LOS ANGELES COUNTY
COMMISSION ON HIV

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Consumer Caucus
Virtual Meeting

Be a part of the HIV movement

Thursday, June 10, 2021
3:00pm to 4:30pm (PST)

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

TO JOIN BY COMPUTER, REGISTER NOW:

https://tinyurl.com/62akuv4e

Event number + Access Code: 145 165 7947

Meeting password: CAUCUS

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1+415-655-0001

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LOS ANGELES COUNTY
COMMISSION ON HIV

CONSUMER CAUCUS (CC) VIRTUAL MEETING AGENDA

THURSDAY, JUNE 10, 2021
3:00 PM – 4:30 PM

TO JOIN BY COMPUTER: https://tinyurl.com/62akuv4e
Meeting password: CAUCUS
TO JOIN BY PHONE: 415.655.0001 **ACCESS CODE:** 145 165 7947

I.	Welcome & Introductions (Co-Chairs)	3:00pm - 3:05pm
II.	COH Meeting Debrief	3:05pm – 3:15pm
III.	Staff Report/Commission Updates	3:15pm - 3:20pm
IV.	Co-Chair Report a. Co-Chair Vacancy b. 2021 Priorities/Workplan Updates + Review	3:20pm - 3:25pm
V.	Discussion: • Revisiting STD Response and Appeal to the Board of Supervisors • Develop Consumer-focused Priorities/Recommendations for Commission • Planning, Priorities & Allocations (PP&A) Committee Updates: ○ Priority Setting and Resource Allocations (PSRA) Review: Ryan White Program Year 30 expense report, paradigms and operating values, service rankings and program directives	3:25pm – 4:25pm
VI.	Announcements	4:25pm-4:30pm
VII.	Adjourn	4:30pm

LOS ANGELES COUNTY COMMISSION ON HIV

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CONSUMER CAUCUS

Meeting Summary for 5.13.21

Attendance may be verified with Commission staff

1. **Welcome + Introductions + Check In**
   Co-Chair Alasdair Burton opened the meeting and led introductions.

2. **COH Meeting Debrief**
   Caucus shared a consensus that the COH meeting was too long but understood there is a lot of information to cover and discussions needing to be held as a result. It was noted that the COH hadn't received "real data" in quite some time, referring to DHSP's surveillance report and HealthHIV's presentation on Commission effectiveness assessment findings, and that it would take some time to digest and unpack the information and formulate next steps in response.

   Concerns were expressed in reaction to the surveillance report and the impact COVID has had on HIV and STIs. Additionally, it was noted that gay men and meth are again becoming the drivers of the epidemic and that continued collaboration with The Walls Las Memorias on their Act Now Against Meth campaign must be a priority.

3. **Staff Report/Commission Updates**
   Dawn Mc Clendon, Commission staff, provided a brief update on key Commission activities:
   - County/Commission Operations. Cheryl Barrit, Executive Director, continues to work with the Board of Supervisor's Executive Office in assessing the readiness of return to in-person work and County reopening and will keep the Commission updated on its progress.
   - HealthHIV Findings. The findings were presented by HealthHIV today at the COH meeting and staff and leadership will work with the committees and working groups to develop next steps and implementation.
   - Ending the HIV Epidemic (EHE)/COH Liaison. As announced earlier at the COH meeting, Bridget Gordon, Co-Chair, will serve as the primary Commission liaison to the DHSP EHE Steering Committee, with Katja Nelson, Kevin Stalter, and Felipe Findley serving as backups. The liaison team represents a diverse set of perspectives and community experience. The liaisons will work as a team and serve as a conduit of information and collaborative opportunities between the Commission and Steering Committee.

4. **Co-Chair Report**

   Co-Chair Vacancy. Co-Chairs reminded the group that a 3rd co-chair seat remains vacant and encouraged those interested to self-nominate or if they know someone who might be interested and eligible, to nominate them.

5. **Legal Needs Assessment Recruitment + Participation**

   Laurie Aronoff, Project Coordinator, AIDS Legal Services Project, Los Angeles County Bar Association and Indira Cameron Banks, Inner City Law Center, announced a HIV Legal Needs Assessment study will be implemented in Los Angeles County (LAC), funded by the California Department of Public Health, Division of HIV and STD Programs (DHSP). The study will identify the unmet legal needs and greatest barriers to service for the most vulnerable people living with HIV in LAC. Results will include recommendations on how best to address these issues. It was noted that legal services are a part of the HIV continuum of care and previously, there had not been a lot of consumer involvement in developing or even aware of legal services in the past. To that end, L. Aronoff indicated that they will be recruiting a diverse group of people living with HIV to form a Community Advisory Committee (CAC) and encouraged Caucus members to participate when recruitment begins. The CAC will require a 6-month commitment.

   The Caucus requested that a one-page recruitment flyer be developed and forwarded to the Caucus co-chairs and COH staff for review. Caucus suggested that this information be disseminated widely, via providers and various HIV service organizations. Additionally, it was recommended that the Inner City Law Center and other legal service providers for people living with HIV be included in the 211LA database and HIV Connect; staff will follow up.

   L. Aronoff and I. Cameron Banks agreed to return to the Caucus at a future meeting to engage in a fuller discussion around legal services and people living with HIV.

6. **Parliamentary Training: How We Run Our Meetings.**

   Jim Stewart, Parliamentarian, provided the last session of the parliamentarian training 101 series; refer to PowerPoint (PPT) slides in meeting packet for more information.

7. **DISCUSSION:**

   - **2021 Priorities/Workplan Updates + Review.**

     Caucus engaged in a robust discussion regarding refocusing the Commission's efforts around the consumer and shared that the HealthHIV findings prepared a framework of how to recenter the Commission's work around the people living with HIV. The Caucus agreed that the next meeting be dedicated to developing a list of consumer-focused priorities/recommendations for the Commission's consideration and implementation, using HealthHIV findings as the framework. It was also suggested that a list of Commission accomplishments be incorporated. Members are

encouraged to submit their recommendations ahead of the June meeting to B. Gordon and/or D. Mc Clendon.

- **NMAC BLOC Training: Revised training dates; determine schedule**
  D. Mc Clendon shared that after staff's review of the Commission's calendar, the NMAC Building Leaders of Color (BLOC) training for consumers would be best slated for September 13-17. The Caucus agreed.

- **Planning, Priorities & Allocations (PP&A) Committee Updates: Priority Setting and Resource Allocations (PSRA) Review: Ryan White Program Year 30 expense report, paradigms and operating values, service rankings and program directives**
  Postponed to June's meeting.

- **Social Determinants of Health Presentation.** C. Barrit will provide more information at the June meeting.

8. **Public Comment + Announcements** None.
9. **Adjournment**

LOS ANGELES COUNTY
COMMISSION ON HIV

Consumer Caucus Workplan 2021

(6.10.21; updates reflected in red italics)

PURPOSE OF THIS DOCUMENT: To identify activities and priorities the Consumer Caucus will lead and advance throughout 2021.
PRIORITIZATION CRITERIA: Select activities that 1) represent the core functions of the COH and Caucus, 2) advance the goals of the local Ending the HIV (EHE) Plan, and 3) align with COH staff and member capacities and time commitment.
CAUCUS RESPONSIBILITIES: 1) Facilitate dialogue among caucus members, 2) develop caucus voice at the Commission and in the community, 3) provide the caucus perspective on various Commission issues, and 4) cultivate leadership within the caucus membership and consumer community.

#	Activities & Lead/Champion(s)	Priority Level (High, Medium, Low)	Approach/Comments/Target Deadline
1	Foster and nurture consumer (both PLWH and HIV-negative) leadership and empowerment in COH and community	High	• Trainings, meeting debriefs and Q&As to be determined by Consumer Caucus and weaved into Consumer Caucus meetings. • *NMAC BLOC training confirmed for September 13-17; more details to follow.*
2	Increase consumer participation at Consumer Caucus/COH meetings, especially individuals from the Black/African American, Latinx, youth, and indigenous communities.	High	• Work with community advisory boards. Explore follow-up opportunities to the CAB conference held in 2019. • Use testimonials from members and use in social media-based recruitment. Staff emailed Commissioners on 2/2/21 to solicit testimonials. No replies received as of 2/18/21. • Encourage consumers to attend caucuses and task forces first as those meetings may be less intimidating than full body or Committee level meetings. • Develop outreach tracking form that Commissioners will use to what events they attended to promote the COH and consumer participation. C. Moreno to share draft template for consideration.
3	Support/partner with Black/African American Community Task Force (BAAC TF), Women's Caucus, Transgender Caucus and Aging Task Force to develop a more coordinated and collaborative planning agenda for consumers from all priority communities on the COH.	High	• Host an "all Caucus/Task Force" meeting to combine planning efforts for consumers from all priority communities. ○ Schedule an "all Co-Chair" meeting to brainstorm and develop agenda. Meeting took place on March 9. Follow up/next steps to be determined. • Help implement BAAC TF, WC and ATF recommendations. • Work with ATF *and Women's Caucus* to coordinate an activity for Long Term Survivors Day (June 5); activity can be leveraged to build consumer-led coalitions. • "All Caucus" Co-Chairs met and determined that "All Caucus" efforts be placed on hold until LAC Human Relations Commission training has concluded.

4	Increase integration of consumer voice into all COH Committees		• *Develop list of consumer-focused priorities/recommendation for Commission consideration/implementation.* • Encourage consumers (including non-COH members) to attend COH Committee meetings. Attendance at meetings may incite consumers to apply to the COH or as Committee members. *Ask Committee and other subgroups to attend Consumer Caucus meetings.* • Encourage at least two consumers attend each Committee and subordinate work group meetings as champions and representatives for CC and report back to CC. • Encourage more consumers to apply to the COH. • Consumer voices should drive the COH agenda. • Provide feedback on updated membership application to create a more consumer friendly format and use as a recruitment tool for consumers • Encourage providers to support and promote consumer participation at COH meetings.

LACBA AIDS Legal Services Project

INNER CITY LAW CENTER 40 YEARS

HIV Legal Needs Assessment
Community Advisory Committee Information Sheet

The Assessment

An HIV Legal Needs Assessment study will be implemented in Los Angeles County (LAC), funded by the California Department of Public Health, Division of HIV and STD Programs. The study will be led by Laurie Aronoff (LACBA AIDS Legal Services Project) and Indira Cameron-Banks (Inner City Law Center). The study will identify the unmet legal needs and greatest barriers to service for the most vulnerable people living with HIV in LAC. Results will include recommendations on how best to address these issues. During the first phase of the study, we seek to recruit a diverse group of people living with HIV to form a Community Advisory Committee ("CAC").

Assessment Design

Designing and implementing a legal Needs Assessment is an investment in resources and time. Designing the assessment with input from the CAC will strengthen the study. With help from the CAC, we look to engage members of the broader community and reach people who are the most vulnerable and directly impacted by unmet legal needs.

Role of the CAC

The CAC will consist of consumers who have agreed to take a leadership role in developing the Needs Assessment. We are seeking 8-10 members to help tailor this study to reach diverse communities impacted by HIV. CAC members will provide feedback on outreach strategies and survey tools. We also plan to hold remote focus group discussions with both providers and consumer groups and want individual CAC members to actively participate in at least two of these guided discussions. It is anticipated that members will be on camera unless prevented by specific circumstances (such as a computer without a camera).

Responsibilities of the CAC

CAC membership is an approximately seven-month commitment from June-December 2021. We anticipate the overall hourly commitment to be approximately ten hours. Volunteers will receive a $50 gift card for attending each meeting to encourage active engagement. One of the primary responsibilities of the CAC is to help ensure cultural humility throughout the Needs Assessment process including a review of the study materials. We anticipate four meetings to be held remotely including an initial introductory meeting to help inform the study, two discussions with consumer groups and a final meeting to discuss findings.

Interested?

Your voice is important! Let it be heard and make an impact in your community. If you are interested in participating in the CAC, please reach out to Laurie Aronoff through email at laronoff@lacba.org or by phone at 213-833-6776. Laurie can answer your questions and provide more details if needed.

Los Angeles Commission on HIV

HIV Planning Assessment

Technical Assistance for HIV Planning

May 13, 2021

HealthHIV
www.healthhiv.org

INTEGRATED HIV/AIDS PLANNING IHAP TA CENTER

HealthHIV Team

Marissa Tonelli
Director of Health Systems Capacity Building

Eve Kelly
Senior Capacity Building Coordinator

Axum Taylor
Capacity Building Intern

HealthHIV

Assessment Goal and Today's Meeting

- Assessment Goal: Provide an external assessment of the LAC COH to determine the effectiveness of the planning body structure, bylaws, policies, and procedures.

- Today's Meeting: Present findings from assessment with full membership to discuss what the data means for the COH and brainstorm suggestions for how to improve the Commission moving forward.

Vision Exercise

Imagine it is one year from today… A large statewide newspaper arrives on your doorstep with a headline about the HIV epidemic in LA County.

What would you like it to say?

Assessment Process

Step 1
Review COH's Documents

Step 2
Full Membership Survey + 6 Key Informant Interviews

Step 3
Present Findings to Members + Provide Final Report

Assessment Goal and Today's Meeting

What does it mean to have an effective planning body?

What are your current markers or measures of effectiveness?

What you and your peers say about measures of effectiveness:

- Data should be used to guide planning
- Community feedback should be incorporated into planning
- Updates on progress should be shared regularly at meetings and in reports to the community
- Priorities should be streamlined to be clear and focused rather than overly complicated

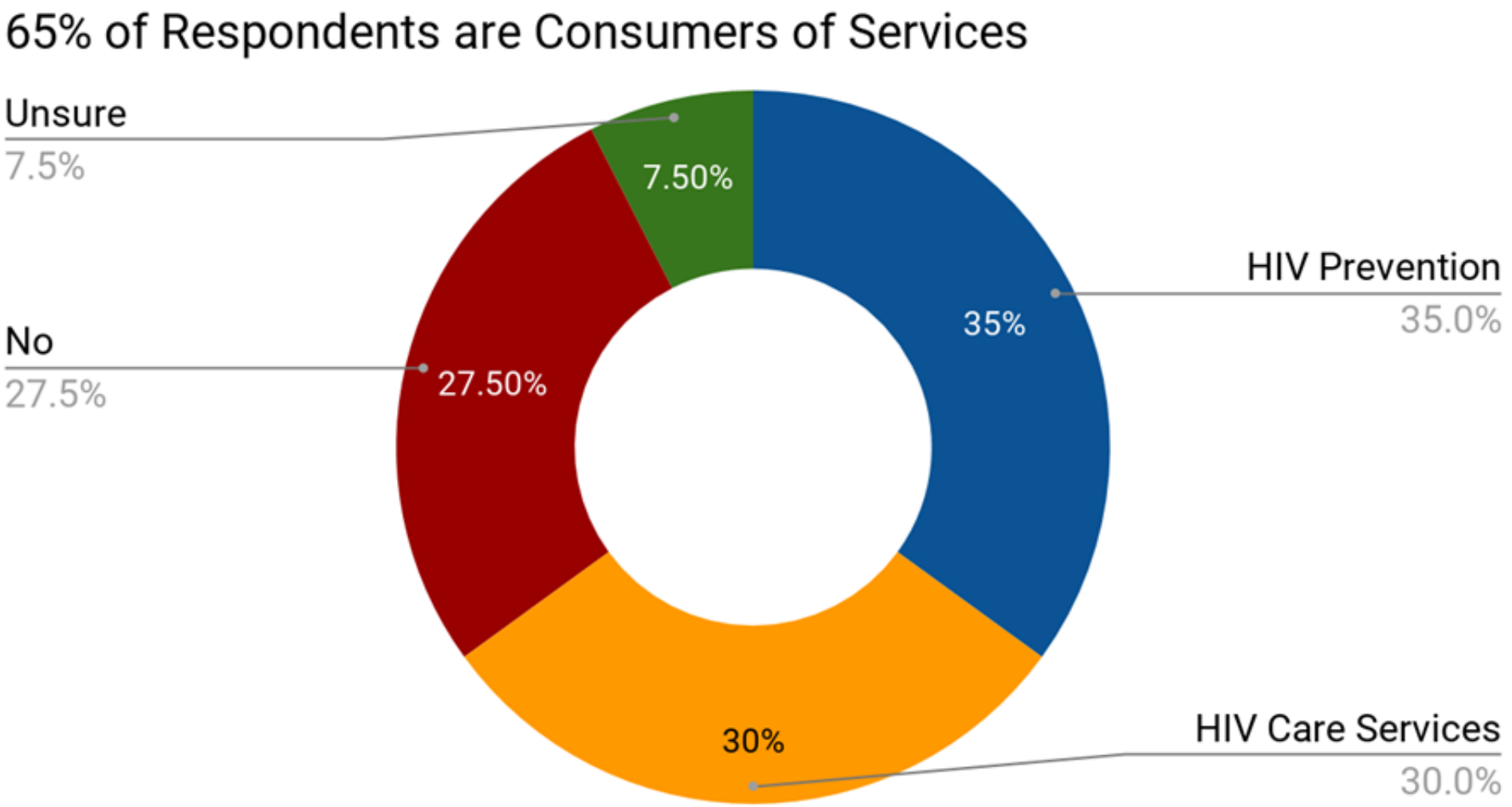
Defining Effectiveness

For this assessment, we define effectiveness as:

How well the planning body's structure, policies and procedures, and consumer engagement supports its ability to carry out its mission and objectives.

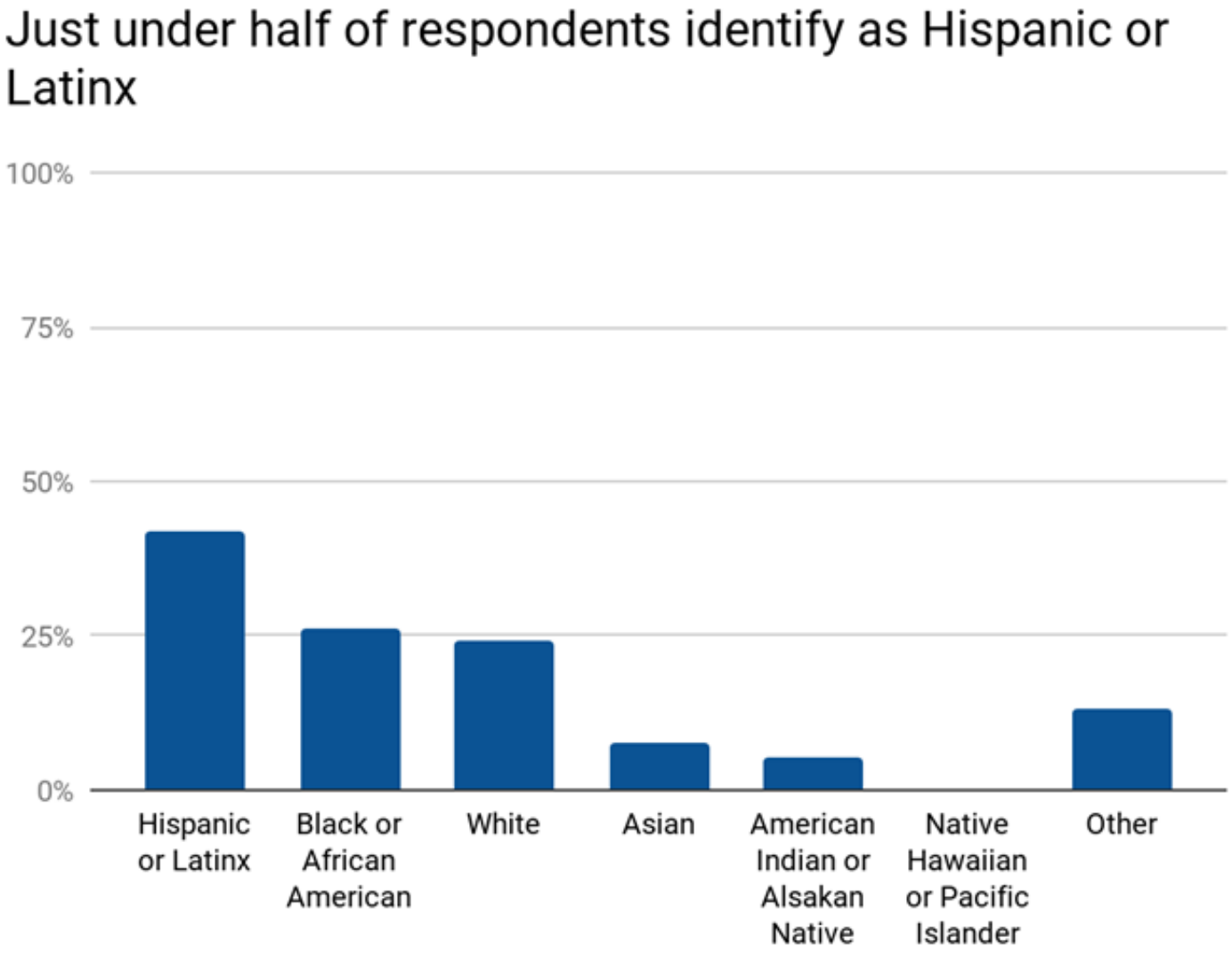
Summary of Findings

Who are the respondents?



HealthHIV

Who are the respondents?



HealthHIV

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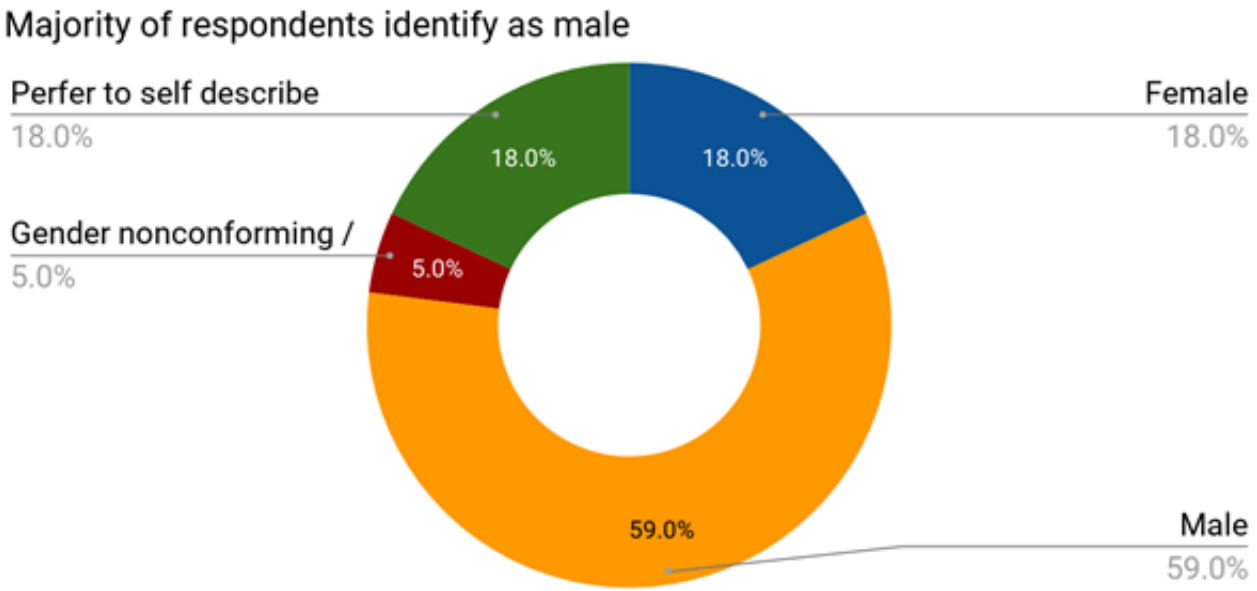
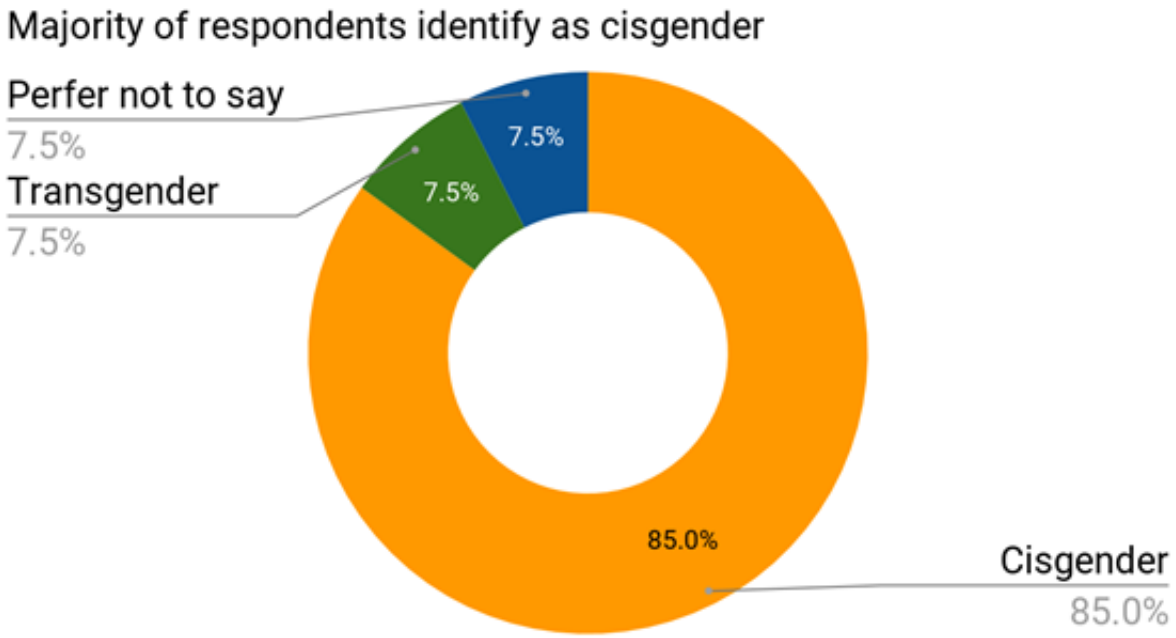




HealthHIV

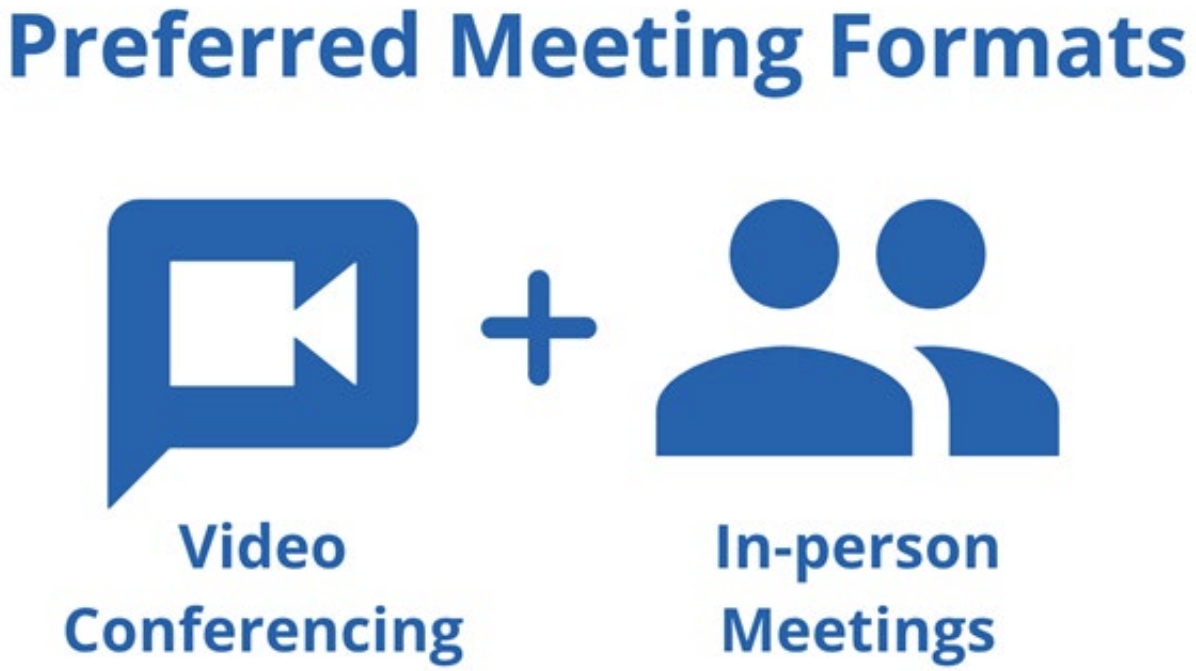
How well does the COH accomplish HIV planning priorities?

More than 60% think the COH adequately...	Fewer than 40% think the COH adequately...
• Uses data to support decision-making • Keeps track of local and/or state health department HIV/AIDS activities • Addresses disparities linked to social determinants of health • Assesses the efficient administration of HIV funds	• Effectively communicates with outside partners and stakeholders • Effectively communicates with the communities impacted by the epidemic in LA County

COH Structure and Function

How respondents like to meet

- Most respondents prefer having meetings via video conferencing while social distancing
- Most respondents want to have in-person meetings again once it is safe
- Many respondents proposed to have a hybrid option if meetings return to in-person



Barriers to Meeting Efficiency

- Agendas are too packed to accomplish the outlined tasks in the set amount of time (44%)
- Meetings are too long to keep members engaged (32%)
- Too many off topic conversations in meetings (25%)
- Too much time on agendas allocated to some things and not to others (24%)
- Meetings are dominated by a few voices (24%)
- Challenge of navigating formal policies and procedures (write-in)
- Adapting to the virtual platform (write-in)
- Finding time to attend long meetings during the workday, especially for unaffiliated consumers (write-in)
- Repetitive use of meeting time to discuss social issues, including racism and cultural bias, rather than take action (write-in)

Barriers to Individual Participation in Meetings

- Distraction due to a feeling of tension and strained relationships among members (46%)
- Feeling uncomfortable speaking as someone with less experience in HIV planning (32%)
- Lack of confidence in their understanding of how the COH operates (24%)
- Feeling that some members are condescending or do not speak in inclusive ways (20%)
- Feeling that consumer input is not valued by providers (write-in)
- Feeling that racism and misogyny at meetings goes unchecked (write-in)

What do you think of the barriers people listed? Are there any you would add?

Write in the chat or unmute yourself

Suggestions for Reducing Barriers

- Move to a consensus based model or re-introduce one or two item parliamentary trainings at full commission meetings
- Make meetings shorter and reducing the amount of items on the agenda
- Prioritize socializing between members by making time for people to get to know one another
- Increase the collaboration between committees and integrate the caucasus more fully into the committee work
- Clarify the purpose, goals, and expected deliverables of the caucuses and taskforces
- Offer more support and training for new members
- Translate the meeting notice and agenda into Spanish for all caucus, taskforce, committee, and commission meetings
- Establish a permanent remote option for meeting participation

1. What do you think of these suggestions?
2. Are there any you would like to prioritize?
3. Are there any you would add?

Write in the chat or unmute yourself

Views on Membership and Engagement

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Incorporation of Community Voices

- The majority of respondents think that the COH incorporates community voices into planning somewhat well (51%) or very well (20%)

- 15% think this is done somewhat poorly.

Suggestions for Engaging More Community Voices

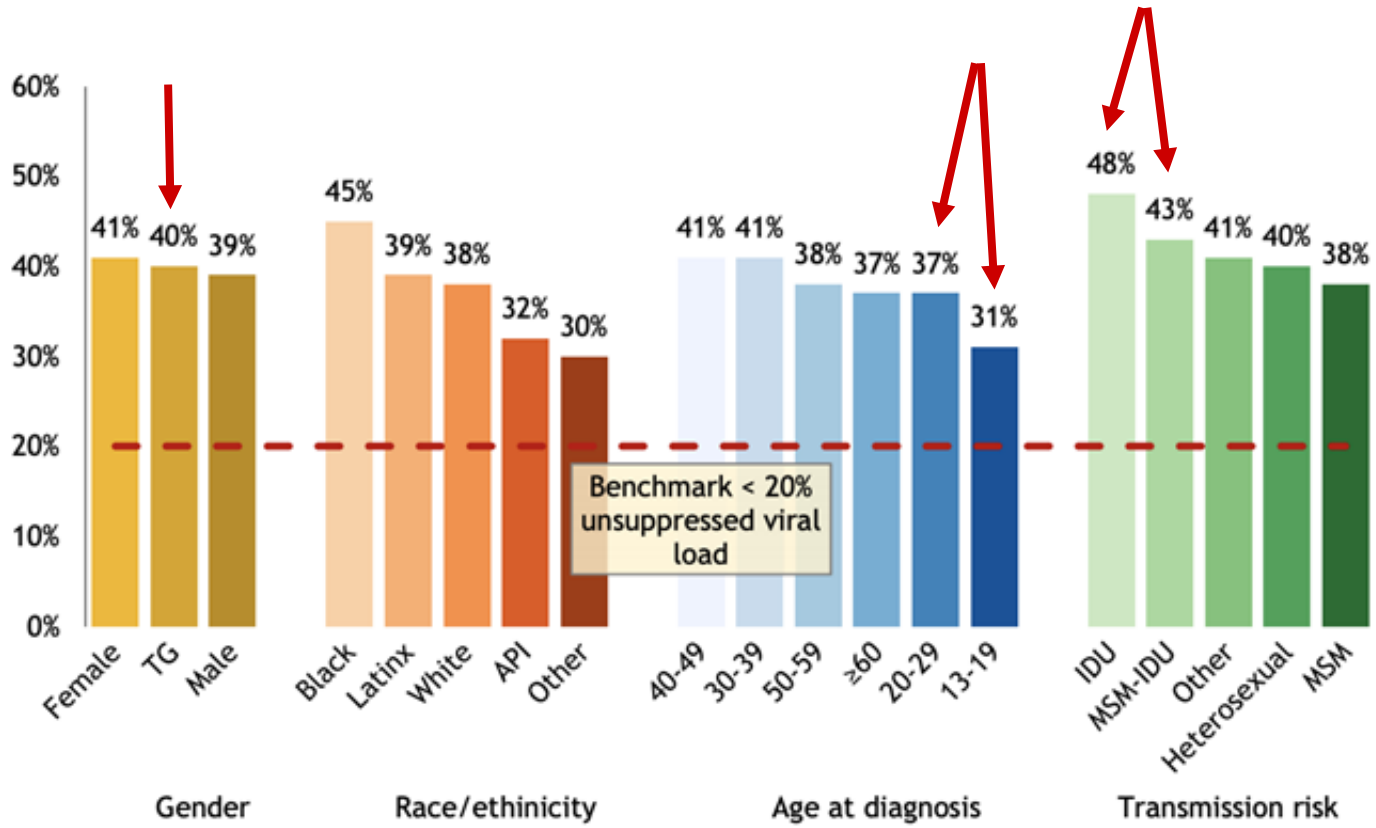
- Hosting meetings in communities of color
- Collaborating with organizations and activists that address the inequities impacting HIV
- Increasing outreach efforts and COH's visibility
- Intentionally welcoming community members and consumers at the start of each meeting and incentivise them to return to meetings
- Addressing technological and other barriers that prevent community members from joining and participating in meetings
- Asking providers to inform their clients about the COH
- Diversifying and providing further support and training to the consumer caucus
- Discuss the best timing/format for public comment during meetings

Gaps in Representation

Less than 10% of respondents (ranged from 0-3 people) identify as:

- Transgender people
- People who injects or formerly injected drugs
- People with viral hepatitis
- Youth (30 or younger)
- People who have engaged in sex work

Figure 38: Unsuppressed viral load[1] by selected demographic and risk characteristics among persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019



Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2019. Published May 2020. http://publichealth.lacounty.gov/dhsp/Reports.htm. Accessed May 2021.

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Gaps in Representation

Respondents listed a lack of representation of the following identities or experiences among members:

- People experiencing homelessness
- Asian people
- Black women
- People who speak Spanish
- People with children
- Medical providers
- People with amphetamine use disorder
- Mental health professionals
- People with managed care experience
- Medi-Cal representatives
- Indigenous/Native American people
- Biostaticians

Reducing Gaps in Representation

1. What would you do to engage more people from communities most impacted by the epidemic in LA?

1. What are your thoughts on improving recruitment efforts?

Write in the chat or unmute yourself

Recruitment and Orientation

- Most respondents said that they thought orientation prepared new members to fully participate in the meetings either well (39%) or fairly well (34%).
- More than half of the respondents agreed that the COH actively engages new members into planning activities in the first one to two months following orientation (51%).
- Remaining challenges:
  - Large learning curve for new members
  - Need to further develop and clarify mentorship program

Suggestions for Improving Orientation

- Institute a training period before transitioning to full membership
- Break the orientation down into more than one meeting
- Prioritize social time among members
- Set clear expectations for mentors

Suggestions for Improving Mentorship

How would you like to see the mentorship program improved?

Write in the chat or unmute yourself

The COH's Impact on the Epidemic in LAC

- Provides a platform for community engagement
- Educates consumers, planners, and providers
- Identifies gaps in care and plans for equitable distribution of resources
  - Makes a conscious effort to address systemic racism and make the commission BIPOC led
- Holds County/DOH accountable for implementing the Ryan White and HOPWA programs
  - Critiques policies impacting HIV
- Creates standards for HIV services providers

Strategies for increasing the impact of the COH

- Practicing better time management in meetings;
- Incorporating more consumer input into planning and increasing promotion of the COH and its work to the community;
- Updating the website and remote meetings to be more interactive;
- Increasing representation of consumers and other impacted communities in the membership (i.e. women, transgender people, youth);
- Using plain language and reducing unnecessary protocols for participation
- Integrating taskforce work throughout the committees; and
- Expanding oversight of prevention and STD funding programming.

Suggested Training Needs

Respondents expressed interest in receiving trainings on:

- Committee structure
- Parliamentary procedures
- Robert's Rules
- Meeting management
- Consensus based facilitation
- Increasing virtual meeting engagement
- Team building
- Incidence vs prevalence
- Public speaking
- Field work
- Critical thinking
- Terminal illness
- Gender pronoun use
- History of the HIV epidemic in LA County
- Health inequities

Suggestions for Additional Training

What other trainings do you think the group would benefit from?

Write in the chat or unmute yourself

Key Takeaways from the Assessment

Areas of Strength	Areas for improvement
• Membershing brings region specific knowledge, lived experience, and a variety of perspectives • Provides structure to reach the community • Provides resources on the current state of HIV prevention and care • Regularly evaluates the plan and effectiveness and accessibility of services • Pushes county partners to improve efficiency and reduces burdens on consumers	• Streamline priorities and meeting agendas and protocol • Clarify and/or integrate caucus and taskforce activities into committees • Increase representation of highly impacted communities on the COH • Reduce barriers for participation in meetings (increase accessibility and training for new members) • Strengthen relationships between members

Reactions

1. What questions do you have about the data?

1. What were you most or least surprised by?

Write in the chat or unmute yourself

Reactions

Where would you like to see the COH go in the next few years?

If you feel comfortable, share your newspaper headline from the beginning!

Write in the chat or unmute yourself

Wrap Up and Next Steps

Stay tuned for final report

Questions or Concerns?

Contact:

eve@healthhiv.org
axum@healthhiv.org

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October 9, 2020

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

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

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

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

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

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

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

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

The 2019 HIV Surveillance Report notes following areas of disparities:

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

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

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

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

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

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

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

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

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

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

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

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

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

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

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

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

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

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

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

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

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

Black/African American Trans Women:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

Endnotes

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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September 24, 2020

Mario J. Pérez, MPH, Director
Division of HIV and STD Programs (DHSP)
Department of Public Health, County of Los Angeles
600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005

Dear Mr. Pérez:

This letter assures that the Los Angeles Commission on HIV (Commission), Los Angeles County's Ryan White Part A Planning Council (PC), has addressed the following items in accordance with the Fiscal Year (FY) 2021 Ryan White Part A application guidance:

a) The Commission can attest that Conditions of Award for 2020 were addressed and met by DHSP. The FY 2020 Part A and MAI Allocation Table, indicating the priority areas established by the Commission was submitted to HRSA, along with the letter of concurrence from the PC Co-Chairs endorsing priorities and allocations. A roster containing information about the members of the Commission and the representativeness table was also submitted as part of the Program Submissions requirement.

b) For PY 30 (Year 2020), the Commission ranked the following as the top ten Ryan White Part A service categories: 1) ambulatory outpatient medical 2) housing; 3) mental health; 4) medical care coordination; 5) outreach; 6) health education/risk reduction; 7) early intervention; 8) emergency financial assistance; 9) medical transportation; and 10) non-medical case management. Through the financial and programmatic reports provided to the Commission by the DHSP for Fiscal Year (FY) 2020 Formula, Supplemental, MAI and other funding sources awarded to the Los Angeles County Eligible Metropolitan Area (EMA), the Commission can attest that financial resources were expended according to the priorities established by the Commission. The Commission understands and supports efforts made by DHSP to maximize Part A and minimize underspending for MAI funds.

c) The Planning, Priorities and Allocations (PP&A) Committee leads the annual priority and allocation setting process for the Commission. Because of the profound impact of COVID-19 on the community and deployment of staff to COVID response activities, the Commission used the following data sources to help inform the FY 2021 priority setting process: 1) Program Year (PY) 29 and first quarter PY 30 Ryan White Service Utilization data; 2) COVID-19 DHSP Provider Survey; 3) COVID-19 Community Survey; 4) program expenditures information; 5) impact of COVID-19 on the County contracting and procurement process; and 6) Part D service utilization data for women ages 18 and over. For Program Year (PY) 31 (Year 2021), the Commission ranked the following as the top ten Ryan White Part A service categories: 1) housing; 2) ambulatory outpatient medical; 3) non-medical case management; 4) emergency financial assistance; 5) psychosocial support; 6) medical care coordination; 7) mental health; 8) medical transportation; 9) early intervention; and 10) outreach. The PY 2021 service rankings were determined under the assumption that the impact COVID-19 public health crisis will persist and will continue to have profound impact on the County and the nation. We speculate that Ryan White services will see an increase in patients as more people lose their jobs and that the affordable housing and homelessness crises will worsen. These recommendations were approved by the full body on September 10, 2020 with the understanding the Commission will need to work with DHSP to

continually track and monitor service needs, all funding sources, and respond accordingly. Regular and timely sharing of expenditures information is a critical piece of the resource allocation process. With the opportunities presented by the national Ending the HIV Epidemic initiative, the Commission will work with DHSP to ensure that EHE-related spending plans are shared with the planning council as these funds will help advance our local goals of ending HIV and must be taken into account in our decision making process.

d) The Commission has established an ongoing comprehensive training and mentorship program for its members, which includes information about the Los Angeles County ordinance establishing the Commission, the Ryan White Program and Part A specifically, the Planning Council legislative authority, committees and Brown Act training. New member orientations are held within a month of membership approval from the Board of Supervisors and the all member annual training was held on October 10, 2019. A make-up session was held on March 5, 2020. New members also received an additional one-hour orientation on their primary committee assignment. Because of COVID-19, the Commission established a series of virtual training for PC members and the public from September 2 to November 19, 2020.

   To foster leadership among unaffiliated consumers, the Consumer Caucus has received additional training targeted to their interests and priority topics. On 4/24/19, the Consumer Caucus received training on "How to Turn Data into Action" from the UCLA. The group also received a public speaking training and quality improvement training from DHSP on 5/9/19; Community Engagement Skills and Strategies: Special Focus on the Important Role of Consumers in the Priority-Setting and Resource Allocations Process on 7/11/19; and Trauma-Informed Care and HIV on 9/12/19. PC staff deliver the training or collaborate with local partners to customize training sessions during regular Consumer Caucus meetings. Unaffiliated consumers on the PC regularly attend local HIV community advisory boards and Service Planning Network meetings throughout the county to share information about the work of the PC and to also bring back critical information about client needs and services to the PC to help inform their discussions and promote service coordination and resource sharing.

   PP&A Committee members also receive training throughout the year during standing meetings on the priority setting and resources allocation process. The purpose of the three hour all member training held in October is to provide a refresher on the roles and responsibilities of the Commission as an integrated HIV prevention and care planning council. To ensure that consumers fully understood the PY 31 recommendations, the PP&A Co-Chairs and DHSP staff meet with the Consumer Caucus on August 28, 2020 to review the allocations table and answer questions regarding how the PP&A Committee arrived at their recommendations. The PSRA process is important and complex and an ongoing training on the decision-making process and will be integrated at all Consumer Caucus meetings to increase parity in knowledge, comfort level among consumers and providers.

   In addition to these formal trainings, staff provide ongoing coaching and support for PC members. "Member" and "Library" tabs have been added to the Commission website so that PC members and interested applicants can access training materials online. A series of virtual trainings for Commissioner and members the public will begin in late August 2020.

If you have any questions or need further assistance, please do not hesitate to contact us at 213.738.2816.

Sincerely,

Bridget Gordon, Co-Chair, Los Angeles County Commission on HIV

Alvaro Ballesteros, Co-Chair, Los Angeles County Commission on HIV

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG VALUES
(APPROVED JANUARY 19, 2021)

PARADIGMS (Decision-Making)

- Compassion: response to suffering of others that motivates a desire to help
- Equity: Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically. [1]

OPERATING VALUES

- Efficiency: accomplishing the desired operational outcomes with the least use of resources
- Quality: the highest level of competence in the decision-making process
- Advocacy: addressing the asymmetrical power relationships of stakeholders in the process
- Representation: ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process
- Humility: Acknowledging that we do not know everything and need to listen carefully to others.

[1] Based on the World Health Organization's (WHO) definition of equity.

LOS ANGELES COUNTY COMMISSION ON HIV
RYAN WHITE PY 31 (FY 2021) REVISED ALLOCATION -MOTION #5

	RW Service Allocation Descriptions	FY 2021 PY 31 Approved 09/10/2020		Revised Allocation PY 31 (FY 2021) (1)	
PY 31 Priority #	Service Category	Part A %	MAI %	Part A %	MAI %
2	Outpatient/Ambulatory Health Services (AOM)	26.38%	0.00%	27.21%	0.00%
NP	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	0.00%	0.00%
26	AIDS Pharmaceutical Assistance (local)	0.00%	0.00%	0.00%	0.00%
12	Oral Health	15.10%	0.00%	13.04%	0.00%
9	Early Intervention Services	0.00%	0.00%	0.59%	0.00%
21	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	0.00%	0.00%
19	Home Health Care	0.00%	0.00%	0.00%	0.00%
18	Home and Community Based Health Services	7.67%	0.00%	6.70%	0.00%
27	Hospice Services	0.00%	0.00%	0.00%	0.00%
7	Mental Health Services	0.75%	0.00%	0.60%	0.00%
23	Medical Nutritional Therapy	0.0%	0.00%	0.0%	0.00%
6	Medical Case Management (MCC)	34.69%	0.00%	29.83%	0.00%
18	Substance Abuse Services Outpatient	0.0%	0.00%	0.0%	0.00%
3	Case Management (Non-Medical) BSS/TCM	3.81%	9.25%	5.91%	10.53%
13	Child Care Services	0.00%	0.00%	1.00%	0.00%
4	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%
11	Food Bank/Home-delivered Meals	7.95%	0.00%	5.94%	0.00%

LOS ANGELES COUNTY COMMISSION ON HIV
RYAN WHITE PY 31 (FY 2021) REVISED ALLOCATION -MOTION #5

		FY 2021 PY 31 Approved 09/10/2020		Revised Allocation PY 31 (FY 2021)	
PY 31 Priority #	**Service Category**	**Part A %**	**MAI %**	**Part A %**	**MAI %**
17	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%
1	Housing Services RCFCI/TRCF/Rental Subsidies with CM	1.15%	90.75%	1.56%	89.47%
14	Legal Services	0.25%	0.00%	0.16%	0.00%
22	Linguistic Services	0.00%	0.00%	0.00%	0.00%
8	Medical Transportation	2.25%	0.00%	1.89%	0.00%
10	Outreach Services (LRP)	0.00%	0.00%	5.56%	0.00%
5	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%
20	Referral	0.00%	0.00%	0.00%	0.00%
24	Rehabilitation	0.00%	0.00%	0.00%	0.00%
25	Respite Care	0.00%	0.00%	0.00%	0.00%
16	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%
	Overall Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Footnote:

1 - Recommended revision approved by the Planning, Priorities and Allocations Committee on 5/18/2021.

Planning, Priorities and Allocations Committee
Service Category Rankings PY 30, 31, 32
Approved 9/10/20

Approved PY 30	PY 31	PY 32	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1	2	2	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
			Medical Subspecialty Services		
			Therapeutic Monitoring Program		
2	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)		
3	7	7	Mental Health Services	C	Mental Health Services
			MH, Psychiatry		
			MH, Psychotherapy		
4	6	6	Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
5	10	10	Outreach Services	S	Outreach Services
			Engaged/Retained in Care		
6	17	17	Health Education/Risk Reduction	S	Health Education/Risk Reduction

Approved PY 30	PY 31	PY 32	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
7	9	9	Early Intervention Services	C	Early Intervention Services
8	4	4	Emergency Financial Assistance	S	Emergency Financial Assistance
9	8	8	Medical Transportation	S	Medical Transportation
10	3	3	Non-Medical Case Management	S	Non-Medical Case Management Services
			Linkage Case Management		
			Benefit Specialty		
			Benefits Navigation		
			Transitional Case Management		
			Housing Case Management		
11	12	12	Oral Health Services	C	Oral Health Care
12	5	5	Psychosocial Support Services	S	Psychosocial Support Services
13	11	11	Nutrition Support	S	Food Bank/Home Delivered Meals
14	13	13	Child Care Services	S	Child Care Services
15	15	15	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
16	18	18	Home Based Case Management	C	Home and Community Based Health Services
17	19	19	Home Health Care	C	Home Health Care
18	16	16	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
19	20	20	Referral	S	Referral for Health Care and Support Services

Approved PY 30	PY 31	PY 32	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
20	21	21	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
21	14	14	Other Professional Services	S	Other Professional Services
			Legal Services		
			Permanency Planning		
22	22	22	Language	S	Linguistics Services
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

SUMMARY - RWP EXPENDITURE REPORT
As of April 8, 2021

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YEAR 30 AND PART B FY 2020 EXPENDITURES BY SERVICE CATEGORIES

1	2	3	4	5	6
SERVICE CATEGORY	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART A AND MAI	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL FULL YEAR ESTIMATED EXPENDITURES (Total Columns 2+3)	COH 2020 ALLOCATION PERCENTAGE APPLIED TO GRANT AWARD DIRECT SRVC PLUS PART B DIRECT SRVC	VARIANCE BETWEEN ALLOCATED BUDGETS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 5 - 4)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 8,226,884	$ -	$ 8,226,884	$ 9,584,184	$ 1,357,300
MEDICAL CASE MGMT (Medical Care Coordination)	$ 13,022,315	$ -	$ 13,022,315	$ 10,513,048	$ (2,509,267)
ORAL HEALTH CARE	$ 5,660,369	$ -	$ 5,660,369	$ 4,960,976	$ (699,393)
MENTAL HEALTH	$ 401,031	$ -	$ 401,031	$ 211,105	$ (189,926)
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,812,687	$ -	$ 2,812,687	$ 2,346,788	$ (465,899)
EARLY INTERVENTION SERVICES (HIV Testing Services)	$ 512,440	$ -	$ 512,440	$ 207,587	$ (304,853)
NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)	$ 1,974,172	$ -	$ 1,974,172	$ 2,291,134	$ 316,962
HOUSING (RCFCI, TRCF, and Permanent Supportive)	$ 3,109,131	$ 3,847,000	$ 6,956,131	$ 7,397,513	$ 441,382
OUTREACH (Linkage and Re-engagement Program and Partner Services)	$ 558,763	$ -	$ 558,763	$ 1,959,762	$ 1,400,999
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ 785,200	$ 785,200	$ 785,200	$ -
MEDICAL TRANSPORTATION	$ 472,750	$ -	$ 472,750	$ 664,982	$ 192,232
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 3,244,420	$ -	$ 3,244,420	$ 2,093,462	$ (1,150,958)
LEGAL	$ 170,705	$ -	$ 170,705	$ 56,295	$ (114,410)
SUB-TOTAL DIRECT SERVICES	$ 40,165,667	$ 4,632,200	$ 44,797,867	$ 43,072,036	$ (1,725,831)

ESTIMATED MAI CARRYOVER

YR 2020 Total Part A + MAI+FY 2019 MAI Carryover	$	44,625,625
YR 2020 Part A and MAI Expenditures	$	45,350,574
	$	**(724,949)**

* Please note, figures in parentheses indicate expenditures exceed allocations

RYAN WHITE PART A SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
SUMMARY REPORT
GRANT YEAR 30 RYAN WHITE PART A FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of April 8, 2021 and invoicing up to January 2021)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART A COH ALLOCATIONS	PART A TOTAL YTD EXPENDITURES	PART A FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	27.24%	7,240,735	8,226,884	$ 1,357,300
4	MEDICAL CASE MGMT (Medical Care Coordination)	29.88%	12,205,044	13,022,315	$ (2,509,267)
11	ORAL HEALTH CARE	14.10%	5,218,694	5,660,369	$ (699,393)
3	MENTAL HEALTH	0.60%	373,077	401,031	$ (189,926)
16	HOME AND COMMUNITY BASED HEALTH SERVICES	6.67%	2,598,891	2,812,687	$ (465,899)
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.59%	447,240	512,440	$ (304,853)
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services)	5.92%	1,289,177	1,341,606	$ 741,300
2	HOUSING (RCFCI, TRCF)	1.42%	406,316	406,316	$ 93,300
5	OUTREACH SERVICES (Linkage and Re-engagement Program and Partner Services)	5.57%	485,031	558,763	$ 1,400,999
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%	0	0	$ -
9	MEDICAL TRANSPORTATION	1.89%	356,297	472,750	$ 192,232
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	5.95%	3,163,649	3,244,420	$ (1,150,958)
21	LEGAL	0.16%	110,705	170,705	$ (114,410)
	SUB-TOTAL DIRECT SERVICES	**$ 35,184,230**	**33,894,856**	**36,830,286**	**$ (1,649,574)**
	QUALITY MANAGEMENT	1,330,192	640,844	750,936	$ 579,256
	ADMINISTRATION (Includes COH Budget) (10% of Part A award)	4,057,158	5,560,431	4,057,158	$ -
	GRAND TOTAL	**$ 40,571,580**	**$ 40,096,131**	**$ 41,638,380**	**$ (1,066,800)**

Year 30 Grant funding for Part A is $40,571,580

*Please note, figures in parentheses indicate expenditures exceed allocations

RYAN WHITE MAI SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE MAI FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of April 8, 2021 and invoicing up to Dec 2020 for Housing and Jan 2021

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	TOTAL ALLOCATION MAI FY 30	MAI FISCAL YEAR 30 TOTAL YTD EXPENDITURES	MAI FISCAL YEAR 30 FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	0.00%			$ -
4	MEDICAL CASE MGMT (Medical Care Coordination)	0.00%			$ -
11	ORAL HEALTH CARE	0.00%			$ -
3	MENTAL HEALTH	0.00%			$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES	0.00%			$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.00%			$ -
10	NON-MEDICAL CASE MANAGEMENT (Transitional Case Management)	6.14%	579,330	632,566	$ (424,339)
2	HOUSING (Permanent Supportive Housing/Housing for Health Program)	93.86%	2,027,112	2,702,815	$ 480,282
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)	0.00%			$ -
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%			$ -
9	MEDICAL TRANSPORTATION	0.00%			$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	0.00%			$ -
21	LEGAL	0.00%			$ -
	SUB-TOTAL DIRECT SERVICES	**3,391,324**	**2,606,442**	**3,335,381**	**$ 55,943**
	ADMINISTRATION (10% of MAI Year 30 award)	376,813	374,606	376,813	$ -
	GRAND TOTAL	**$ 3,768,137**	**$ 2,981,048**	**$ 3,712,194**	**$ 55,943**

The total MAI funding for Year 30 is $3,768,137 plus $285,908 from Year 29 approved roll over funding. However, this table only reflects the base award without the carryover funds

*Please note, figures in parentheses indicate expenditures exceed allocations

RYAN WHITE PART B SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE PART B FUNDING EXPENDITURES THROUGH MARCH 2021 (as of April 8, 2021 and invoicing through February 2021)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART B BUDGET	PART B TOTAL YTD EXPENDITURES	PART B FULL YEAR ESTIMTED EXPENDITURES	VARIANCE TOTAL BUDGET VS. FULL YR. ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE				$ -
4	MEDICAL CASE MGMT SVCS (Medical Care Coordination)				$ -
11	ORAL HEALTH CARE				$ -
3	MENTAL HEALTH				$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES				$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)				$ -
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)				$ -
2	HOUSING (RCFCI, TRCF)	3,714,800	3,660,088	3,847,000	$ (132,200)
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)				$ -
15	SUBSTANCE ABUSE TREATMENT- RESIDENTIAL	785,200	785,200	785,200	$ -
9	MEDICAL TRANSPORTATION				$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT				$ -
21	LEGAL				$ -
	SUB-TOTAL DIRECT SERVICES	**$ 4,500,000**	**$ 4,445,288**	**$ 4,632,200**	$ (132,200)
	QUALITY MANAGEMENT	$ -	$ -	$ -	$ -
	ADMINISTRATION (10% of Part B award)	$ 500,000	$ 295,408	$ 368,489	$ 131,511.00
	GRAND TOTAL	**$ 5,000,000**	**$ 4,740,696**	**$ 5,000,689**	**$ (689)**

Year 2 State allocation for Part B is $5,000,000.

*Please note, figures in parentheses indicate expenditures exceed allocations