LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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EXECUTIVE COMMITTEE
Meeting

Thursday, August 24, 2023
1:00pm-3:00pm (PST)
510 S. Vermont Ave
9th Floor, Terrace Conference Room A
Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

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

For those attending in person, as a building security protocol, attendees entering from the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting to access the Terrace Conference Room (9th flr) where our meetings are held.

For Members of the Public Who Wish to Join Virtually, Register Here:
https://lacountyboardofsupervisors.webex.com/weblink/register/r9cd5948ef9632a34881746ff0e5962ad
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2531 672 9910

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that 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. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

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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

EXECUTIVE COMMITTEE

THURSDAY, AUGUST 24, 2023 | 1:00PM - 3:00PM

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

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r9cd5948ef9632a34881746ff0e5962ad
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2531 672 9910

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

AGENDA POSTED: August 18, 2023

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

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

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

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 á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

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

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Introductions, Roll Call, & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Agenda	**MOTION #2**	1:07 PM – 1:08 PM
5.	Approval of Meeting Minutes	**MOTION #3**	1:08 PM – 1:10 PM

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

8. Executive Director/Staff Report 1:15 PM – 1:30 PM

A. Commission (COH)/County Operational Updates

- November 9, 2023 COH Annual Conference

9. Co-Chair Report 1:30 PM – 1:45 PM

A. Welcome COH Co-Chair Pro Tem, Joseph Green

B. August 10, 2023 COH Meeting | FOLLOW UP & FEEDBACK

C. September 14, 2023 COH Meeting Agenda Development

(1) 2024-2026 Co-Chair Open Nomination & Elections
(2) 2023 United States Conference on HIV/AIDS (USCHA) Report
(3) Presentation: HIV Surveillance Update & Data Challenges for LA County Native American Communities (Part 2: Programmatic Overview)
(4) Presentation: LA County Department of Health Services (DHS) Data on HIV Cascade
(5) New/Renewing Member Applications
(6) Universal Service Standards
(7) National HIV Awareness Days
   a. September 18 National HIV/AIDS and Aging Awareness Day #HIVandAging
   b. September 27 National Gay Men's HIV/AIDS Awareness Day #NGMHAAD

B. Conferences, Meetings & Trainings | OPEN FEEDBACK

(1) 2023 United States Conference on HIV/AIDS (USCHA) | September 5-9, 2023

C. Member Vacancies & Recruitment

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

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI
(2) Fiscal
(3) Ending the HIV Epidemic (EHE) Initiative | UPDATES
(4) Mpox | UPDATES

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

A. Operations Committee

(1) Membership Management
   a. Seat Vacate | Mallery Robinson **MOTION #4**
   b. Renewal Application – PP&A Committee-Only| Miguel Martinez **MOTION #5**
   c. Parity, Inclusivity & Reflectiveness (PIR) | UPDATES
(2) Assessment of the Administrative Mechanism (AAM) | UPDATE
(3) Policies & Procedures
   a. Bylaws Review Taskforce (BRT) | UPDATE
(4) 2023 Training Schedule | REMINDER
(5) Recruitment, Retention and Engagement

B. Standards and Best Practices (SBP) Committee

(1) Universal Service Standards | **MOTION #6**
(2) Prevention Services Standards Review| UPDATES

(3) Medical Care Coordination (MCC) Review | UPDATES

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

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

(1) Los Angeles Housing Service Authority (LAHSA) Data Request Update

(2) Fiscal Year 2022 RWP/MAI Expenditures and Utilization Report (AOM and MCC)

(3) Maximizing Ryan White Program Funds Ahead of Medi-Cal Expansion

D. Public Policy Committee (PPC)

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

a. 2023-2024 Legislative Docket | UPDATES
b. 2023-2024 Policy Priorities | UPDATES
c. Coordinated STD Response | UPDATES
- DPH Memo in response to STD Board of Supervisors (BOS) motion
- 2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings

d. House Appropriations FY24 Labor-HHS Spending Proposal
e. Act Now Against Meth (ANAM) | UPDATES

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

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

A. Aging Caucus
B. Black/AA Caucus
C. Consumer Caucus
D. Transgender Caucus
E. Women's Caucus
F. Bylaws Review Taskforce
H. Prevention Planning Workgroup

V. NEXT STEPS 2:45 PM – 2:55 PM

13. Task/Assignments Recap

14. Agenda development for the next meeting

VI. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

Adjournment for the meeting of August 24, 2023.

PROPOSED MOTIONS	
MOTION #1:	Approve remote attendance by members due to "emergency circumstances", per AB 2449.
MOTION #2	Approve the Agenda Order as presented or revised.
MOTION #3	Approve the meeting minutes, as presented or revised.
MOTION #4	Approve seat vacate for Mallery Robinson (Alternate) as recommended by the Operations Committee, as presented or revised, and forward to the full body at its September 14, 2023 meeting for approval.
MOTION #5	Approve PP&A Committee-only membership renewal application for Miguel Martinez, as presented or revised, and forward to full body at its September 14, 2023 meeting for approval.
MOTION #6	Approve the Universal Service Standards and forward to full body for approval at its September 14, 2023 meeting, as presented or revised.

LOS ANGELES COUNTY COMMISSION ON HIV

2023 MEMBERSHIP ROSTER| UPDATED 7.31.23

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2021	June 30, 2023	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2022	June 30, 2024	
3	City of Long Beach representative	1	EXC|OPS	Everardo Alvizo, LCSW	Long Beach Health & Human Services	July 1, 2021	June 30, 2023	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2022	June 30, 2024	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2021	June 30, 2023	
6	Director, DHSP	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2022	June 30, 2024	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2022	June 30, 2024	
8	Part C representative	1	PP	Leon Maultsby	Charles R. Drew University	July 1, 2022	June 30, 2024	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2021	June 30, 2023	
10	Part F representative			***Vacant***		July 1, 2022	June 30, 2024	
11	Provider representative #1	1	OPS	Jose Magana	The Wall Las Memorias	July 1, 2021	June 30, 2023	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2022	June 30, 2024	
13	Provider representative #3	1	SBP	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2021	June 30, 2023	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2022	June 30, 2024	
15	Provider representative #5	1	SBP	Byron Patel	Los Angeles LGBT Center	July 1, 2021	June 30, 2023	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2022	June 30, 2024	
17	Provider representative #7	1	EXC	Alexander Luckie Fuller ***(LOA)***	**TBD**	July 1, 2021	June 30, 2023	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2022	June 30, 2024	
19	Unaffiliated consumer, SPA 1			***Vacant***		July 1, 2021	June 30, 2023	
20	Unaffiliated consumer, SPA 2			***Vacant***		July 1, 2022	June 30, 2024	
21	Unaffiliated consumer, SPA 3			***Vacant***		July 1, 2021	June 30, 2023	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2022	June 30, 2024	
23	Unaffiliated consumer, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
24	Unaffiliated consumer, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2021	June 30, 2023	Mallery Robinson (SBP)
26	Unaffiliated consumer, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2021	June 30, 2023	Dechelle Richardson (PP&A)
28	Unaffiliated consumer, Supervisorial District 2	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2022	June 30, 2024	Juan Solis (SBP)
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
32	Unaffiliated consumer, at-large #1	1	PP&A	Lilieth Conolly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
33	Unaffiliated consumer, at-large #2	1	OPS	Shonte Daniels	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
34	Unaffiliated consumer, at-large #3			***Vacant***		July 1, 2022	June 30, 2024	
35	Unaffiliated consumer, at-large #4	1	EXC|OPS |PP&A	Joseph Green	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2022	June 30, 2024	
37	Representative, Board Office 2	1	EXC|OPS	Danielle Campbell, MPH	Charles Drew University	July 1, 2021	June 30, 2023	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2022	June 30, 2024	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2021	June 30, 2023	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2022	June 30, 2024	
41	Representative, HOPWA	1	PP&A	Jesus Orozco	City of Los Angeles, HOPWA	July 1, 2021	June 30, 2023	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2021	June 30, 2023	
44	HIV stakeholder representative #1	1	PP	Alasdair Burton	No affiliation	July 1, 2022	June 30, 2024	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2021	June 30, 2023	
46	HIV stakeholder representative #3	1	PP	Pearl Doan	No affiliation	July 1, 2022	June 30, 2024	
47	HIV stakeholder representative #4	1	PP&A	Redeem Robinson ***(LOA)***	No affiliation	July 1, 2021	June 30, 2023	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2022	June 30, 2024	
49	HIV stakeholder representative #6	1	PP	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	July 1, 2021	June 30, 2023	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2022	June 30, 2024	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2022	June 30, 2024	
	TOTAL:	40						

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

LOA: Leave of Absence

Overall total: 43

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/24/23

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL *	**Danielle**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
CONNOLLY	**Lilieth**	Unaffiliated consumer	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DANIELS	**Shonte**	Unaffiliated consumer	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	No Affiliation	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
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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
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	**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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
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
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

510 S. Vermont Ave. 14th Floor • Los Angeles, CA 90020
TEL : (213) 738-2816 EML: HIVCOMM@LACHIV.ORG WEB: 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.

EXECUTIVE COMMITTEE MEETING MINUTES

July 27, 2023

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

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER & MEETING GUIDELINES/REMINDERS

Bridget Gordon, Co-Chair, Commission on HIV (COH), commenced the meeting at around 1:01 PM and provided an overview of the meeting guidelines.

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

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

ROLL CALL (PRESENT): M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, M. Peréz, K. Stalter, J. Valero, and B. Gordon.

3. **ASSEMBLY BILL 2449 ATTENDANCE NOTIFICATION FOR "EMERGENCY CIRCUMSTANCES"**
   MOTION #1: Approve remote attendance by members due to "emergency circumstances," per AB 2449. ***Not applicable.***

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

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

II. PUBLIC COMMENT

6. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.**
   No public comments.
   Although not a public comment, Commissioner Kevin Donnelly provided a general comment regarding lack of promotion or awareness of Ryan White Program services, such as Medical Care Coordination, and noted that if providers are waiting for clients to approach them for referrals, we are already too late in reaching those in need.

III. COMMITTEE NEW BUSINESS ITEMS

7. **OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.**
   No committee new business items.

IV. REPORTS

8. **EXECUTIVE DIRECTOR/STAFF REPORT**
   A. Commission (COH)/County Operational Updates
   - **HRSA Site Visit Findings**
     Cheryl Barrit, MPIA, Executive Director, led the Committee through a review of HRSA's findings and highlighted the conflict-of-interest findings, noting that contracted provider members can no longer vote on priority-setting and resource

allocation-related items for their respective RWP-funded services and that service categories must be presented for vote individually and no longer collectively via a slate.

C. Barrit also noted HRSA's finding regarding DHSP's participation on the Commission and highlighted that DHSP is not allowed to vote, thereby abstaining from all votes until bylaws have been updated to reflect updated process. Staff is currently seeking guidance from County Counsel and HRSA regarding the extent of DHSP's membership and/or participation on the COH.

C. Barrit referred to the Commission's Corrective Action Plan (CAP) located in the packet, which has been submitted to HRSA and is pending approval.

- An inquiry was made whether contracted provider members can still deliberate and participate in the PSRA-related discussions; staff will seek clarification from HRSA and report back.

- November 9, 2023 Annual Meeting Preparation
  C. Barrit reported that staff are in the preliminary stages of planning for the November 9 Annual Meeting and are tracking recommendations from the membership and Consumer Caucus for agenda development. C. Barrit referred to the proposed list of recommendations in the packet, noting the tradition of carving out space for DHSP to present on the State of HIV. Staff will work towards finalizing the agenda at the next Committee meeting.

  The Committee expressed interest in having BOS representation either as part of the agenda or in attendance, memoriam for those who are no longer with us, and an awards presentation to honor those on the front lines.

9. CO-CHAIR REPORT

A. August 10, 2023, COH Meeting Agenda Development
B. Gordon reviewed the agenda items proposed for the August 10 COH meeting; refer to meeting agenda.

B. September 14, 2023, COH Meeting Agenda Development
B. Gordon reviewed the agenda items proposed for the September 14 COH meeting; refer to meeting agenda.

C. Conferences, Meetings & Trainings | OPEN FEEDBACK
(1) 2023 International AIDS Society 12th Annual Conference on Science – July 23-26, 2023
(2) 2023 United States Conference on HIV/AIDS (USCHA) – Sept 5-9, 2023

Commissioners Lilieth Conolly, Miguel Alvarez and Kevin Donnelly all received scholarships to attend the USCHA on behalf of the Commission and will report back at the September 14 COH meeting on their experiences.

D. Member Vacancies & Recruitment

As a reminder, COH promotional materials will be made available at upcoming in-person meetings for outreach and recruitment efforts. The Commission's digital toolkit can be access via its website HERE. Members are encouraged to use these resources for outreach and recruitment activities.

10. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

A. Fiscal, Programmatic and Procurement Updates

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

(2) Fiscal – *No fiscal update provided.*

(3) Mpox | UPDATES

Mario J. Perez, MPH, Director (DHSP) reported the following:

- COVID numbers continue to decline and that DPH's focus continues to center around Mpox vaccination promotion and preparing for the Fall months which can signal an uptick in cases.
- Local Mpox cases remain low, with three (3) reported cases this week. However, M. Perez stressed the urgency of those living with HIV (PLWH) to get at least one (1) Mpox vaccination as data shows that the severity of Mpox is significantly minimized for those who are vaccinated; only 24% of PLWH are vaccinated.
- Launch of an incentive program for PLWH out of care which provides a $50 gift card per visit and Mpox vaccination. For PLWH who are not virally suppressed will receive a $100 giftcard.
- An overall $400 million spending cut to Disease Intervention Specialists (DIS) nationwide, amounting to approximately $13 million locally over a two-year period, as part of Congress' debt ceiling deal. As a result, DHSP is in process of reassessing its workforce as many of its staff are funded through this effort.
- Reference to the Washington Post article on DoxyPEP and shared that DHSP is promoting guidance on DoxyPEP to all of its providers to increase their comfort level in prescribing. MSMs, Transgender Persons, those with recent STD diagnosis, and those who ask for DoxyPEP are good candidates. Updates on additional investment of resources around DoxyPEP and Syphilis will be provided at a future meeting.
- DHSP enlisted "OnCall," a group of former pharmaceutical representatives, to train them in sexual health topics (e.g., PrEP, Syphilis, DoxyPEP); they've been deployed to over 1,000+ medical offices across LA County for educating providers on sexual health and prevention.

- 2023 HIV Surveillance Report will be available on DHSP's website next week in a more user-friendly format. M. Perez briefly mentioned that the epidemiological curve looks great in comparison to the 2022 surveillance data.
- The County's BOS supported an additional $10 million this fiscal year to help with STD control efforts and that conversations are being held with 11 community-based organizations with ties to STD clinical services to determine best approach to address the STD crisis in LA County.
- Increased attention regarding the Bicillen shortage citing its critical nature as a prevention tool in protecting the health of an unborn child from a mother who is diagnosed with Syphilis. M. Perez shared that providers are using Doxycycline as an alternative, citing it is more intensive and not necessarily the best alternative.

11. STANDING COMMITTEE REPORTS

A. **Operations Committee**

(1) 2023 Membership Renewal Slate MOTION #4

- 2023 Membership Renewal | Danielle Campbell, MPH: Rep, Board Office 2 (Seat #37) **MOTION #4 (**√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)

(2) New Member Applications

- Dr. David Hardy, Alternate **MOTION #5** (√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)
- Ronnie Osorio, Alternate **MOTION #6** (√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)
- Ish Herrera, Unaffiliated Consumer Representative, SPA 2 **MOTION #7** (√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)
- Russel Ybarra, Unaffiliated Consumer Representative, SPA 3 **MOTION #8** (√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)
- Erica Robinson, Alternate **MOTION #9 (**√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)
- Sandra Cuevas, Part F Representative **MOTION #10 (**√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)

- Lauren Gersh, SBP Committee-Only Member **MOTION #11 (**√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)

(3) Parity, Inclusivity & Reflectiveness (PIR) | UPDATES

Updates will be reflected and presented once applicants are appointed by the BOS and are official members.

12. STANDING COMMITTEE REPORTS (CONT'D)

B. Operations Committee (cont'd)

(4) Assessment of the Administrative Mechanism (AAM) | UPDATE

Everardo Alvizo, Operations Committee Co-Chair, reported at its last meeting, Dr. Michael Green (DHSP) led the Committee in a review of DHSP's response and feedback of the PY 31 AAM recommendations and provided suggestions on the focus of the next AAM which will be discussed at the next Committee meeting.

(5) Policies & Procedures

a. Revised Policy #08.3204: Commission and Committee Member Attendance

MOTION #12 (√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, J. Green, K. Nelson, K. Stalter, J. Valero & B. Gordon. ABSTAIN: M. Perez)

Language was added to provide a 14-day grace period post-absence for members to notify staff of an absence.

b. Bylaws Review Taskforce (BRT) | UPDATE

BRT scaled back its focus to address low hanging fruit and HRSA's findings. BRT currently conducting a thorough review of the bylaws. All meetings are open to the public.

(6) 2023 Training Schedule

"Public Health 101" virtual training is scheduled for August 16, 2023 @ 3-4:30PM. While this is not a mandatory training for members, all are encouraged to participate. Training recordings are available on the COH's website HERE.

(7) Recruitment, Retention and Engagement

As a reminder, hard copies of COH promotional materials will be made available at upcoming in-person meetings. The COH's Digital Toolkit is available on the COH's website HERE.

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

Kevin Donnelly, PP&A Co-Chair, reported the following:

- Committee is experiencing challenges in meeting quorum and cancelled its July meeting to allow for a summer break.

- The Committee engaged in a robust discussion on guidance to DHSP amid MediCal expansion to prevent folx from falling through the cracks.
- Stakeholder community listening sessions are in the planning stages; a questionnaire is currently being developed to assess client's needs.
- The Committee will be reviewing DHSP's utilization and expenditure reports at its next meeting to identify needs and gaps.

D. Standards and Best Practices (SBP) Committee

Erika Davies, SBP Committee Co-Chair, reported the following:

(1) **Nutrition Support Services Standards | MOTION #13 (**√Approved by Roll Call: YES: M. Alvarez, E. Alvizo, E. Davies, K. Donnelly, K. Stalter, J. Valero & B. Gordon. ABSTAIN: K. Nelson)

(2) Universal Service Standards | UPDATES

The Committee is finalizing the Universal Service Standards and will be presented to the Executive Committee at its next meeting for approval.

(3) Prevention Services Standards Review| UPDATES

The Prevention Planning Workgroup is currently reviewing the draft Prevention standards and noted that updates will present an opportunity to include prevention tools such as PrEP, LAIP, DoxyPEP.

(4) Medical Care Coordination (MCC) Review | UPDATES

The Committee will continue tis review of MCC at its August meeting.

E. Public Policy Committee (PPC)

Katja Nelson, PPC Committee Co-Chair, reported the following:

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

a. 2023-2024 Legislative Docket | UPDATES

No updates; bills moving through committees.

b. 2023-2024 Policy Priorities | UPDATES

No updates.

c. Coordinated STD Response | UPDATES

- **DPH Memo in response to STD Board of Supervisors (BOS) motion**
- **2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings**

On behalf of PPC, staff has developed a public comment speaker schedule with guided talking points to help empower consumer members with lived experience to champion programs and services that support the health and wellness of our HIV prevention and care communities at the County's Health Deputies and BOS meetings. Members are encouraged to sign up to support requests for increased dedicated funding to address the STD crisis in Los Angeles County.

d. House Appropriations FY24 Labor-HHS Spending Proposal

The House Labor, HHS Appropriations Subcommittee passed a FY2024 spending bill that would eliminate all $542 million in funding for the Ending the HIV Epidemic in the U.S. initiative. The Ending the HIV Epidemic (EHE) cuts include $220 million at the CDC; $165

million from the Ryan White HIV/AIDS Program, and $157 million from HRSA Community Health Centers that focus on PrEP.

The House Appropriations Committee passed the Transportation, Housing and Urban Development, and Related Agencies FY2024 spending bill that includes $505 million, an increase of $6 million, for the Housing Opportunities for Persons with AIDS (HOPWA) program.

F. Public Policy Committee (PPC) (cont'd)

e. Act Now Against Meth (ANAM) | UPDATES

No updates.

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

The Committee is currently discussing strategies in developing a white paper consisting of recommendations on what the community would like to see via RWP modernization and cautioned that not everyone is on board, i.e., status neutral proponents, Southern states.

G. CAUCUS, TASK FORCE, AND WORKGROUP REPORTS

(1) Aging Caucus

K. Donnelly, Caucus Co-Chair, shared that the Caucus is finalizing its September 22, 2023, Sexual Health Summit in partnership with the City of LA Department of Disability.

(2) Black/African American Caucus

Dawn Mc Clendon, COH Staff, reported that the Caucus is continuing its planning for community listening sessions to address the state of HIV in the Black community, and continues to work with DHSP to finalize the organizational capacity needs assessment. D Mc Clendon shared that the Caucus is an official vendor of the 2023 Taste of Soul.

(3) Consumer Caucus

Alasdair Burton, Caucus Co-Chair, reported that the Caucus received an overview of the Nutrition Support Services Standards and provided feedback. Additionally, the Caucus discussed ideas for the Annual Meeting and strategies for engaging consumers.

(4) Transgender Caucus

Jose Rangél-Garibay, COH staff, reported that the Caucus is currently planning for the Trans Health Summit scheduled for November 2 2023, will cover topics: Community Building Space, Policy and Advocacy, Trans History, Trans Media, Trans and HIV, Building Collaborative Partnerships

(5) Women's Caucus

Dawn Mc Clendon, COH Staff, reported that the Caucus met on July 17, 2023 and discussed the PP&A Program Directives and DHSP's response concerning women-centered programming**.** DHSP shared that the Childcare RFA is ongoing and continuous despite an initial deadline being applied. The Caucus will conduct a hybrid meeting on October 17th and will continue its review and discussion around the PP&A directives and Caucus recommendations.

(6) Bylaws Review Taskforce (BRT)

E. Alvizo, Co-Chair, reported that the BRT continues to meet monthly to review the Bylaws for updates and that staff is currently working with County Counsel for guidance. All virtual meetings are open to the public.

(7) Mission & Vision Statement Workgroup.

K. Donnelly, Co-Chair, reported that the workgroup will go on hiatus and reconvene once the BRT concludes given similar overlapping efforts. K. Donnelly shared there will be an opportunity at the upcoming Annual Meeting to solicit recommendations for revisions to the Mission & Vision Statement.

(8) Prevention Planning Workgroup (PPW)

K. Donnelly reported that the PPW is currently reviewing the Prevention standards and will provide recommendations to SBP.

V. NEXT STEPS

13. TASK/ASSIGNMENTS RECAP

- All motions to be elevated to the August 10th COH meeting.
- COH Co-Chair Pro-Tem Open Nomination & Election will be held at the August 10 COH meeting.
- 2023 Annual Conference agenda development will be agendized for the next meeting.

14. AGENDA DEVELOPMENT FOR THE NEXT MEETING

- Refer to minutes.

VI. ANNOUNCEMENTS

15. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS

VII. ADJOURNMENT

16. ADJOURNMENT FOR THE MEETING OF JULY 27 2023.

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT FOR PLANNING AND DISCUSSION PURPOSES ONLY **ANNUAL CONFERENCE AGENDA OUTLINE** **NOVEMBER 9, 2023** **Vermont Corridor Terrace Level (510 S. Vermont Ave, LA CA 90020)**	
AGENDA ITEM	**WHO/TOPIC**
Call to Order and Roll Call (9:00-9:15)	Co-Chairs and Executive Director
Welcome, Opening Remarks, Meeting Objectives, and Recognition of Service 9:15-9:30am	Co-Chairs
Los Angeles County State of HIV/STDs 9:30-10:30am	**Mario Pérez and DHSP staff:** • Successes • Challenges • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support DHSP's efforts to address HIV/STDs in the County.
The County's Response to the Intersection of HIV and Substance Use | Harm Reduction and Other Services, DPH, Substance Abuse Prevention and Control (SAPC) 10:30am-11:15am	**Dr. Sid Puri, Associate Medical Director of Prevention, SAPC** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support substance use/harm reduction efforts in the County.
BREAK **11:15-11:30am**	
PrEP, Long-acting PrEP, Doxy PEP | Strategies for Increasing Access and Utilization among Priority Populations 11:30 – 12:30pm	**Dr. Ardis Moe – (*Invited, awaiting response)*** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support increasing access and utilization of PrEP, LAI PrEP, and Doxy PEP in the County.
LUNCH w/ Speakers Housing and People Living	Supervisor Lindsey Horvath, Third District and LAHSA Commission Chair **(?)** Dr. Va Lecia Adams Kellum, CEO Los Angeles Homeless Services Authority

with HIV **12:30 – 1:30pm**	**(?)** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to help address or support affordable housing for PLWH and priority populations.
Consumer-focused Community Discussion Intergenerational Perspectives on Community Building and Resilience **1:30-2:30pm**	• Need consumer panelists representing 1980s to current era • Facilitated session with audience participation • Possible facilitators: AJ King?, Lise Ransdell?, Others? • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to help build a united community across generations to end HIV.
BREAK 2:30-2:45	
Enhancing Access to Mental Health Services for PLWH **2:45-3:30pm**	Dr. Lisa Wong, Director, Los Angeles County Department of Mental Health **(?)** • At the end of the session, attendees will be asked to write down at least 3 community call to action ideas focusing on what the Commission can do to address or support mental health services for PLWH and priority populations.
Public Comments **3:30 pm to 3:45pm**	
Closing remarks and by co-chairs/Adjourn **3:45-4pm**	
RECEPTION, NETWORKING, RAFFLE PRIZES **4pm to 5pm**	

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
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Miguel Martinez

Application on file at Commission office

Planning Council/Planning Body Reflectiveness (Updated 8.17.23)

(Use HIV/AIDS Prevalence data as reported FY 2022 Application)

Race/Ethnicity	Living with HIV/AIDS in EMA/TGA*		Total Members of the PC/PB		Non- Aligned Consumers on PC/PB	
	Number	Percentage**	Number	Percentage**	Number	Percentage**
White, not Hispanic	13,965	27.50%	10	23.26%	4	40.00%
Black, not Hispanic	10,155	20.00%	14	32.56%	5	50.00%
Hispanic	22,766	44.84%	11	25.58%	1	10.00%
Asian/Pacific Islander	1,886	3.71%	4	9.30%	0	0.00%
American Indian/Alaska Native	300	0.59%	0	0.00%	0	0.00%
Multi-Race*	1,705	3.36%	4	9.30%	0	0.00%
Other/Not Specified	0	0.00%	0	0.00%	0	0.00%
Total	50,777	100%	43	100%	10	100%
Gender	Number	Percentage**	Number	Percentage**	Number	Percentage**
Male	44,292	87.23%	27	62.79%	5	50.00%
Female	5,631	11.09%	13	30.23%	5	50.00%
Transgender	854	1.68%	2	4.65%	0	0.00%
Unknown	0	0.00%	1	2.33%	0	0.00%
Total	50,777	100%	43	100%	10	100%
Age	Number	Percentage**	Number	Percentage**	Number	Percentage**
13-19 years	122	0.24%	0	0.00%	0	0.00%
20-29 years	4,415	8.69%	2	4.00%	0	0.00%
30-39 years	9,943	19.58%	12	28.00%	0	0.00%
40-49 years	11,723	23.09%	11	26.00%	2	20.00%
50-59 years	15,601	30.72%	11	26.00%	5	50.00%
60+ years	8,973	17.67%	7	16.00%	3	30.00%
Other	0	0.00%	0	0.00%	0	0.00%
Total	50,777	99.99%	43	100%	10	100.%

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

Non-Aligned Consumers = 23% of total PC/PB

*Multi-Race: 4 commissioners indicated multi-race but did not specify their exact races/ethnicities.

LOS ANGELES COUNTY
COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV
FY 2022-2023 ASSESMENT OF MECHANISM (AAM)
APPROACH AND FOCUS PROPOSAL
DRAFT 8.17.23

FOR DISCUSSION PURPOSES ONLY

BACKGROUND

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

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

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

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

METHODOLOGY

Utilize a consultant to conduct key informant interviews and focus groups to harness ideas on specific action steps to shortening the contracting process along with administrative changes needed to activate and simplify alternative options such as but not limited to, sole sourcing, third party administrators, and contract extensions.

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

Division of HIV and STD Programs (DHSP)

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

Department of Public Health

1. Office of the Director
2. Contracts and Grants

Board of Supervisors

1. Health Deputies
2. Administrative Deputies
3. Chiefs of Staff

Chief Executive Office

- Administrative Services Division, Contracts and Procurement team

Contracted Agency Perspectives

- Interview a representative sample from DHSP-funded agencies.

Consumer Focus Group

- Consumers of HIV prevention and care services

Possible Questions/Prompts

1. What recommendations do you have for improving the County contracting and procurement process? What recommendations do you have for expediting the County contracting and procurement process?
2. What existing steps, review and approval levels, and paperwork may be eliminated to make the contracting process less cumbersome for DHSP, DPH, and providers?
3. How did the County expedite contracts during the COVID pandemic? How can the expedited contracting process during the COVID pandemic be applied to HIV and STD contracts?
4. Describe how the County's protracted contracting process impact DHSP, agencies and the consumers.
5. Understand the reason behind push back and lack of support to expedite contracts.
6. The County and City of Los Angeles issued a joint declaration of local emergency for homelessness on January 1, 2023. How can this local emergency declaration be leveraged to expedite HIV/STD contracts?

PROPOSED TENTATIVE TIMELINE

Secure feedback and approval from Operations, Executive and full Commission on AAM focus and approach for FY 2022-2023	August-September 2023
Secure project consultant	September-November 2023
Selected project consultant to review interview questions and study approach with Operations, Executive, and COH.	December 2023-January 2024
Conduct assessment	February-April 2024
Develop report	April-May 2024
Present draft, findings, to Operations and Executive Committees	May- June 2024
Present final report to full Commission for	July 2024

adoption	

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

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

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

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

  DHSP is responsible for identifying unbiased, non-conflicted evaluators for review panels. That is difficult, e.g., there were 36 proposals for one RFP. Serving requires significant time for no pay and evaluators must sign a statement of no conflict of interest so local providers are often ineligible. Evaluators have been recruited, e.g., from Las Vegas, San Diego and San Francisco, but often nonlocal people are not invested in participating. DHSP has recommended DPH leadership identify a list similar to a jury pool for a 12-month period. DPH showed interest, but has not acted.
- Contractors are selected and funding recommendations are developed based on evaluation scores as well as funding requirements, geographic distribution of services and targeted

populations defined in the solicitation. Proposers may request a debriefing after the recommendations to review their proposals. They may appeal decisions.

- Services are solicited for a variety of reasons, e.g., to meet emerging need, redefine services, replace expiring contracts, [or] utilize new grant funding. DHSP tends not to apply for short-term grants, e.g., 24-36 months, because the time is too short to contract services within the grant term. For longer term grants, DHSP typically begins solicitation at the same time it applies for the grant to facilitate service implementation. Delegated authority allows DHSP to increase or decrease funds for a service by a certain percentage or time, but eventually services will need to be resolicited.
- Prior to applying for funding, DHSP must receive DPH approval by showing: purpose of funding, why it is needed, specifically how it will be used and how services will be implemented in the community.
- Concurrently, DHSP begins work on a Board Letter for approval to receive grant funds which includes: the amount of funds to be received in response to an application submitted on a certain date requesting a certain amount; how funds will be used and a proposed list of contractors. The Board Letter is required even for the annual Ryan White grant. DHSP cannot technically contract any services if the Health Resources Services Administration (HRSA) or another grantor delays its Notice of Grant Award. HRSA often has delayed its Notice of Grant Award from one to six months.
- A sole source solicitation allows DHSP to identify an agency or agencies that it knows can do the work in the way it needs to be performed without putting the contract out to bid. DHSP has to prove to the Board that no other contractors can provide the needed service or that sole source is needed to expedite the work and the identified provider(s) are well-qualified to do the work.
- Generally, the Board does not approve sole source contracting. It did approve DHSP to use sole source for Medical Care Coordination (MCC) expansion after the Commission advocated for it and data supported the beneficial impact of MCC.
- Other solicitation forms theoretically save time, but rarely do so in practice. The RFP process takes the most time, but offers more clarity about what is wanted and proposer submittal requirements are more stringent so results are better.
- Dr. Green said the County's process is determined by the Board, Chief Executive Office and Auditor-Controller. Multiple attempts to persuade the Board to streamline the process were met with opposition but, as noted with MCC, the Board allows adjustments if need is demonstrated.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS

Approved by COH on 2/11/21

Draft as of 08/01/23 for

Executive Committee Review.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients. The Standards are intended to help Ryan White Part A funded agencies meet the needs of their clients. Providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Universal Standards of Care to reflect current guidelines from federal and national agencies on HIV care and treatment, and to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in the County. The development of the Standards includes guidance from service providers, consumers and members of the Los Angeles County Commission on HIV, Standards and Best Practices Committee.

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all PLWH in Los Angeles County
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how maintaining an undetectable viral load results in no risk of HIV transmission
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally, and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Prevent information technology security risks and protect patient information and records
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services
- Ensure that the quality of service and materials given to patients during telehealth encounter is similar with in-person visits.

1. GENERAL AGENCY POLICIES

All agencies offering Ryan White services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility. Agency policies and procedures facilitate service delivery as well as ensure safety and well-being of clients and staff. Agencies are encouraged to build their telehealth technology infrastructure and capacity to include videoconferencing to facilitate patient-provider connectivity and relationships.

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient.	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[1]
1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Customer Support Program[2] 1-800-260-8787. DHSP Customer Support Program information is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.

[1] California Department of Health Care Services Telehealth Provider Manual can be accessed here https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

[2] More information on the Customer Support Program can be found here: DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

1.5 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16- 02[3]	1.5 Written eligibility requirements on file.
1.6 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities.	1.6 Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information.
1.7 Agency maintains progress notes of all communication between provider and client.	1.7 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided Recommended referrals linking clients to needed services (See Section 6: Referrals and Case Closure)
1.8 Agency develops or utilizes an existing crisis management policy.	1.8 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.9 Agency develops a policy on utilization of Universal Precaution Procedures[4,5]. Staff members are trained in universal precautions.	1.10 Written policy or procedure on file. Documentation of staff training in personnel file.
1.10 Agency ensures compliance with Americans with Disabilities Act[6] (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must comply with the ADA requirements.	1.10 ADA criteria on file at all sites.
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

[3] PCN 16-02 RWHAP Services Eligible Individuals and Allowables Uses of Funds (hrsa.gov)
[4] Bloodborne Infectious Diseases | NIOSH | CDC
[5] Bloodborne Pathogens - Worker protections against occupational exposure to infectious diseases | Occupational Safety and Health Administration (osha.gov)
[6] Laws, Regulations & Standards | ADA.gov

2. CLIENT RIGHTS AND RESPONSIBILITIES

A key component of HIV/AIDS service delivery is the historic and continued involvement of people living with HIV in the design and evaluation of services. The quality of care and quality of life for people living with HIV/AIDS is maximized when people living with HIV are active participants in their own health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand the importance of their input in the development of HIV programming.

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment. • Focus groups
2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services.	2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain language and available in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.

2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made.	2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.
2.5 Agency provides each client a copy of the *Patient & Client Bill of Rights & Responsibilities (Appendix B)* document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be removed from services and the process that occurs during involuntary removal	2.5 *Patient and Client Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

Staff must be well qualified and, if necessary, hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all staff will be able to provide timely, linguistically, and culturally competent care to people living with HIV. Staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. The AIDS Education Training Center (AETC)[7] offers a variety of training for the HIV workforce.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	**Documentation**
3.1 Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served. Employment is an essential part of leading an independent, self-directed life for all people, including those living with HIV/AIDS. Agencies should develop policies that strive to hire PLWH in all facets of service delivery, whenever appropriate.	3.1 Hiring policy and staff resumes on file.

[7] Welcome | AIDS Education and Training Centers National Coordinating Resource Center (AETC NCRC) (aidsetc.org)

3.2 If a position requires licensed staff, staff must be licensed to provide services.	3.2 Copy of current license on file.
3.3 Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV. Continuing to take HIV medications as directed is imperative to stay undetectable. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and HIV Navigation Services (HNS)[8] provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care • Providing care for older adults • Mental Health First Aid	3.3 Documentation of completed trainings on file
3.4 New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-level orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the job description. c. Additional trainings appropriate to the job description and Ryan White service category.	3.4 Documentation of completed trainings on file
3.5 Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	3.5 Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services[9] (CLAS) in Health and Health Care. As noted in the CLAS Standards[10], ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial,

[8] HIV Navigation Services | Treat | Effective Interventions | HIV/AIDS | CDC
[9] Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov)
[10] CLAS Standards - Think Cultural Health (hhs.gov)

ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. The standards below are adapted directly from the National CLAS Standards.

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement. For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.

Cultural competence and acknowledging implicit bias rely on behaviors, attitudes, and policies that come together in a system, agency, or among individuals that reduces stigma and enables effective delivery of services. Linguistic competence is the ability to communicate effectively with clients, including those whose preferred language is not the same as the provider's, those who have low literacy skills, and/or those with disabilities. Cultural and linguistic competence is a goal toward which all service providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities, and understanding that culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime. However, agencies should ensure staff are involved in a continual process of learning, personal growth, and training that increases cultural and linguistic competence, addresses implicit bias, decreases stigma, and enhances the ability to provide appropriate services to all individuals living with HIV/AIDS.

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. Interpretation refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, lived experience etc.)
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file a. Checklist of resources onsite that are available for client use. b. Type of accommodations provided documented in client file.

4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights and Responsibilities* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

All clients who request or are referred to HIV services will participate in an intake process conducted by appropriately trained staff. The intake worker will review client rights and responsibilities, explain available services, the confidentiality and grievance policy, assess immediate service needs, and secure permission to release information

5.0 INTAKE AND ELIGIBILITY	
Standard	**Documentation**
5.1 Intake process begins within 5 days of initial contact and is completed within 30 days of initial contact with client.	5.1 Completed intake on file that includes, at minimum: • Client's legal name, name if different than legal name, and pronouns • Address, phone, and email (if available). A signed affidavit declaring homelessness should be kept on file for clients without an address. • Preferred method of communication (e.g., phone, email, or mail) • Emergency contact information • Preferred language of communication • Enrollment in other HIV/AIDS services. • Primary reason and need for seeking services at agency If client chooses not to complete the intake within 30 days of initial contact, document attempts to contact client and mode of communication in client file.
5.2 Agency determines client eligibility	5.2 Documentation includes: • Los Angeles County resident • Income equal to or below the required Federal Poverty Level (FPL) as determined by Division of HIV & STD Programs • Verification of HIV diagnosis

6. REFERRALS AND CASE CLOSURE

A client case may be closed through a systematic process that includes case closure justification and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of resources available for the client for referral purposes. If the client does not agree with the reason for case closure, they should follow the grievance policy at the provider agency and/or be referred to the Department of Public Health, Division of HIV and STD Programs Customer Support Program[11].

6.0 REFERRALS AND CASE CLOSURE	
Standard	**Documentation**
6.1. Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals a. Staff will provide referrals to link clients to services based on assessments and reassessments	6.1 Identified resources for referrals at provider agency (e.g. lists on file, access to websites) a. Written documentation of recommended referrals in client file
6.2 If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance use, housing)	6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	6.3 Attempts to contact client and mode of communication documented in file. a. Justification for case closure documented in client file
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.

[11] DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

6.5 Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure.	6.5 Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights and Responsibilities* document. (Refer to Appendix B).

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

The Ryan White HIV/AIDS Program Part A provides assistance to communities that are most severely impacted by the HIV epidemic. Part A funds must be used to provide core medical and support services for people living with HIV.

Core Medical Services	**Description**
Ambulatory Outpatient Medical (AOM) Services	HIV medical care access through a medical provider.
Home-based Case Management	Specialized home care for homebound clients.
Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.
Medical Specialty Services	Medical care referrals for complex and specialized cases.
Mental Health Services	Psychiatry, psychotherapy, and specialized cases.
Oral Health Services (General & Specialty)	General and specialty dental care services.
Supportive Services	**Description**
Benefits Specialty Services	Assistance navigating public and/or private benefits and programs (health, disability, etc.).
Language Translation Services	Translation services for non-English speakers and deaf and/or hard of hearing individuals.
Legal Services	Legal information, advice, and services.
Nutrition Support Services	Home-delivered meals, food banks, and pantry services.
Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that provides 24-hour care.
Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery form drug or alcohol use disorders.
Transitional Case Management	Support for incarcerated individuals transitioning from County jails back to the community.
Transitional Residential Care Facility (TRCF)	Short-term housing that provides 24-hour assistance to clients with independent living skills.
Transportation Services	Ride services to medical and social services appointments.

APPENDIX B: PATIENT & CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

It is the provider's responsibility to provide clients a copy of the Patient & Client Bill of Rights and Responsibilities in all service settings, including telehealth. The purpose of this Patient and Client Bill of Rights is to help enable clients to act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As someone newly entering or currently accessing care, treatment, or support services for HIV/AIDS, you have the right to:

A. Respectful Treatment and Preventative Services

1. Receive considerate, respectful, professional, confidential, and timely care and preventative services (such as screenings and vaccinations) in a safe client-centered, trauma-informed environment without bias.
2. Receive equal and unbiased care according to your age and needs in accordance with federal and State laws.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related services.
4. Be informed of the names and work phone numbers of the physicians, nurses, and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care services.
6. Receive services that are culturally and linguistically appropriate, including having a full explanation of all services and treatment options provided clearly in your own language and dialect.
7. Review your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the U.S. Department of Health and Human Services[12] (HHS), the Centers for Disease Control and Prevention[13] (CDC), the California Department of Health Services[14], and the County of Los Angeles Department of Public Health[15].
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or care services.
4. Have their phone calls and/or emails answered with 1-5 business days based on the urgency of the matter.

C. Participate in the Decision-making Treatment Process

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.

[12] HIV Treatment Guidelines | NIH
[13] Guidelines and Recommendations | Clinicians | HIV | CDC
[14] HIV Care Program
[15] LA County Department of Public Health

5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal, and be assured that you have the right to change your mind later.
6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.
8. Refuse any offered services or end participation in any program without bias or impact on your care.
9. Be informed of the procedures at the agency for resolving misunderstandings, making complaints, or filing grievances.
10. Receive a response to a complaint or grievance within 30-45 days of filing it.
11. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services[16] (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. (Your agency will ask you to acknowledge receipt of this document.)
2. Keep your HIV status confidential. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. (Your physician has the right to accept or refuse your request with an explanation.)

E. Billing Information and Assistance

1. Receive complete information and explanation in advance of all charges that may be incurred for receiving care, treatment, and services as well as payment policies of your provider.
2. Receive information on any programs to help you pay and assistance in accessing such assistance and any other benefits for which you may be eligible.

F. Patient/Client Responsibilities

In order to help your provider give you the care to which you are entitled, you also have the responsibility to:

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and understand the consequences of failing to adhere to the recommended course of treatment or of using alternative treatments.
5. Understand that cases may be closed if the client:
    i. Relocates out of the service area
    ii. Is no longer eligible for the service(s)
    iii. Discontinues the service(s)
    iv. No longer needs the service(s)

[16] Home - Division of Appeals Policy (lmi.org)

v. Puts the agency, service provider, or other clients at risk
vi. Uses the service(s) improperly or has not complied with the services agreement
vii. Is deceased
viii. Has had no direct agency contact, after repeated attempts, for a period of 12 months

6. Keep your appointments and commitments at this agency or inform theagency promptly if you cannot do so.
7. Keep your provider or main contact informed about how to reach you confidentiallyby phone, mail, or other means.
8. Follow the agency's rules and regulations concerning patient/client care and conduct.
9. Be considerate of your providers and fellow clients/patients and treat them withthe respect you yourself expect.
10. Refrain from the use of profanity or abusive or hostile language; threats, violence, or intimidations; carrying weapons of any sort; theft or vandalism; sexual harassment and misconduct.
11. If you are a person living with a Substance Use Disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

For More Help or Information

Your first step in getting more information involving any complaints or grievances is to speak with your provider or a designated client services representative or patient or treatment advocate at the agency. If this does not resolve the problem in a reasonable time span, or if serious concerns or issues arise and you would like to speak with someone outside the agency, you may call the number below for confidential, independent information and assistance.

Division of HIV and STD Programs | Customer Support Program
(800) 260-8787 | 8:00 am – 5:00 Monday – Friday

APPENDIX C: TELEHEALTH RESOURCES

- **Federal and National Resources:**
  - HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CARE Action Newsletter October 2019: https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf
- **Telehealth Discretion During Coronavirus:**
  - AAFP Comprehensive Telehealth Toolkit: https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
  - ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth
  - ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf
  - AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
  - CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services."
  - CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"
  - CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
  - Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency
  - Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

Ryan White Program Year 32
Care Utilization Data Summary

Part 1 - Ambulatory Outpatient Medical and Medical Care Coordination

Aug 15, 2023
COH Planning, Priorities, and Allocations Committee

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

Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) Service Cluster

BACKGROUND

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

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

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

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

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

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

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

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

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

Outcomes and Indicators

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

- HIV Care Continuum Outcomes (engagement in care, Retention in Care (RiC) and viral suppression (VS) among EHE priority and RWP priority populations
- RWP service utilization and expenditure indicators by service category:
    - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
    - Service units per client=Total service units/Number of clients
    - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
    - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

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

WHAT DATA CAN AND CANNOT TELL US

This report will estimate for the current reporting year:

- How many unique RWP clients were served?
- What types of clients accessed RWP services?
  - How many clients?
  - Which clients are we serving?
  - Which services did they access?
- How did clients use services?
  - Which services did they use?
  - How were they utilized?
  - How much of the service did they receive?
  - Were there differences or disparities in how clients received services?
- Are we making progress toward targets for local and federal HIV care continuum (HCC) outcomes?
  - How are RWP clients doing compared to LAC overall?
  - How are clients doing within service categories?
  - Are there differences/disparities in outcomes?

What we cannot estimate using this report:

- What services clients need compared to what they receive (service gaps)
- Why the number of clients may change over time
- How many PLWDH in LAC are uninsured
- Why there are disparities in utilization or outcomes
- Characteristics of or service use among PLWDH outside of the RWP

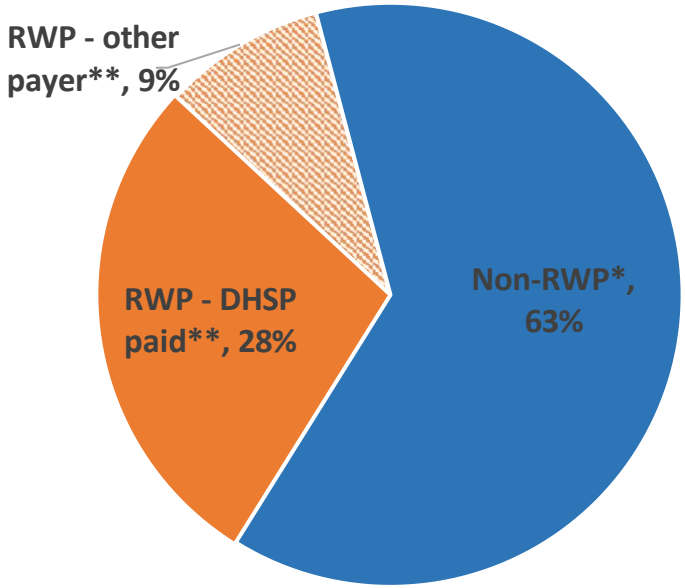
RYAN WHITE PROGRAM CLIENTS

Figure 1 below estimates RWP services use among people living with diagnosed HIV (PLWDH) in LAC in RWP Year 32 (March 1, 2022 - February 28, 2023).

- The orange section shows the percent of PLWDH who accessed RWP services that were paid for by DHSP RWP funds. This will be the population of focus for this report.
- The orange and white stripe section shows the percent of PLWDH who accessed RWP services that were ultimately paid for by another source such as Medi-Cal, Medi-Care, or other insurance
- The blue section shows the percent of PLWDH who did not use any RWP service. This means they receive medical care and other services through other systems of care.

In RWP Year 32, approximately 1 in 4 PLWDH received at least one RWP service paid by DHSP with RWP funds.

Figure 1. Use of RWP services among PLWDH in LAC (N=53,577), Year 32*



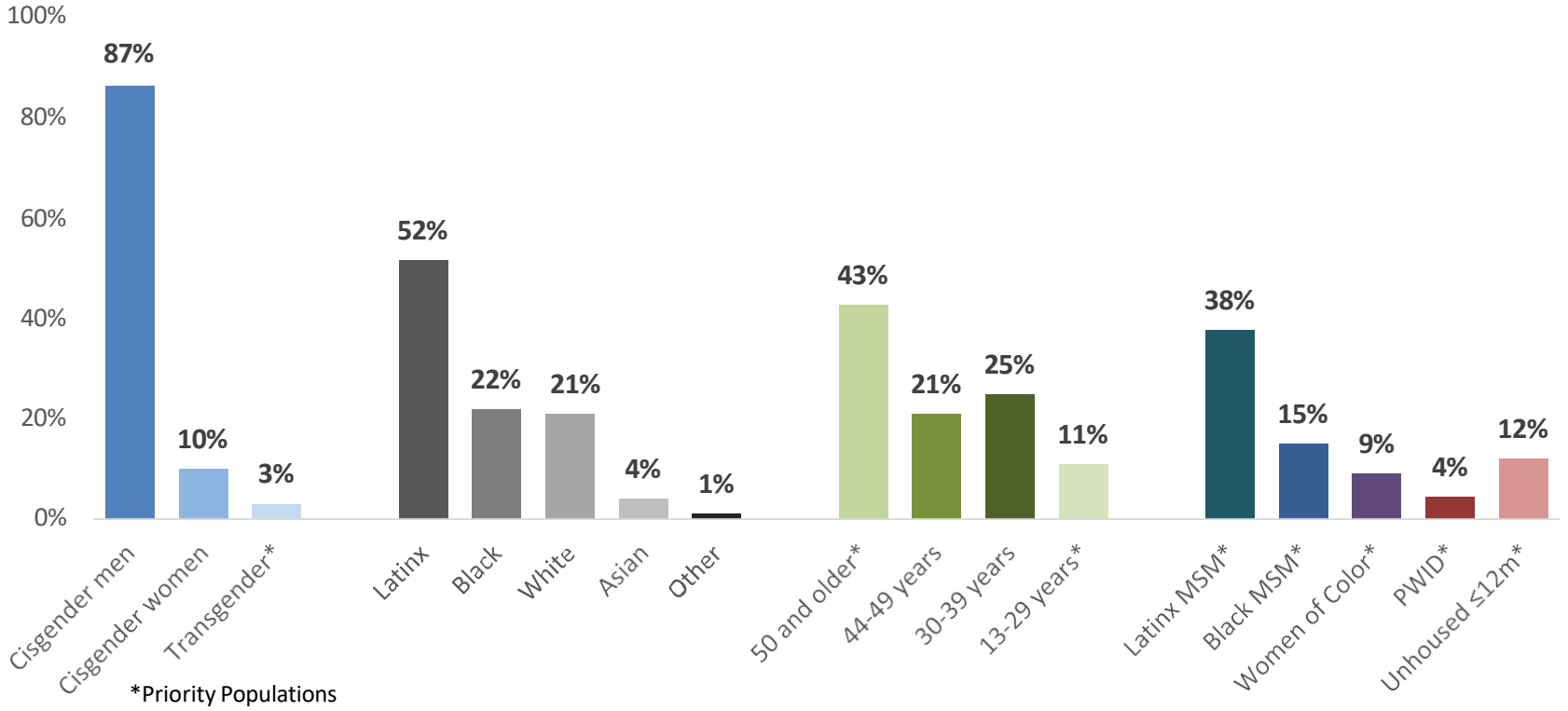
*LAC surveillance data for calendar year 2022 (Jan-Dec 2022)
**CaseWatch data for RWP year 32 (Mar 2022-Feb 2023)

Socio-Demographic Characteristics and Social Determinants of Health among RWP Clients

Of the 14,772 RWP clients **who** accessed RWP funded services in Year 32, 24% received at least one RWP-supported medical care visit in the reporting period.

In Year 32, the majority of RWP clients were Latinx or Black/African American (52% and 22%, respectively), cisgender male (87%), PLWH ≥ Age 50 (43%), living at or below the Federal Poverty Level (63%), MSM (71%) and residing in Hollywood-Wilshire Health District (19%). (Figure 2, Supplemental Table 1)

Figure 2. Demographic Characteristics and Priority Populations among RWP Clients in LAC, Year 32

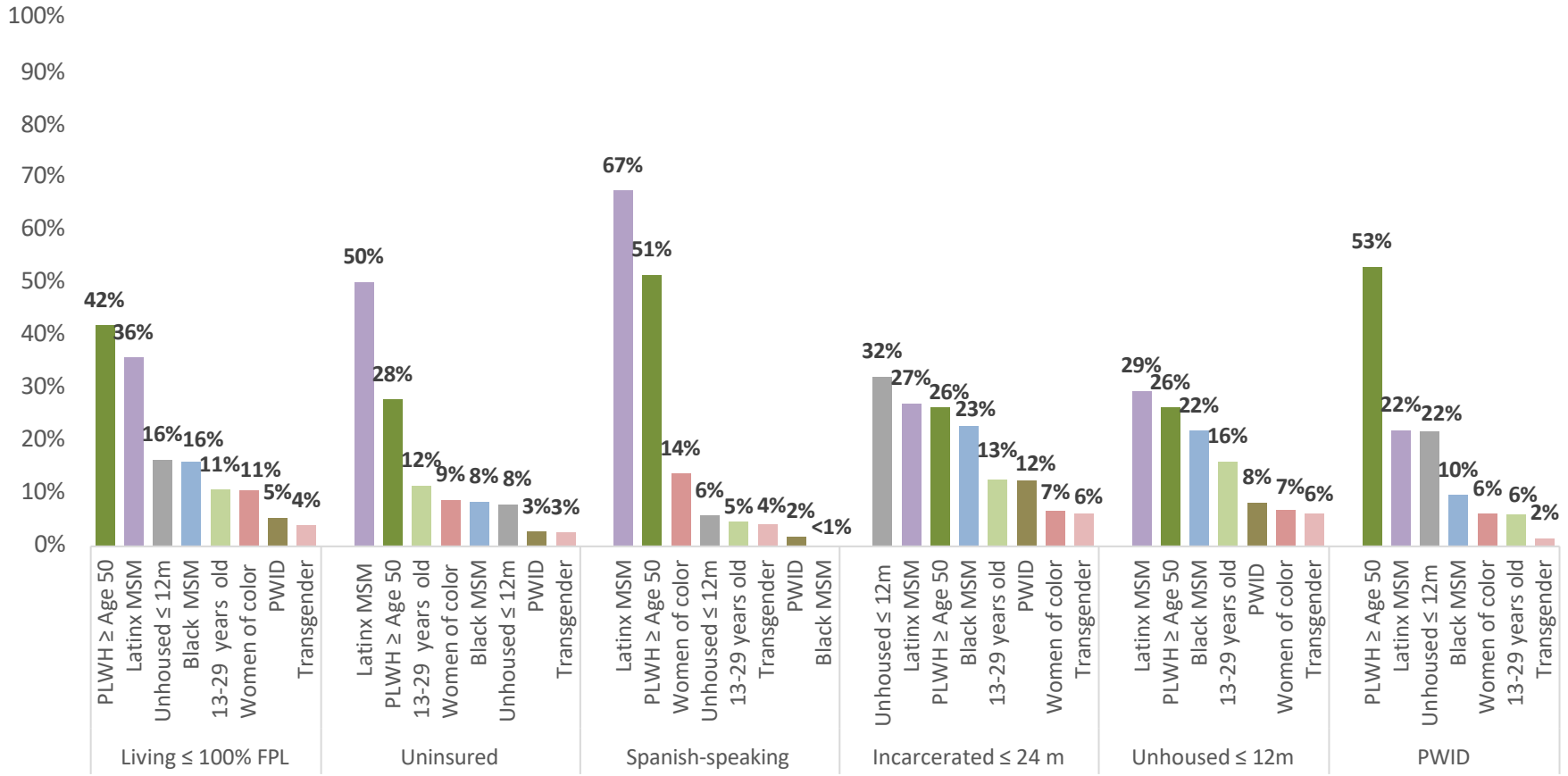


The demographic characteristics of RWP clients have remained stable over the past five RWP years *except for age*. The percent of clients aged 50 and older has increased overtime, reflecting the aging HIV epidemic locally and across the US. For more information about client characteristics over time, please refer to Supplemental Table 1.

Figure 3 presents key determinants of health by priority population:

- **Living at or below FPL**: highest among PLWH ≥ Age 50 (42%) followed by Latinx MSM (36%)
- **Uninsured**: highest among Latinx MSM (50%) followed by PLWH ≥ Age 50 (28%)
- **Primary Spanish-Speakers**: highest among Latinx MSM (67%) followed by PLWH ≥ Age 50 (51%)
- **Recent Incarceration**: highest among unhoused in past 12 m (325) followed by Latinx MSM (27%)
- **Unhoused in the Reporting Period**: highest among Latinx MSM (29%) followed by PLWH ≥ Age 50 (26%)
- **PWID**: highest among PLWH ≥ Age 50 (53%) followed by Latinx MSM and unhoused in past 12 m (22% each)

Figure 3. Social Determinants of Health by Priority Populations among RWP Clients in LAC, Year 32

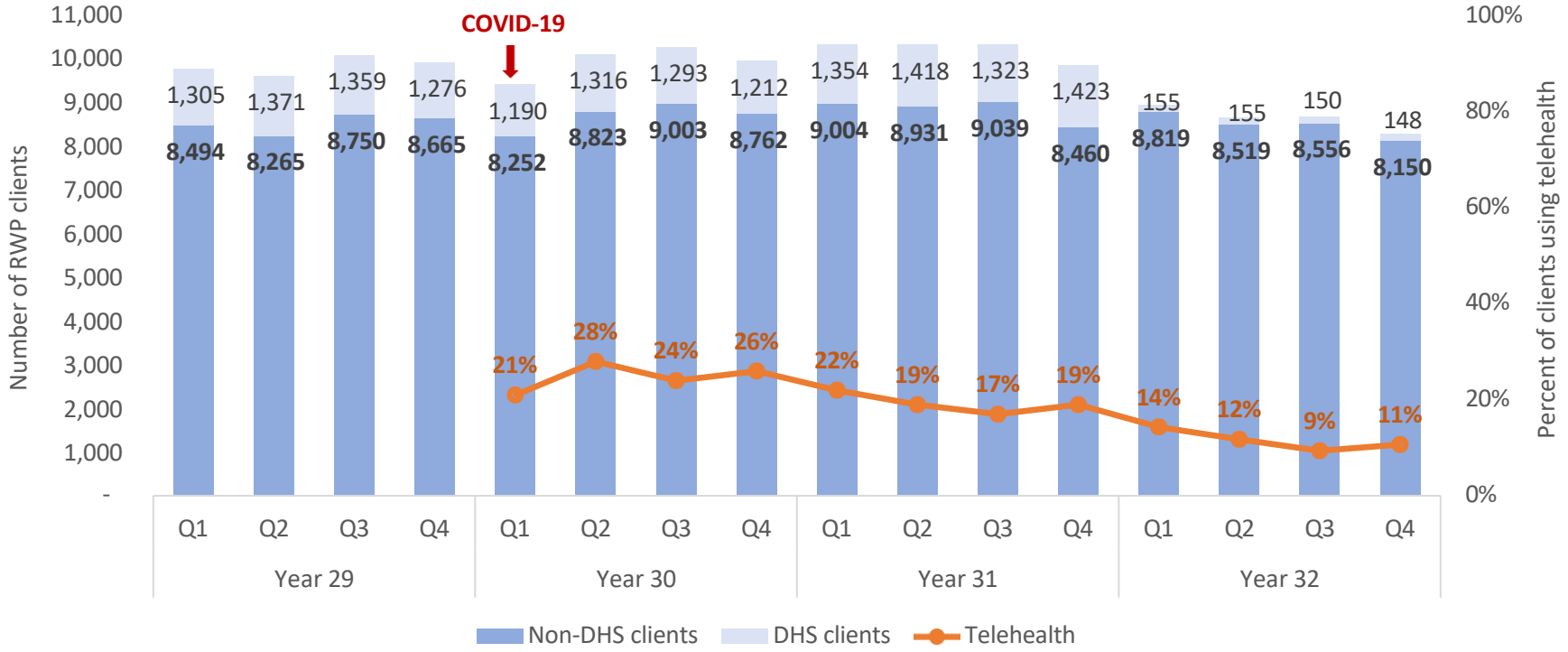


SERVICE UTILIZATION

Figure 4 below shows the number of RWP clients accessing services for RWP Years 29-32 (March 1, 2019 – February 28, 2023) by quarter to show the impact of the COVID-19 pandemic on utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. Each bar represents the total number of clients by quarter. The light blue part of the bar shows the number of DHS clients. The darker blue part of the bar shows the number of all other (non-DHS) clients. We can see that the total number of clients decreased starting in quarter 1 of Year 32 however we can see the utilization of RWP by non-DHS clients has remained stable.

The orange line shows the percent of RWP services that were utilized through telehealth modalities. Telehealth was a critical strategy to promote continuity of care for RWP clients during the COVID-19 pandemic. MCC, AOM, Non-Medical Case Management (NMCM), Mental Health (MH), and Home-Based Case Management (HBCM) continued to be offered to clients with a telehealth option through Year 32. About 25% of RWP clients received at least one of the RWP services via telehealth in Year 32 (43% in Year 31). RWP services with the highest usage of telehealth were MH (51%), MCC (35%), and AOM (23%). Supplemental Table 2 provides more detail about telehealth services.

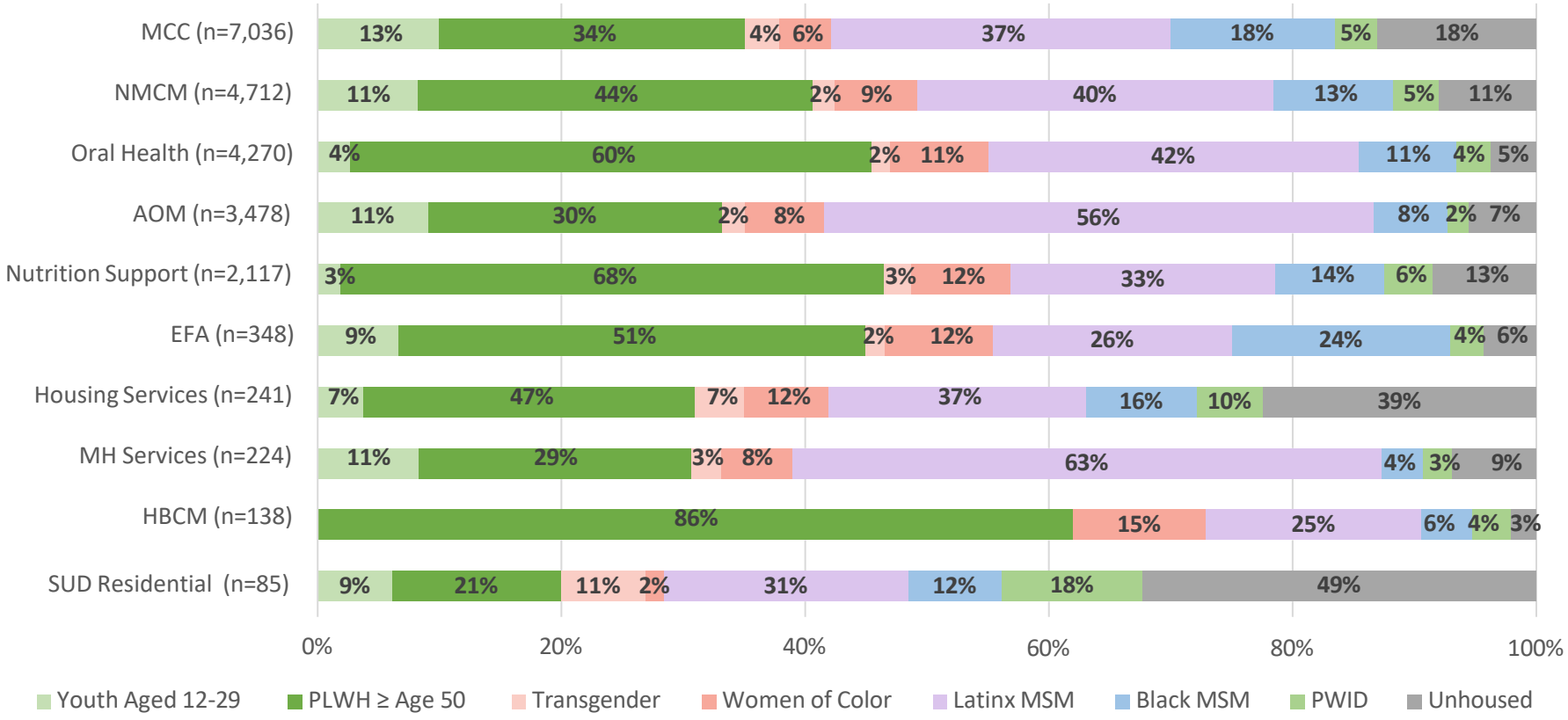
Figure 4. Service Usage and Telehealth Usage among RWP Clients, Years 29-32 by quarter



SERVICE UTILIZATION AMONG PRIORITY POPULATIONS

In Year 32, the MCC, Non-Medical Case Management (NMCM) and Oral Health services were used by the highest number of RWP clients. The figure below presents use of each service category by priority populations.

Figure 5. Utilization of RWP Services by Service Categories and by Priority Populations, LAC, Year 32

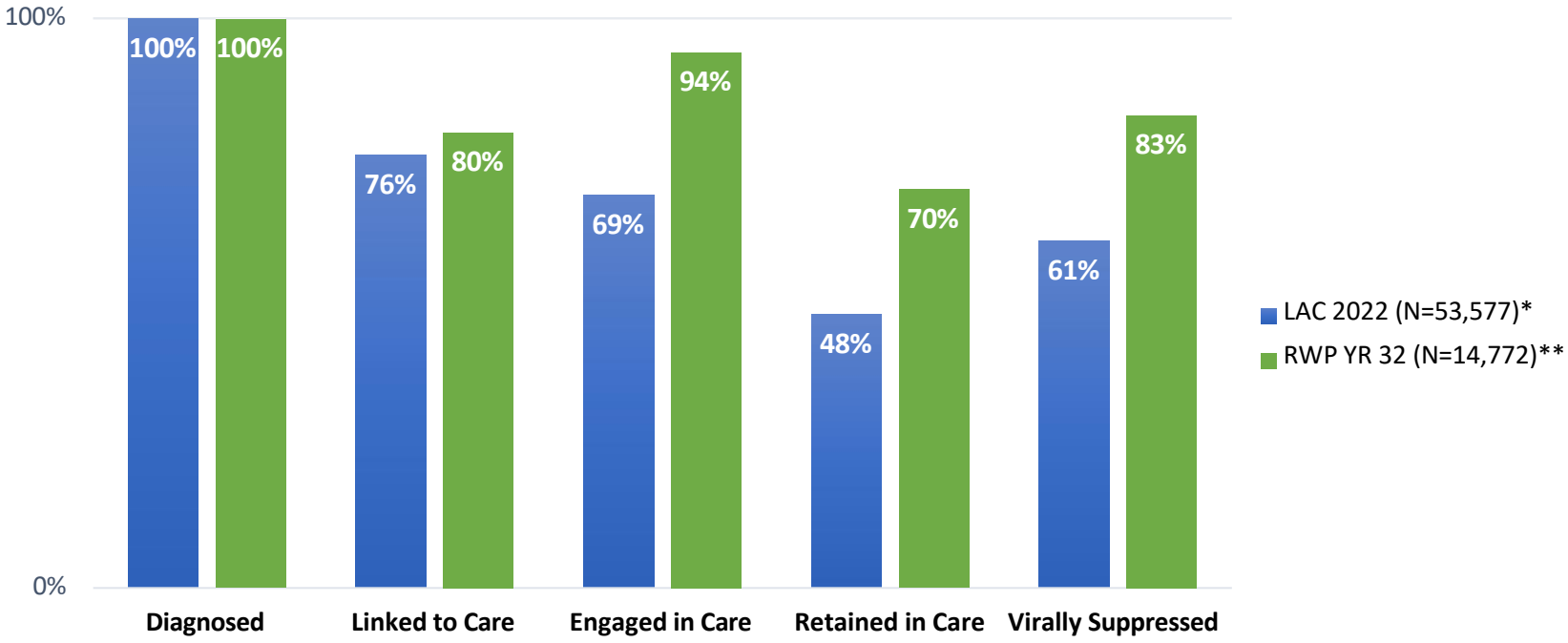


Among priority populations, the highest usage of all services was among Latinx MSM and/or PLWH ≥ Age 50, with the exception of Housing and SUD Residential services where the highest percentage of people utilizing these services was among unhoused people.

HIV CARE CONTINUUM FOR RWP CLIENTS

Figure 6 below shows Health Care Continuum (HCC) outcomes for RWP clients compared to all PLWH in LAC. Higher proportions of RWP clients were linked to care within 30 days of diagnoses, engaged in care, retained in care (RiC) and achieved viral suppression (VS) in RWP Year 32 compared to all PLWH in LAC. Of the 14,772 clients who received RWP services in Year 32, 94% were engaged in care, 70% were retained in care (RiC), and 83% achieved viral suppression (VS) in the past 12 months.

Figure 6: HIV Care Continuum Comparing People Living with Diagnosed HIV and Ryan White Program Clients in Year 32, Los Angeles County

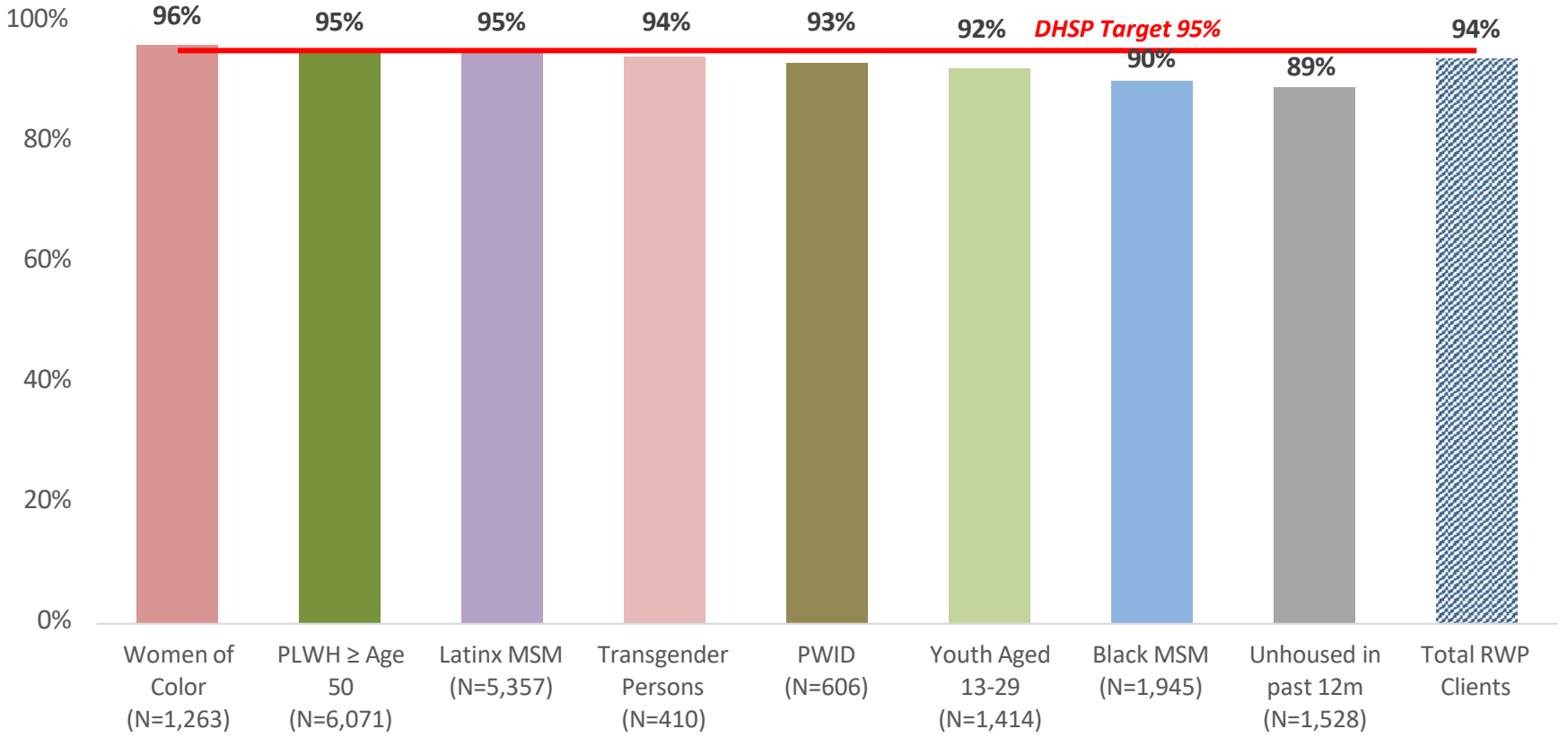


*LAC surveillance data for calendar year 2022 (Jan-Dec 2022)
**CaseWatch data for RWP year 32 (Mar 2022-Feb 2023)

- ***Engagement in HIV Care***

Figure 7 shows engagement in HIV care defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period among priority populations. Engagement in care for RWP clients was the highest among women of color (96%), following by PLWH ≥ 50 year of age and Latinx cisgender MSM (95% each). Engagement in care was lowest for Black cisgender MSM (90%) and unhoused in past 12 months (89%).

Figure 7: Engagement in HIV Care among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]

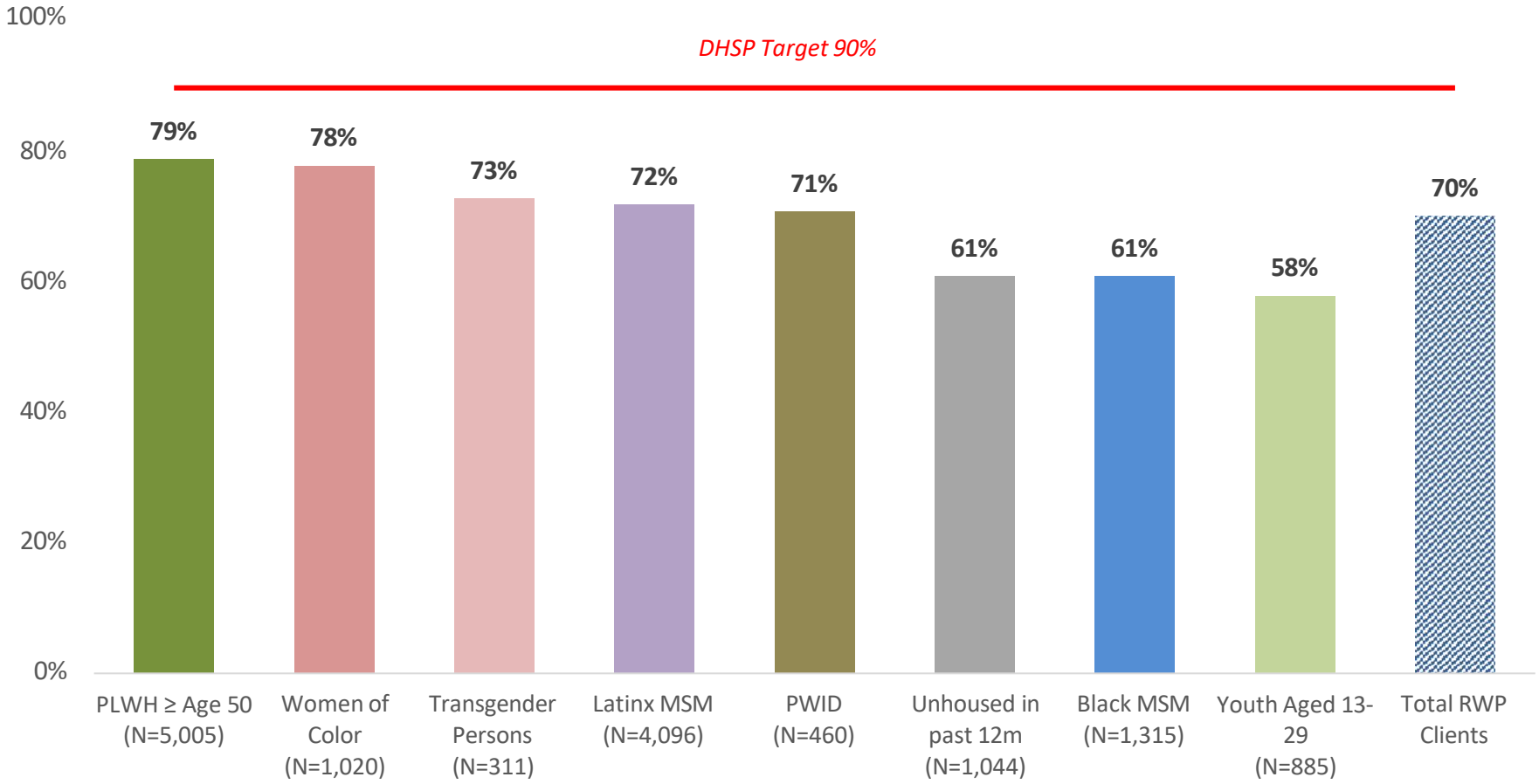


[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

- ***Retention in Care***

Figure 8 shows retention in care (having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period) among priority populations. The percent of RWP clients retained in care was the highest for PLWH aged 50 and older (79%) and cisgender women of color (78%). Retention in care was lowest among youth aged 13-29 (58%).

Figure 8: Retention in Care among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]

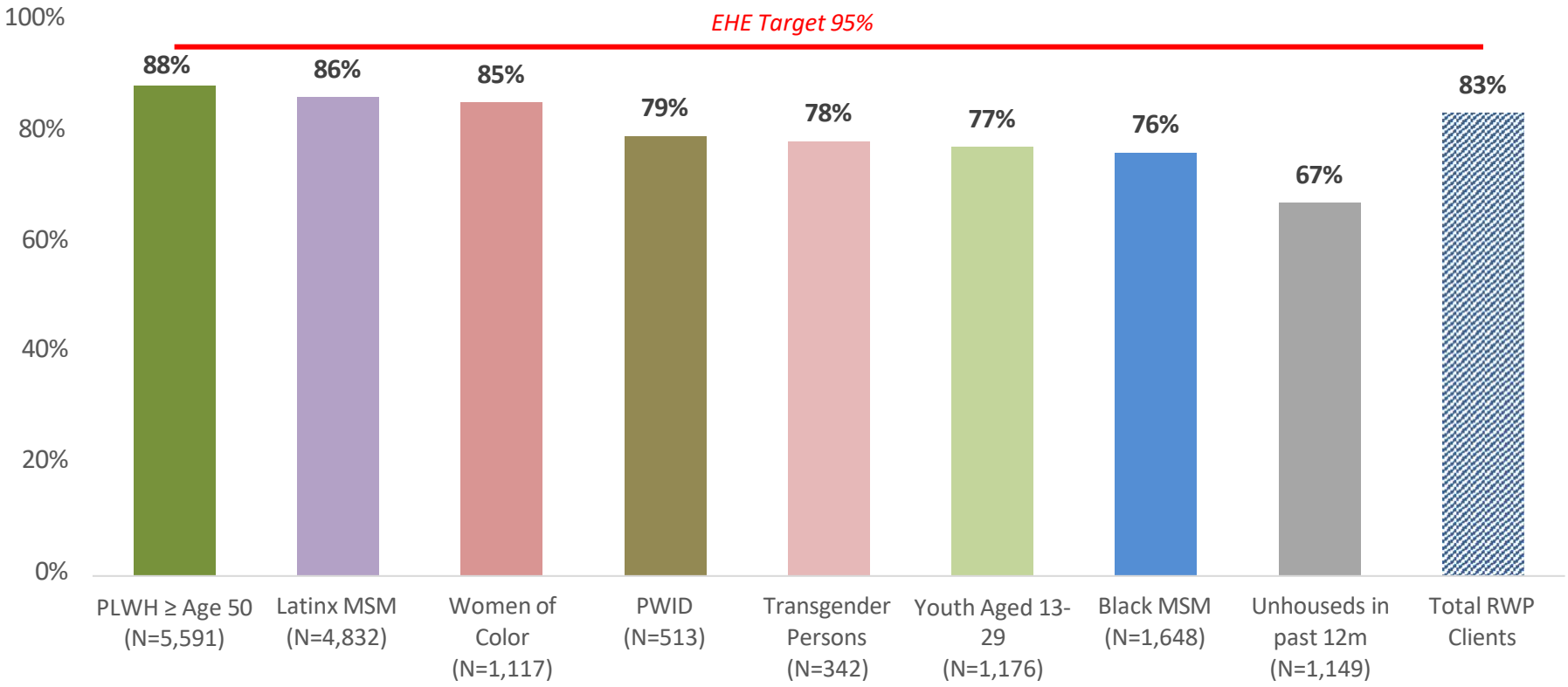


[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

- ***Viral Suppression***

Figure 9 shows viral suppression (viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period) among priority populations. Among priority populations, the percent of RWP clients who were virally suppressed was the highest for clients aged 50 and older (88%), and the lowest for people who were experiencing homelessness in past 12 months (67%).

Figure 9: Viral Suppression among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]



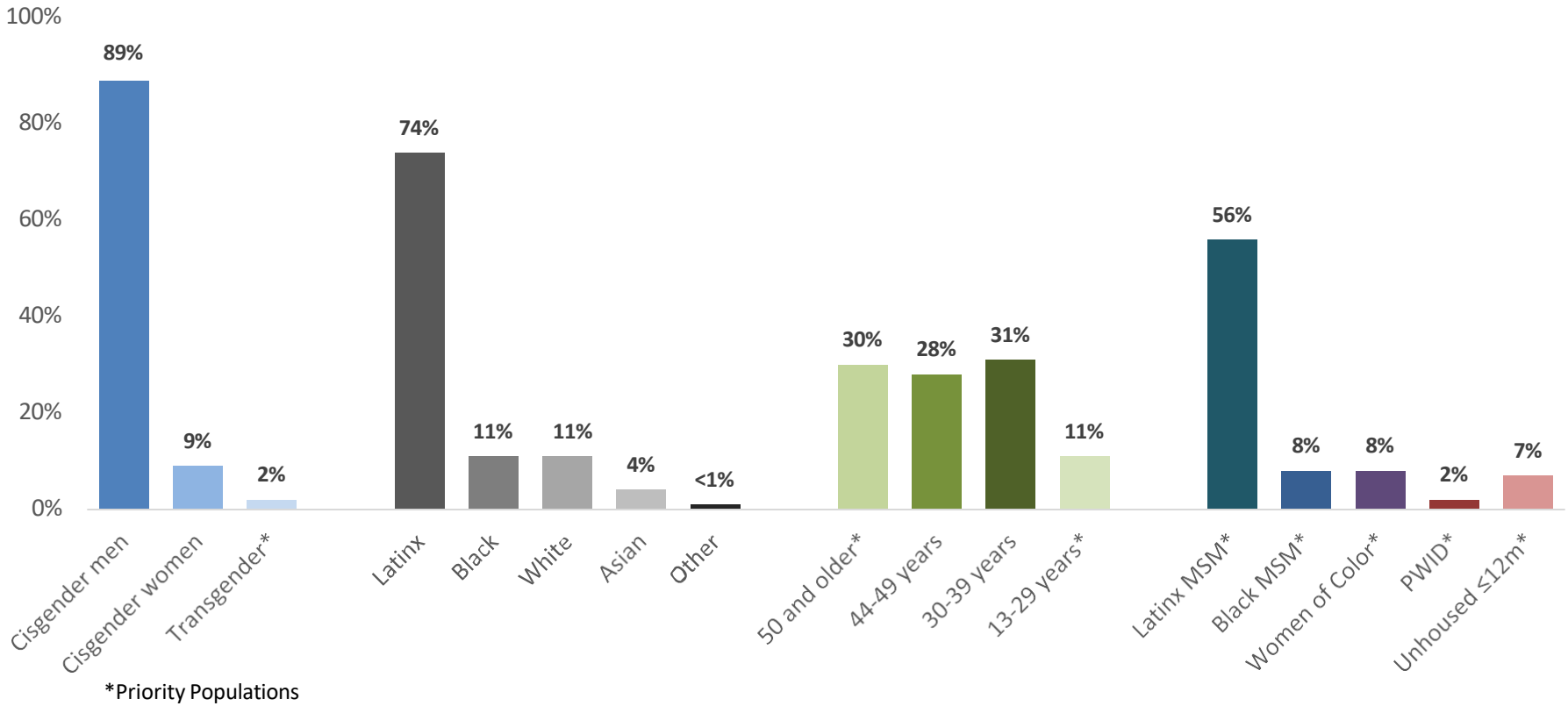
[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

Please see the supplemental tables for details on changes in HCC outcomes over time.

AMBULATORY OUTPATIENT MEDICAL (AOM)

- ***Population Served:***
  - 3,478 clients received AOM services in Year 32.
  - Among those the highest percentages of clients receiving AOM services were among cisgender men, Latinx, aged 30-39 years old and PLWH ≥ Age 50, MSM, and residing in Hollywood-Wilshire HD.
  - By priority populations the highest percentage receiving AOM services was among Latinx MSM (56%) followed by clients aged 30-39 years old (31%) and clients aged 50 years and older (30%). (Figure 10)

Figure 10. Demographic Characteristics and Priority Populations among AOM Clients in LAC, Year 32

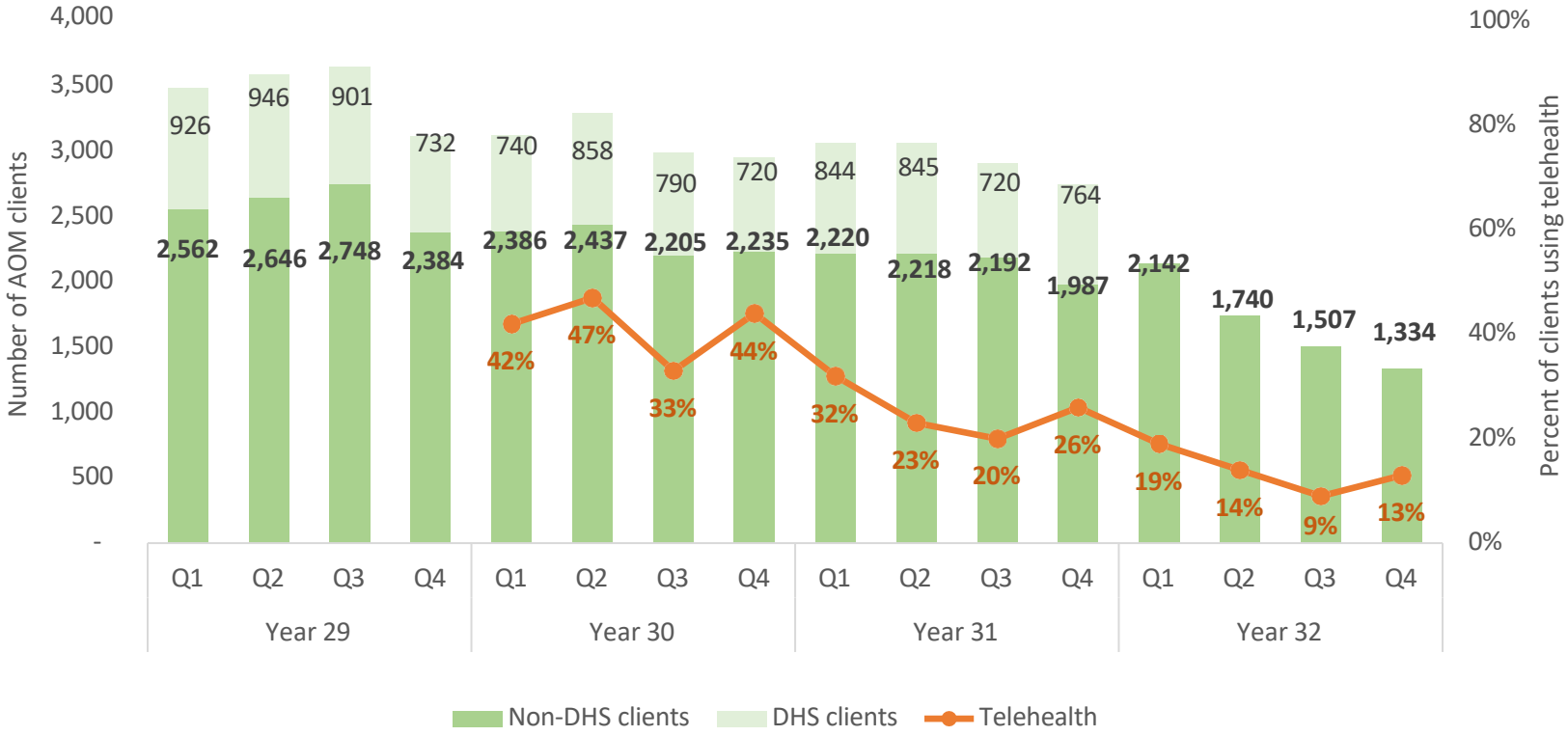


- ***Telehealth:***

Figure 11 below shows the number of RWP clients accessing AOM services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on AOM utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light green part of the bar shows the number of DHS clients. The darker green part of the bar shows the number of all other (non-DHS) clients. The total number of AOM clients decreased starting in quarter 1 of Year 32; however, we can see the utilization of AOM services by non-DHS clients has remained stable.

The orange line shows the percent of AOM services that were utilized through telehealth modalities. About 23% of AOM visits were offered via telehealth in Year 32. This is lower than telehealth percentage in Year 31 (39%), however it remains an important mode of healthcare for certain populations, including White (27%), non-binary/non-conforming gender identity (50%), incarcerated ever (37%), people experiencing homelessness (22%), PWID (32%), and residing in Hollywood-Wilshire HD (27%).

Figure 11. Number of Department of Health Services (DHS) and Non-DHS AOM Clients by Quarter in LAC, RWP Years 30-32



- ***Service Utilization and Expenditures:***
  - Year 32 Funding Sources: **RWP Part A (100%)**
  - Percentage of RWP Clients Accessing AOM in Year 32: **24%**
  - Unit of Service: **Visits**

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

Priority Populations	Unique Clients	% of Clients	Total Visits	% of Visits	Visits per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total AOM clients	*3,478*	*100%*	*8,891*	*100%*	*2.6*	*$1,692*	*$5,884,932 (Part A)*
Latinx MSM	1,961	**56%**	5,306	**60%**	**2.7**	**$1,791**	$3,511,936
PLWH ≥ Age 50	1,045	30%	2,622	29%	2.5	$1,661	$1,735,450
Youth Aged 12-29	397	11%	844	9%	2.1	$1,407	$558,627
Women of Color	282	8%	756	9%	**2.7**	**$1,774**	$500,381
Black MSM	263	8%	513	6%	2.0	$1,291	$339,544
Unhoused in past 12 m	241	7%	529	6%	2.2	$1,453	$350,135
Transgenders Persons	84	2%	202	2%	2.4	$1,592	$133,700
Persons who inject drugs (PWID)	75	2%	193	2%	2.6	**$1,703**	$127,743

Table 1 Highlights

- *Population Served:* Approximately one-third of clients accessing AOM services were MSM of color (32%): 28% Latinx MSM and 4% Black MSM.
- *Service Utilization:*
  - About two-thirds of the total AOM visits were attended by MSM of color (66%): 60% by Latinx MSM and 6% by Black MSM.
  - Visits per client were highest among Latinx MSM and women of color (2.7 visits per client each) and lowest among Black MSM (2.0 visits per client) compared to total AOM clients and other subpopulations.
  - The percent of AOM visits was higher relative to their population size among Latinx MSM and women of color represented (56% vs 60% and 8% vs 9%).
- *Expenditures:*
  - Latinx MSM, women of color, and PWID had higher expenditures per client than the average for all AOM clients ($1,692)
  - Compared to the percent out of total AOM clients, Latinx MSM, women of color, and PWID (1-2%) had disproportionally higher expenditures per client

- ***Health Care Continuum (HCC) Measures***

Table 2 below shows HCC outcomes for RWP clients receiving AOM services in Year 32. AOM clients had better HCC outcomes compared to RWP clients who did not receive AOM services.

Table 2. HIV Care Continuum Outcomes for AOM Clients and non-AOM Clients in LAC, Year 32

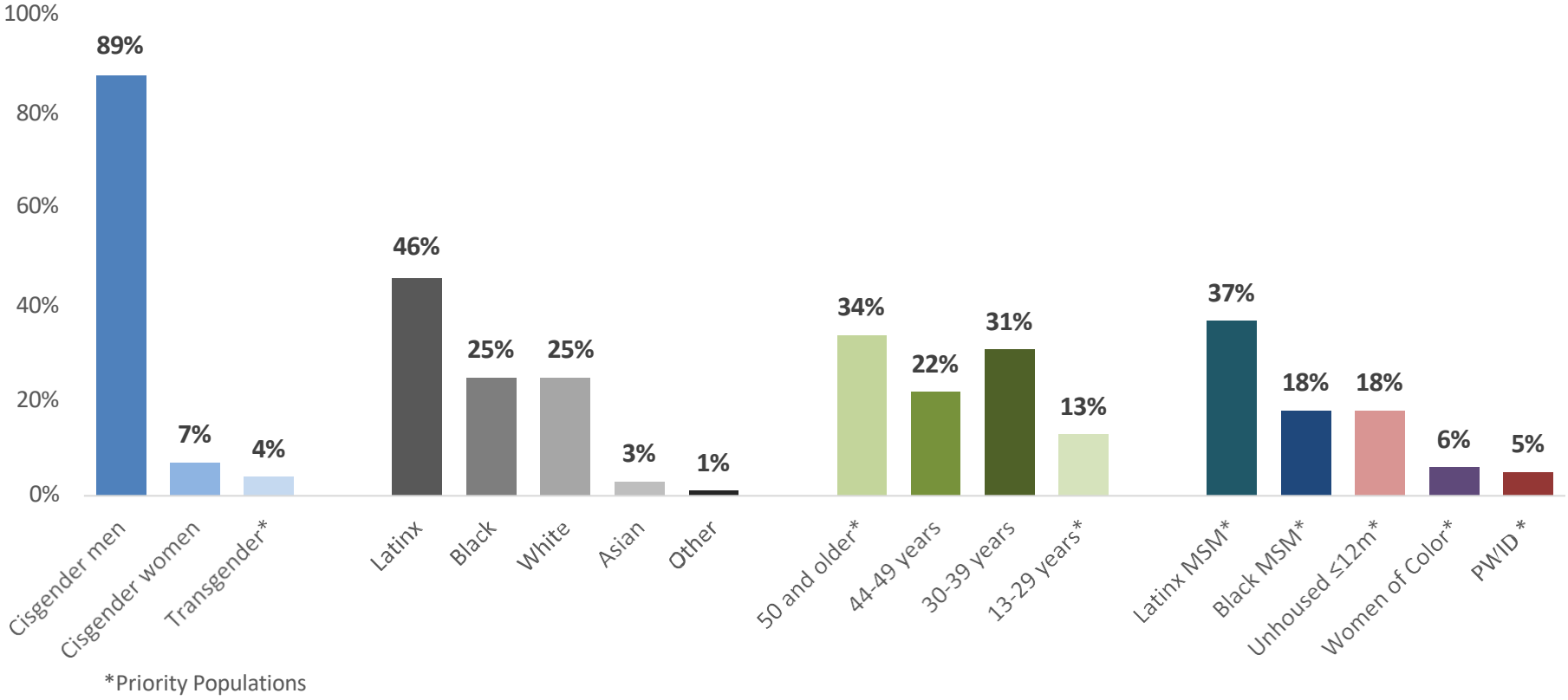
HCC Measures	AOM clients		Non-AOM clients	
	N	Percent	N	Percent
Engaged in HIV Care [a]	3,421	98%	10,425	92%
Retained in HIV Care[b]	2,586	74%	7,795	69%
Suppressed Viral Load at Recent Test[c]	2,164	89%	9,170	81%

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

MEDICAL CARE COORDINATION (MCC)

- ***Population Served:***
  - 7,036 clients received MCC services in Year 32.
  - Among those the highest percentages of clients receiving MCC services were among cisgender men, Latinx, aged 50 and older, MSM, and residing in Hollywood-Wilshire HD.
  - By priority populations the highest percentage receiving MCC services was among Latinx MSM (37%) and PLWH ≥ Age 50 (34%). (Figure 12)

Figure 12. Demographic Characteristics and Priority Populations among MCC Clients in LAC, Year 32

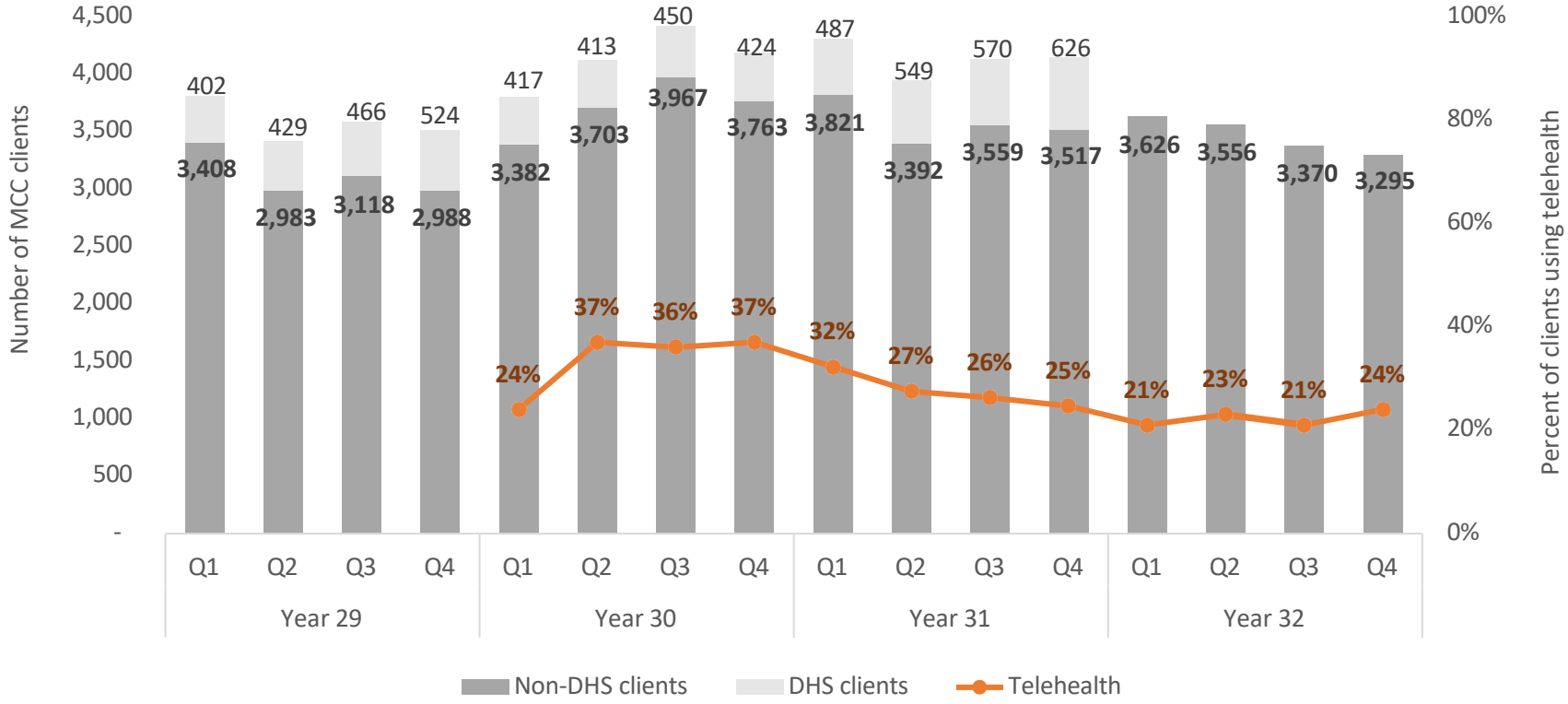


- ***Telehealth:***

Figure 12 below shows the number of RWP clients accessing MCC services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on MCC utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light grey part of the bar shows the number of DHS clients. The darker grey part of the bar shows the number of all other (non-DHS) clients. The total number of MCC clients decreased starting in quarter 1 of Year 32; however, we can see the utilization of MCC services by non-DHS clients has remained stable.

The orange line shows the percent of MCC services that were utilized through telehealth modalities. About 35% of MCC visits were offered via telehealth in Year 32. Although it is lower than the telehealth percentage in Year 31 (46%), it remains an important mode of healthcare for certain populations, such as Latinx (37%), transgender (48%), incarcerated over 2 years ago (38%), and unhoused in past 12 m (38%), PWID (74%), and residing in Hollywood-Wilshire HD (34%).

Figure 12. Telehealth Usage among MCC Clients, Years 30-32 by Quarter, LA County



- ***Service Utilization and Expenditures:***
  - Year 32 Funding Sources: **RWP Part A (92%), MAI (8%)**
  - Percentage of RWP Clients Accessing MCC in Year 32: **48%**
  - Unit of Service: **Hours**

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

Priority Populations	Unique Clients	% of Clients	Total Hours	Hours per Client	Percent of Hours	Expenditures per Client	Estimated Expenditures by subpopulation
Total MCC clients	***7,036***	***100%***	***91,401***	***13.0***	***100%***	***$1,375***	***$8,918,584 (Part A), $752,548 (MAI)***
Latinx MSM	2,628	37%	33,835	12.9	37%	$1,361	$3,577,401
PLWH ≥ Age 50	2,369	34%	33,470	14.1	37%	$1,494	$3,538,809
Black MSM	1,276	18%	14,957	11.7	16%	$1,239	$1,581,415
Unhoused in past 12 m	1,234	**18%**	22,235	18.0	**24%**	**$1,905**	$2,350,924
Youth (29 years and younger)	942	13%	12,122	12.9	13%	$1,361	$1,281,668
Women of Color	403	6%	7,498	18.6	8%	**$1,967**	$792,769
Persons who inject drugs (PWID)	330	5%	6,674	20.2	7%	**$2,138**	$705,647
Transgender Persons	265	4%	4,131	15.6	5%	$1,648	$436,774

Table 3 Highlights

- *Population Served:* Over half of clients using MCC services in Year 30 were MSM of color - 37% were Latinx MSM and 18% were Black MSM.
- *Service Utilization:*
  - Over half of the total MCC hours were used by MSM of color (53%): 37% by Latinx MSM and 16% by Black MSM.
  - Hours per client were highest among PWID (20.2 hours per client) and women of color (18.6 hours per client), and the lowest among Black MSM (11.7 hours per client) compared to total MCC clients and other subpopulations.
  - Unhoused MCC clients representing 18% of all MCC clients used the higher number of MCC hours per client (24%).
  - The percent of MCC hours was higher relative to their population size among women of color, transgender, PLWH ≥ Age 50, and PWID
  - The percent of MCC hours was lower relative to their population size among Black MSM
- *Expenditures:*
  - PWID had the highest expenditures per client ($2,138), followed by women of color ($1,967) and unhoused ($1,905)
  - PWID, women of color, unhoused, transgender, PLWH ≥ Age 50 had higher expenditures per client than the average for all MCC clients
  - Compared to the population size, unhoused people, PLWH ≥ Age 50, women of color and PWID had disproportionally higher expenditures per client

- ***Health Care Continuum (HCC) Measures***

Table 4 below shows HCC outcomes for RWP clients receiving MCC services in Year 32. RWP clients receiving MCC services in Year 32 had worse HCC outcomes compared to RWP clients who were not enrolled in the MCC program.

Table 4. Health Care Continuum among MCC Clients and non-MCC Clients in LAC, Year 32

HCC Measures	MCC clients		Non-MCC clients	
	N	Percent	N	Percent
Engaged in HIV Care[a]	6,395	91%	7,451	96%
Retained in HIV Care[b]	4,380	62%	6,001	78%
Suppressed Viral Load at Recent Test [c]	6,836	77%	5,441	88%

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

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. Main findings for service utilization are presented below in Table 5.

Table 5. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	AOM	MCC
Primary Populations Served	• Latinx and Black • Cisgender male • PLWH ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH aged 30-39 and ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH ≥ Age 50 • MSM
Utilization over time	• Decreased over time by 6% from Year 28 and 13% from Year 31 due to exit of DHS from RWP	• 35% lower number of RWP clients in Year 32 compared to Year 31 due to DHS exit from RWP	• 15% decrease in the number of MCC clients in Year 32 compared to Year 31, due to DHS exit from RWP
Telehealth	• Telehealth usage decreased to 25% compared to Year 31 (43%). The highest telehealth usage among: - Latinx - Non-binary and transgender clients - PWID - Unhoused	• 23% of AOM services provided via telehealth. The highest telehealth usage among: - Non-binary clients - Unhoused - PWID	• About 35% of MCC services were provided via telehealth in Year 32. The highest telehealth usage among: - Transgender people - Women of Color - Unhoused - PWID
HCC outcomes	• The lowest percentage of engagement in care was among unhoused people and Black MSM • The lowest percentage of RWP clients RiC was among youth aged 13-29, Black MSM and unhoused • The lowest percentage of VS was among unhoused	• AOM clients had higher engagement and RiC and VS compared to non-AOM clients	• MCC clients had lower engagement, RiC and VS compared to non-MCC clients
Service Units per Client	N/A (units vary)	3 visits per client	13 hours per client
Expenditures	$45.9 million: $42.1 million - Part A $3.8 million - MAI	Total $5,884,932 (Part A) $1,692 per client	$8,918,584 (Part A), $752,548 (MAI) $1,375 per client

Latinx MSM	• The largest populations receiving RWP services • About 25% of Latinx MSM received RWP services via telehealth • The 3rd highest percentage of engagement in HIV care • The 2nd highest percentage of VS • The highest percentage of Spanish-speakers • The highest percentage of uninsured	• Represented over a half of all AOM clients (56%) and accounted for about 60% percentage of services provided • Among priority populations average numbers of visits and expenditures were higher than respective average numbers for all AOM clients The highest per client visits and expenditures among priority populations	• 37% MCC clients and accounted for the same percentage of services provided Average number of visits and expenditures were slightly lower than respective average numbers for all MCC clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• 8% of all AOM clients and accounted for about 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• 18% of all MCC clients and accounted for about 16% of services provided • Average number of visits and expenditures were lower than respective average numbers for all MCC clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low MCC service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The 3rd highest percentage of uninsured among priority populations • The lowest percentage of RiC among priority populations	• 11% of all AOM clients but accounted for 9% of AOM services • Lower per client service units (visits) and expenditures than average for all AOM clients • Reasons for low AOM service utilization are unclear but may reflect	• 13% of all MCC clients and accounted for the same percentage of service hours provided • Lower per client service hours and expenditures than the average for all MCC clients

		poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• One of the lowest utilizers of MCC services as demonstrated by the percentage of total visits they received and average hours per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • The 2nd highest percentage of engagement in care among priority populations • The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • The 2nd highest percentage of uninsured, Spanish-speaking, and unhoused people	• 30% of all AOM clients and accounted for 29% of AOM services • One of the highest utilizers of AOM services as demonstrated by the percentage of total visit. • Moderately lower per client service units (visits) and expenditures than respective average for all AOM clients	• 34% of all MCC clients and accounted for 37% of services provided • One of the highest utilizers of MCC services as demonstrated by the percentage of total hours they received and average hours per client • Expenditures per client were above the average for all MCC clients
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • The 2nd highest percentage of RiC among priority populations	• 8% of all AOM clients and accounted for 9% of services provided • The second highest utilizers of AOM services as demonstrated by the number of visits per client. • The second highest per client expenditures for AOM services among priority populations	• 6% of all MCC clients and accounted for 8% of services provided • The highest utilizers of MCC services as demonstrated by the number of hours per client • The 2nd highest per client expenditures for MCC services among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • The highest percentage of unhoused people • The 2nd highest percentage of people living ≤ FPL	• 2% of all AOM clients and accounted for the same percentage of services provided • Lower per client visits and expenditures than respective averages for all AOM clients	• 4% of MCC clients and accounted for 5% of services provided • Average number of service hours and expenditures were considerably higher than respective average numbers for all MCC clients

		• Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• 7% of clients receiving AOM service and 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients	• 18% of clients receiving MCC service and accounted for 24% percentage of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • High utilization of MCC services by unhoused people may be reflective of complexity of social and behavioral issues in this subpopulation.
PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • The 2nd highest percentage of unhoused in past 12 m	• 2% of clients receiving AOM service and accounted for the same percentage of services provided • Average number of visits and expenditures were higher than respective average numbers for all AOM clients • The 2nd highest number of per client AOM visits among priority populations • The 3rd highest per client expenditures for AOM services among priority populations	• 5% of clients receiving MCC service and accounted for 7% of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • The highest number of per client hours of MCC service among priority populations • The highest per client expenditures for MCC services among priority populations

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