Mental health services for Spanish-speaking (primary language) people living with HIV including clients with co-occurring disorders, specifically substance use disorder.
Buddy Program	Psychosocial Support	$101,100	Peer program assisting newly diagnosed clients or elderly clients access medical care, stay on track with medication and create social connectiveness.

EHE Priority Populations	Psychosocial Support	$3,000,000	Funding supports Seeking Safety or Cognitive Behavioral Therapy for Adherence and Depression (CBT-AD). Seeking Safety is a present-focused, multi-session intervention designed to help clients attain safety from trauma and/or substance abuse without requiring clients to delve into traumatic memories. Cognitive Behavioral Therapy for Adherence and Depression is a modular-based intervention that addresses ART adherence and depression.
MCC	Medical Case Management	$722,354	Teams co-located in clinics in Los Angeles County consisting of a Medical Care Manager, Patient Care Manager, Retention Outreach Specialist, and Case Workers address PLWH's unmet medical and non-medical support needs in an effort to improve HIV care continuum outcomes.
Ryan White Media Campaign	Outreach	$825,000	Funds support the development and implementation of Ryan White Services media campaign, including literature review/environmental scan, stakeholder engagement, brand & concept focus group, campaign development (concept development, social/digital media strategy, website development, media planning and placement, reporting), campaign implementation, press materials, community outreach educational materials, and public health detailing.
Street Medicine*	AOM	$1,500,000	Funds support the design, development, and implementation of street medicine services for people experiencing homelessness with HIV.

**RFP released January 2024*

DHSP Solicitations Priorities 2024

I. Active solicitations:

1. **Case Management - Home-Based Services WOS**

2. **Community Engagement – Clinical Provider Trainings & Health Fairs Services WOS**

II. Upcoming Solicitations (List by Priority, estimated release dates)

1. **Administrative Auditing Services** – release Feb. 24

2. **Prevention Services** – release Aug/Sep. 2024
   Category #1 - HIV Testing Services
   Category #2 – Biomedical Services
      a. PrEP Services
      b. PEP Services
      c. Navigation Services
   Category #3 - Vulnerable Populations Services
   Category #4 - STD Screening, Diagnosis and Treatment Services

3. **Nutrition Support Services** – release Oct. 2024

4. **Transportation Services** – release Oct. 2024

5. **Ambulatory Outpatient Medical Services (AOM)** – release Nov. 2024
   Category #1 – AOM Services
   Category #2 – MAX Clinic Services

6. **Medical Care Coordination Services (MCC)** – release Nov. 2024

7. **Residential Care Services** – release Nov. 2024
   Category #1 - Residential Care Facilities for Chronically Ill

   Category #2 - Transitional Residential Care Facilities

   Category #3 - SUD Transitional Housing

8. **Non-Medical Case Management – Benefits Specialty Services** – Nov. 2024

9. **Psychosocial Support/Peer Support Services** – release TBD

10. **Clinical Quality Management Services** – release TBD

LOS ANGELES COUNTY
COMMISSION ON HIV

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

POLICY/ PROCEDURE:	NO. 09.5203	Priority Setting and Resource Allocations (PSRA) Framework and Process

DRAFT 12.27.23

SUBJECT: The Commission's Priority Setting and Resource Allocations (PSRA) framework, process and specifics.

PURPOSE: To outline the Commission's service prioritization and resource allocations process, as mandated by the Ryan White Treatment Modernization Act (Ryan White) and Los Angeles County Charter Code 3.29.

BACKGROUND:

- Service prioritization and resource allocations are two of the Part A planning councils' chief responsibilities, detailed specifically in Ryan White legislation and confirmed in County Charter Code.

- In accordance with Health Resources and Services Administration (HRSA) guidance, the Commission sets service priorities based on consumer need and determines allocations from priorities and other factors such as service capacity, other sources of funding, service utilization and cost-effectiveness.

- As defined in its ordinance, the Commission establishes priorities and allocations of Ryan White Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee' s allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations and Comprehensive HIV plan, without the review of individual contracts; provide and monitor directives to the grantee on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the Board of Supervisors and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan.

POLICY:

- This policy outlines the Priority Setting and Resource Allocation (PSRA) process used to

- prioritize services and allocate resources—in accordance with governing Ryan White and County code legislation—encompassing the specific partners, responsibilities, steps, tasks and timelines associated with the process.

- The PSRA process is led by the Commission's Planning, Priorities and Allocations (PP&A) Committee. The Division of HIV and STD Programs (DHSP) provides critical information; consumer input is collected through the Comprehensive HIV Plan and other assessments; and provider input is collected through focus forums, surveys and Commission participation.

- The policy details the expectations and timing of stakeholder involvement in the multi-year Ryan White Part A funding cycle determined by the HRSA Ryan White HIV/AIDS Program (RWP). The process allows for ongoing stakeholder input at several key junctures. Multi-year allocations are intended to conclude prior to the submission of the RWP Part A application. Allocations are reviewed annually to ensure alignment with and responsiveness to community needs and funding requirements.

PRINCIPLES AND CRITERIA[1]:

A. **Priorities and allocations are data based**. Decisions are based on the data, not on personal preferences. Commissioners should avoid presenting anecdotal information or personal experiences during the decision making, focusing on needs assessments, and cost/service utilization data rather than a single person's experience.

B. **Conflicts of interest are stated and followed.** Commission members must state areas of conflict according to the approved Conflict of Interest Policy, and cannot participate in open discussions or vote on the related service categories in which they have a conflict. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s), and neither initiate discussion nor vote on priorities or allocations for those service categories. S/he can answer questions directed by other members, and can vote on priorities and allocations when they are presented as a whole list. (Model Priority Setting and Resource Allocation Process, Compendium of Materials for Planning Council Support Staff. EGM Consulting, LLC. 2018).

Commented [BC1]: Ask new HRSA PO for clarification.

[1] Model Priority Setting and Resource Allocation Process, Compendium of Materials for Planning Council Support Staff. EGM Consulting, LLC. 2018.

C. The data provide the basis for changes in **priorities or allocations from the previous year**. The data indicate changes in service needs/gaps and availability based on information from the various data sources.

D. **Needs of specific populations and geographic areas** are an integral part of the discussion in the data presentations and the decision making. They may also lead to recommendations to the Recipient on how best to meet the priorities.

E. **Final vote** on the complete priorities and allocations will be presented by the Planning, Priorities and Allocations Committee Co-Chairs to the full planning council for a roll-call vote.

F. **Paradigms and operating values** are selected and used by the PP&A Committee to help guide their decision-making in setting service priorities and resource allocations. The PP&A Committee reviews the paradigms and operating values selected and approved from the previous year as the foundation for current year PSRA process or reallocations. (Attach)

G. **The Commission's Status Neutral HIV and STI Delivery System framework** is used by the PP&A Committee to ensure that service priorities and resources allocations emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being. (Attach)

H. Decisions should help to ensure **parity in access to care**, for all Ryan White-eligible HIV/AIDS population groups and for PLWH/A regardless of where they live in the County.

I. Discussions and decisions should have a major focus on **improving performance on the HIV Care Continuum/Treatment Cascade,** focusing on areas of concern – such as linkage to care or retention in care. Reducing unmet need (the number of people who know they are HIV-positive but are not in care) requires deciding how many "new" or "lost to care" clients should be identified, estimating the mix of services they will need from RWHAP Part A, and allocating funds sufficient to meet those needs. Where a choice needs to be made between providing a wider range of services to more individuals and getting additional people into care, the Planning Council will give priority to getting more people key services (among them primary care and medications).

J. The Commission members will keep in mind current goals, objectives, and priorities from its **Comprehensive HIV Plan (CHP)** to be sure they receive appropriate attention in decision making.

Policy 09.5203 **:** Priority Setting and Resource Allocations (PSRA) Framework and Process
Last Revised: *May 12, 2011; (XX, XX 2024)*

PROCEDURE(S):

1. The priority setting process should consider services needed to provide and/or support a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services. Funding availability and unmet needs associated with these service priorities are considered during the resource allocation process.

2. The list of HRSA fundable service categories (core and support) and the definitions of these services will be presented by the Commission staff.

3. The list of HIV prevention categories from the most recently approved Prevention Service Standards will be presented by the Commission staff.

4. DHSP compiles service utilization reports (including, but not limited to, clients served, priority populations, expenditures per client), anticipated service delivery goals/objectives, expenditures reports, surveillance reports, prevention data (including, but not limited to, counseling and testing and PrEP and PEP utilization),and programmatic and fiscal challenges and opportunities for service improvements.

4. The PP&A Committee convenes a combined meeting with the Consumer Caucus during the first quarter of the year to:
   a) review process paradigms and operating values and provide feedback;
   b) review summary of findings from the most recent Ryan White Service Utilization Reports and HIV prevention data provided by DHSP;
   c) review most recent HIV prevention and care financial reports from DHSP; and
   d) review key goals, objectives and metrics from the Comprehensive HIV Plan, Ending the HIV Epidemic Plan, and other key pertinent documents; and
   e) harness feedback on service category priorities and allocations from consumers.

5. The PP&A Committee formally organizes focus groups at various provider stakeholder meetings or conducts provider surveys as needed to inform the PSRA process.

6. During July-August, the PP&A Committee deliberates and prioritizes services categories in rank order (highest need is #1 priority). The principal data and information used for priority-setting are the Comprehensive HIV Plan, relevant needs assessment, the HIV epidemiology report, fiscal and programmatic reports, and service utilization reports.
   a) The PP&A Committee only ranks service priorities once—regardless of funding scenario—as they indicate the services most needed regardless of changes in the funding picture or in which different resources available.
   b) The PP&A Committee compiles and/or reviews the data and feedback it has collected from DHSP, community listening sessions and/or surveys and reviews it in June, prior to service prioritization.

Commented [BC2]: For PP&A and Consumer Caucus discussion. Intended to engage consumers more in the PSRA process and increase knowledge/skills around using data, understanding the RWP/CDC-funded programs.

7. During July-August after the service categories have been ranked and prioritized, the PP&A Committee determines resource allocations for services:
   a) Allocations can be made by actual amounts or percentages based on specific expenditure proposals, although percentages allow more flexibility to respond to variances in the funding awards.
   b) Allocations may change in each of the selected funding scenarios.
   c) It is strongly encouraged that stakeholders who suggest funding allocations for specific service categories also present accompanying recommendations to advise how the continuum of care will accommodate those suggested modifications to funding levels.
   d) Additional streams of funding are identified in each service category, with amounts locally dedicated for HIV services where the information is available.
   e) The PP&A Committee, in collaboration with DHSP, compiles a resource inventory for allocation-setting, and uses it to help determine capacity and other resources when allocating funds.

8. The PP&A Committee recommends and secures approval for service priorities and funding allocations at the August or September Commission meeting, prior to the RWP Part A grant application submission deadline.

9. When a reallocation of funds is necessary, adequate data to support the movement of funds between service categories will be presented, considered, and fully documented in the minutes of the meeting during which the reallocation of funds is approved. Proposed re-allocations must be submitted to the Commission for approval. All changes in allocations must be accompanied with a written justification detailing the reasons for the modifications.

10. During the month (30 days) following the approval of resource allocations by Commission, the PP&A Committee will consider appeals regarding its PSRA process. Appeals must be presented to the PP&A Committee at its monthly meeting immediately following the Commission meeting in which the allocations were adopted. The following two types of appeals will be considered:
    a) new factual information that may have led to different decisions if the information had been available during the PSRA process, and/or
    b) questions or complaints about decision-making that did not conform to the process as outlined.

11. In October-November, the PP&A Committee compiles information and suggestions made throughout the PSRA process to further elaborate on its priority and allocation decisions by developing “directives.”
    a) These “directives” are framed as “guidance”, “recommendations”, and/or “expectations” and are intended to detail “how best to meet the need” or as “other factors to be considered” to be forwarded to DHSP the Commission and/or its various committees, and/or other stakeholders, as appropriate.

b) The guidance, recommendations and expectations further define minimum quality of care standards, implementation practices and/or mechanisms to respond to specific operational or system needs.
c) Once completed and approved by the PP&A Committee, the directives are forwarded to the Executive Committee and the Commission for approval.
d) The approved directives are transmitted to DHSP for consideration and implementation if deemed to be feasible by DHSP. DHSP will review the directives and report to the PP&A Committee which recommendations are feasible with a timeline for implementation.
e) DHSP shall provide periodic updates at PP&A Committee meetings.

12. In addition to its other business, the PP&A Committee devotes the intervening months between each year's PSRA process to further study identified service categories, populations and/or related planning issues, and implements committee activities accordingly to compile the necessary data.

NOTED AND APPROVED: _____ **EFFECTIVE DATE:** _____

Original Approval: May 1, 2011 *Revision(s): XX*

Policy 09.5203 **:** Priority Setting and Resource Allocations (PSRA) Framework and Process
Last Revised: *May 12, 2011; (XX, XX 2024)*

ATTACHMENTS
Paradigms and Operating Values
Status Neutral HIV and STI Service Delivery System Framework

Los Angeles County Department of Public Health Division of HIV and STD Programs Proposed Revisions to FY 2023 (PY 33) Allocations

APPROVED BY COH 06.08.23

	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**

		Allocations Approved by the Commission on HIV		Allocations Proposed by the Division of HIV and STD Programs						
	Service Category	**FY 2023 Approved Part A Allocations (approved 1/13/22)**	**FY 2023 Approved MAI Allocations (approved 1/13/22)**	**FY 2023 Part A Recommendation**	**RecommendedFY 2023 Part A %**	**FY 2023 MAI Recommendation**	**Recom-mended FY 2023 MAI %**	**Total FY 2023 Part A/MAI Recommended $**	**Recom-mended Total FY 2023 Part A/MAI %**	Notes
SERVICES (71.1%)	Outpatient/Ambulatory Medical Services	25.51%	0.00%	$ 7,033,345	18.59%	$ -	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.
	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%	0.00%	$ 6,658,822	17.60%	$ -	0.00%	**$ 6,658,822**	**16.19%**	No change.
	Early Intervention Services	0.00%	0.00%	$ 3,160,651	8.36%	$ -	0.00%	**$ 3,160,651**	**7.68%**	Allocation includes Linkage and Reengagement Program and new DPH Clinic Health Services program. Funding will help support a status-neutral approach using Part A funds.
	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.

CORE	Home and Community Based Health Services	6.78%	0.00%	$ 2,565,974	6.78%	$ -	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%	0.00%	$ 1,290,874	3.41%	$ -	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.
	Medical Nutritional Therapy	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Medical Case Management (MCC)	28.88%	0.00%	$ 9,162,605	24.22%	$ -	0.00%	**$ 9,162,605**	**22.27%**	Reduction in Part A allocation by to account addition of EIS, Out reach and EFA allocations and estimated YR 33 MCC expenditures.
	Substance Abuse Services Outpatient	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
ES (28.9%)	Case Management (Non-Medical) Benefits Specialty	2.44%	0.00%	$ 923,917	2.44%	$ -	0.00%	**$ 923,917**	**2.25%**	No change.
	Case Management (Non-Medical) TCM - Jails	0.00%	12.61%	$ -	0.00%	$ 417,154	12.61%	**$ 417,154**	**1.01%**	No change.
	Child Care Services	0.95%	0.00%	$ 360,299	0.95%	$ -	0.00%	**$ 360,299**	**0.88%**	No change.
	Emergency Financial Assistance	0.00%	0.00%	$ 1,569,808	4.15%	$ -	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.
	Food Bank/Home-delivered Meals	8.95%	0.00%	$ 3,386,813	8.95%	$ -	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%	0.00%	$ 220,719	0.58%	$ -	0.00%	**$ 220,719**	**0.54%**	No change.
	Housing Services TRCF	0.38%	0.00%	$ 145,065	0.38%	$ -	0.00%	**$ 145,065**	**0.35%**	No change.

Los Angeles County Department of Public Health Division of HIV and STD Programs Proposed Revisions to FY 2023 (PY 33) Allocations

SUPPORT SERVIC	Housing Services /Rental Subsidies with CM	0.00%	87.39%	$ -	0.00%	$ 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.
	Legal Services	1.00%	0.00%	$ 379,213	1.00%	$ -	0.00%	**$ 379,213**	**0.92%**	No change.
	Linguistic Services	0.65%	0.00%	$ 246,819	0.65%	$ -	0.00%	**$ 246,819**	**0.60%**	No change.
	Medical Transportation	2.17%	0.00%	$ 721,771	1.91%	$ -	0.00%	**$ 721,771**	**1.75%**	Part A allocation reduced due to estimated YR 33 expenditures
	Outreach Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Psychosocial Support Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	New Buddy Program is supported using EHE funds.
	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**		

LOS ANGELES COUNTY COMMISSION ON HIV
APPROVED ALLOCATIONS FOR
PROGRAM YEARS (PYs) 33 AND 34 (Approved by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

	FY 2022 RW Allocations (PY 32)[1]					FY 2023 RW Allocations (PY 33)[2]			FY 2024 RW Allocation (PY 34)[2]		
PY 32 Priority #	Core/ Support Services	Service Category	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI %[3]	Part A %	MAI %	Total Part A/ MAI %[3]
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
2	S	Non-MedicalCase Management - BSS/TCM/CM for new positives/RW clients	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
7	C	Mental Health Services	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
10	C	Early Intervention Services	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
11	S	Medical Transportation	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
12	S	Nutrition Support Food Bank/Home-delivered Meals	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
13	C	Oral Health Services	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
14	S	Child Care Services	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
15	S	Other Professional Services - Legal Services	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
18	C	Home Based Case Management	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
19	C	Home Health Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
20	S	Referral	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
22	S	Language	0.65%	0.00%	0.60%	0.65%	0.00%		0.65%	0.00%	
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
24	S	Rehabilitation	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
25	S	Respite Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
26	C	Local Pharmacy Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
27	C	Hospice	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
		Overall Total	**100.0%**	**100.00%**	**100%**	**100.0%**	**100.0%**	**0.00%**	**100.0%**	**100.00%**	**0.00%**

Footnotes:

1 - Service Category Rankings and Allocation Percentages Approved by the Commission on 09/09/2021

2 - PY 33 and 34 Allocation percentages approved by PP&A on 11/16/2021 and the Executive Committee on 12/09/2021

3 - To determine total percentages, funding award amounts for Part A and MAI must be known.

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Recommendations for Service Category Rankings
For Program Years (PY) 33 and 34

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1	1	1	Housing	S	Housing
			Permanent Support Housing		
			Transitional Housing		
			Emergency Shelters		
			Transitional Residential Care Facilities (TRCF)		
			Residential Care Facilities for the Chronically Ill (RCFCI)		
2	2	2	Non-Medical Case Management	S	Non-Medical Case Management Services
			Linkage Case Management		
			Benefit Specialty		
			Benefits Navigation		
			Transitional Case Management		
			Housing Case Management		
3	3	3	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
			Medical Subspecialty Services		
			Therapeutic Monitoring Program		
4	4	4	Emergency Financial Assistance	S	Emergency Financial Assistance
5	5	5	Psychosocial Support Services	S	Psychosocial Support Services
6	6	6	Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
7	7	7	Mental Health Services	C	Mental Health Services
			MH, Psychiatry		
			MH, Psychotherapy		

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
8	8	8	Outreach Services	S	Outreach Services
			Engaged/Retained in Care		
9	9	9	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
10	10	10	Early Intervention Services	C	Early Intervention Services
11	11	11	Medical Transportation	S	Medical Transportation
12	12	12	Nutrition Support	S	Food Bank/Home Delivered Meals
13	13	13	Oral Health Services	C	Oral Health Care
14	14	14	Child Care Services	S	Child Care Services
15	15	15	Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
16	16	16	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
17	17	17	Health Education/Risk Reduction	S	Health Education/Risk Reduction
18	18	18	Home Based Case Management	C	Home and Community Based Health Services
19	19	19	Home Health Care	C	Home Health Care
20	20	20	Referral	S	Referral for Health Care and Support Services
21	21	21	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
22	22	22	Language	S	Linguistics Services

Approved PY 32(1)	PY 33(2)	PY 34(2)	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
23	23	23	Medical Nutrition Therapy	C	Medical Nutrition Therapy
24	24	24	Rehabilitation Services	S	Rehabilitation Services
25	25	25	Respite	S	Respite Care
26	26	26	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27	27	27	Hospice	C	Hospice

Footnote:
1 – Service rankings approved 9/09/2021
2 – PY 33 & 34 Executive Committee Recommendations approved 11/16/2021 and Executive Committee Approved 12/09/2021

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under...an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals
Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care
Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

See also Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.