



LOS ANGELES COUNTY
COMMISSION ON HIV



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PLANNING, PRIORITIES & ALLOCATIONS COMMITTEE MEETING

Tuesday, January 21, 2025
1:00pm – 3:00pm (PST)

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020

**As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.*

Agenda and meeting materials will be posted on our website at
<https://hiv.lacounty.gov/planning-priorities-and-allocations-committee>

Register Here to Join Virtually

<https://lacountyboardofsupervisors.webex.com/weblink/register/rf546839b4edd3e05727af2339d651127>

Public Comments

You may provide public comment in person, or alternatively, you may provide written public comment by:

- Emailing hivcomm@lachiv.org
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

** Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting. All public comments will be made part of the official record.*

Accommodations

Requests for a translator, reasonable modification, or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act, are available free of charge with at least 72 hours' notice before the meeting date by contacting the Commission office at hivcomm@lachiv.org or 213.738.2816.



Scan QR code to download an electronic copy of the meeting packet. Hard copies of materials will not be available in alignment with the County's green initiative to recycle and reduce waste. If meeting packet is not yet available, check back prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.

together.

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MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: <https://hiv.lacounty.gov>

**AGENDA FOR THE REGULAR MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV
PLANNING, PRIORITIES, &
ALLOCATIONS COMMITTEE**

TUESDAY, JANUARY 21, 2025 | 1:00 PM – 3:00 PM

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

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:

To Register + Join by Computer:

<https://lacountyboardofsupervisors.webex.com/weblink/register/rf546839b4edd3e05727af2339d651127>

To Join by Telephone: 1-213-306-3065

Password: PLANNING Access Code: 2531 549 6353

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Felipe Gonzalez Co-Chair <i>Rita Garcia (Alternate)</i>	Al Ballesteros, MBA	Lilieth Conolly
Michael Green, PhD	William King, MD, JD	Miguel Martinez, MPH, MSW	Daryl Russell
Harold Glenn San Agustin, MD	Dee Saunders	LaShonda Spencer, MD	Lambert Talley (Alternate)
Jonathan Weedman			
QUORUM: 7			

AGENDA POSTED: January 16, 2024

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

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

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

- | | |
|---------------------------------------|-------------------|
| 7. Executive Director/Staff Report | 1:15 PM – 1:22 PM |
| a. Operational and Commission Updates | |

- b. 2025 Commission on HIV Work Plan
- c. 2027-2031 Integrated HIV Plan

- 8. Co-Chair Report 1:22 PM – 1:30 PM
 - a. 2025 Committee Co-Chair Elections
 - b. 2025 Planning, Priorities and Allocations Committee Strategic Priorities

- 9. Division of HIV and STD Programs (DHSP) Report 1:30 PM – 1:50 PM

V. DISCUSSION ITEMS 1:50 PM—2:55 PM

- 10. Antelope Valley Data Overview

- 11. Directives Development and Approval

MOTION #3: Approve the Ryan White PY35-37 Program Directives, as presented or revised.

VI. NEXT STEPS 2:55 PM – 2:57 PM

- 12. Task/Assignments Recap
- 13. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:57 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

- 15. Adjournment for the meeting of January 21, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order, as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.
MOTION #3	Approve the Ryan White PY35-37 Program Directives, as presented or revised.



CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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



HYBRID MEETING GUIDELINES, ETIQUETTE & REMINDERS

(Updated 7.15.24)

- This meeting is a **Brown-Act meeting** and is being recorded.
 - Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
 - Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

- **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

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

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

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

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial [HERE](#) or contact Commission staff at hivcomm@lachiv.org.



COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 1/3/25

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
ALE-FERLITO	Dahlia	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	Miguel	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	Jayda	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	AI	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & Linked Referral...(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
Transportation Services			
BURTON	Alasdair	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	Danielle	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Transportation Services
CIELO	Mikhaela	Los Angeles General Hospital	No Ryan White or prevention contracts
CONOLLY	Lilieth	No Affiliation	No Ryan White or prevention contracts
CUEVAS	Sandra	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	Mary	Bartz-Altadonna Community Health Center	Biomedical HIV Prevention/EHE

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	Erika	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	Kevin	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	Kerry	ViiV Healthcare	No Ryan White or prevention contracts
FRAMES	Arlene	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	Arburtha	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA	Rita	No Affiliation	No Ryan White or prevention contracts
GERSH (SBP Member)	Lauren	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
			Residential Care Facility - Chronically Ill
Data to Care Services			
GONZALEZ	Felipe	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	Bridget	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	Joseph	Unaffiliated representative	No Ryan White or prevention contracts
HALFMAN	Karl	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	David	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	Ismael "Ish"	Unaffiliated representative	No Ryan White or prevention contracts
JONES	Terrance	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	Lee	Unaffiliated representative	No Ryan White or prevention contracts
KING	William	W. King Health Care Group	No Ryan White or prevention contracts

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
MARTINEZ-REAL	Leonardo	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	Leon	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MENDOZA	Vilma	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	Mark	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLETTE	Andre	Men's Health Foundation	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
			Data to Care Services
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
			Residential Care Facility - Chronically Ill
Data to Care Services			
OSORIO	Ronnie	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	Byron	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
Transportation Services			
PERÉZ	Mario	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	Dechelle	AMAAD Institute	Community Engagement/EHE
ROBINSON	Erica	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	Daryl	Unaffiliated representative	No Ryan White or prevention contracts
SATTAH	Martin	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	Harold	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral...(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SAUNDERS	Dee	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	LaShonda	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	Kevin	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	Lambert	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	Justin	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	Jonathan	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	Russell	Capitol Drugs	No Ryan White or prevention contracts



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

**PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A)
COMMITTEE MEETING MINUTES
November 19, 2024**

COMMITTEE MEMBERS			
P = Present P* = Present as member of the public; does not meet AB 2449 requirements A = Absent EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Matthew Muhonen	LOA
Felipe Gonzalez, Co-Chair	EA	Daryl Russell	P
Al Ballesteros, MBA	P	Harold Glenn San Agustin, MD	P
Lilieth Conolly	AB2449	Dee Saunders	EA
Rita Garcia	A	LaShonda Spencer, MD	A
Michael Green, PhD, MHSA	EA	Lambert Talley	A
William King, MD, JD	P	Jonathan Weedman	LOA
Miguel Martinez, MPH, MSW	P	Joseph Green	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Lizette Martinez			
DHSP STAFF			
Paulina Zamudio			

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

*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.

*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission’s website. Click [HERE](#).

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:00pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

K. Donnelly conducted roll call vote and committee members were reminded to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, L. Connolly, W. King, M. Martinez, D. Russell, H. San Agustin, K. Donnelly, J. Green

3. Approval of Agenda

MOTION #1: Approve the Agenda Order (**✓Passed by Consensus**)

4. Approval of Meeting Minutes

MOTION #2: Approval of Meeting Minutes (**✓Passed by Consensus**)

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS

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

There was no committee new business.

IV. REPORTS

7. Executive Director/Staff Report

a. Operational and Commission Updates

- C. Barrit, Executive Director, reported that the Commission on HIV (COH) will be hosting two events in December in commemoration of World AIDS Day 2024. One event will be held in Antelope Valley in collaboration with Supervisorial District 5 on December 3rd at Bartz-Altadonna Community Health Clinic. The Black Caucus will be hosting an event on December 6th in collaboration with Supervisorial District 3 at Charles Drew University. See COH [Events webpage](#) for more details.

8. Co-Chair Report

a. PP&A Committee December Meeting

- K. Donnelly reported that the December PP&A Committee meeting is cancelled. The committee will reconvene on January 21, 2025.

b. 2025 Co-Chair Nominations

- K. Donnelly opened up the floor for 2025 PP&A Committee co-chair nominations.
- K. Donnelly and F. Gonzalez were nominated for 2025 PP&A Committee co-chairs.
- Nominations will remain open until the committee reconvenes on January 19, 2025, at which elections will be held.

c. Antelope Valley Listening Sessions

- K. Donnelly reported that the Antelope Valley Listening Sessions, held on October 28, 2024, went well and there was great discussion held. The listening sessions in the Antelope Valley revealed challenges such as lack of knowledge of services within the area, limited access to care in outlying areas and outside of traditional business hours, and stigma around HIV, sexual orientation, and gender identity.
- Commission staff provided an overview of findings from the listening sessions, highlighting key challenges and recommendations from the community to improve HIV care and prevention services. See [meeting packet](#) and [event summary](#) for more details.
- It was noted that there is a lack of infrastructure to provide comprehensive HIV prevention and care services, as well as support services. Many providers exist in the area as satellite offices with limited hours and staff.
- Attendees expressed a need to form a coalition in the Antelope Valley with the focus to regularly convene and educate providers/agencies on resources available and develop a referral process.
- The committee suggested requesting surveillance and care continuum data within the Antelope Valley from the Division of HIV and STD Programs (DHSP) to assess the true scope of HIV in the area. It was noted that the total population of people living with HIV in the Antelope Valley is not vary large.

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

- There was no DHSP report.

V. DISCUSSION ITEMS

10. Paradigm and Operating Values Updates and Approval

MOTION #3: Approve the Paradigms and Operating Values, as presented or revised.

- The committee approved the Paradigms and Operating Values. **MOTION #3: Approve the Paradigms and Operative Values, as presented or revised. (Approved; A. Ballesteros – Y, L. Conolly-Y, W. King-Y, M. Martinez- Y, D. Russel-Y, H. San Agustin-Y, K. Donnelly, J. Green-Y)**

11. Review DHSP HIV and STD Surveillance Dashboards

- Commission staff provided an overview of the Los Angeles County HIV and STD Surveillance Dashboards. Staff highlighted key geographic areas with increased HIV incidence and demonstrated how the dashboard can be manipulated to get information by region, gender identity, race/ethnicity, etc.
- See the DHSP Data Dashboard [website](#) for more details.

12. Directives Development

- The group reviewed the revised suggested directives; see [meeting packet](#) for more details.

Suggested directives were compiled from suggestions made a various Commission, Committee and/or Consumer meetings and discussions and align with needs identified via data reports.

VI. NEXT STEPS

13. Task/Assignments Recap

- a. Commission staff will revise suggested directives to reflect recommendations/revisions suggested during discussion.
- b. Commission staff will send a send an email reminding the committee that the December PP&A meeting is cancelled and that the group will reconvene on January 21, 2025.

14. Agenda Development for the Next Meeting

- a. Review Antelope Valley Surveillance and Care Continuum data from DHSP.
- b. Elect 2025 PP&A Committee Co-chairs.
- c. Complete directive development.

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

- 16. Adjournment for the Meeting of November 19, 2024.**
The meeting was adjourned by K. Donnelly at 4:00pm.

December 20, 2024

Dear Ryan White HIV/AIDS Program Colleagues,

As many of you know, earlier this year the Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau (HAB) introduced [Ryan White Program 2030 \(RWP 2030\)](#), a renewed vision for the Ryan White HIV/AIDS Program (RWHAP). Building on 35 years of success and innovation, RWP 2030 integrates lessons learned from the RWHAP and the Ending the HIV Epidemic in the U.S. (EHE) initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP **while expanding efforts to identify and engage individuals with HIV who are undiagnosed or out-of-care**¹.

Achieving this goal will require a comprehensive, collaborative approach that builds upon existing successes and resources while fostering innovation². At its core, RWP 2030 reflects our shared commitment to improving health outcomes for people with HIV. This vision calls on the HIV community to establish and strengthen partnerships, prioritize community engagement, and utilize focused interventions to end the HIV epidemic.

Since 2010, viral suppression among people receiving HIV medical care through the RWHAP has increased significantly, from 69.5% to 90.6% in 2023. Thanks to advancements in treatment, HIV is now a manageable chronic condition for individuals who remain engaged in care, allowing them to live long, healthy lives while preventing transmission to others. Despite this progress, we recognize that approximately 40% of people with HIV in the U.S. are either undiagnosed or not receiving regular care, contributing to most new HIV infections. Addressing these gaps is essential to achieving our goal of ending the epidemic.

Through EHE, we have seen the power of targeted investments and innovative strategies. In 2022, EHE-funded providers served over 22,000 individuals who were new to care and re-engaged more than 19,000 individuals who were out of care. Remarkably, 79.2% of individuals new to care achieved viral suppression, underscoring the effectiveness of our collective efforts. These successes highlight the importance of combining strategic investments with community-driven planning to achieve high-impact outcomes.

Ryan White Program 2030 emphasizes the importance of sustaining care for those already engaged in the RWHAP, while expanding our reach to ensure timely diagnosis and sustained treatment for underserved communities. This will require collaboration across sectors, innovation in care delivery, and a commitment to addressing barriers to care. We must also engage individuals with lived experience and non-traditional partners to inform program planning³ and care models that are responsive to the needs of diverse communities.

¹ Legal authority: §§ 2602(b)(4), 2617(b), 2664(a), and 2671(c) of the Public Health Service (PHS) Act.

² Legal authority: §§ 2603(b)(2)(B), 2620, 2654(c), and 2691 of the PHS Act.

³ Legal authority: § 2681 of the PHS Act.

Ryan White HIV/AIDS Program recipients play a critical role in advancing the goals of RWP 2030 and are responsible for employing sound planning and decision-making processes to determine which HIV related services are prioritized and how much to fund them. As part of these responsibilities, RWHAP recipients must continue to base service priorities and resource allocation decisions on the size, demographics, and needs of people with or affected by HIV. RWP 2030 specifically entails a renewed focus on reaching those who are undiagnosed or out of care. This may necessitate a re-evaluation of existing resource allocations to ensure outreach, engagement, and support efforts are effectively scaled to meet the needs of these especially high-need populations while still addressing the needs of individuals who are currently receiving care through the RWHAP.

We encourage you to begin engaging your partners in discussions about this vision and its implications for your work. Over the next several months, HRSA HAB will work to develop additional guidance and tools to support your efforts in implementing RWP 2030. The [RWHAP Best Practices Compilation](#) contains effective innovative interventions and best practices on outreach, linkage to and engagement in care. [TargetHIV](#) also contains a number of trainings, resources, and reference guides to support recipients and subrecipients in providing care to people with HIV. HAB is also planning a series of listening sessions in 2025 to ensure that RWP 2030 is informed by diverse perspectives and to better understand the challenges and barriers to implementing this vision.

We are confident that, with your continued partnership, we can realize the goals of RWP 2030 and bring us closer to ending the HIV epidemic. If you have questions, please contact your HRSA HAB Project Officer.

Thank you for your unwavering dedication to improving the lives of people with HIV.

Sincerely,

/Laura W. Cheever/

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



January 17, 2025

Dear Ryan White HIV/AIDS Program Grant Recipients and Substance Use Prevention, Treatment, and Recovery Services Block Grant Single State Authority Directors (SSAs):

Improving the care and treatment of people with HIV is a shared priority across the public health community. The [National HIV/AIDS Strategy for the United States](#) identifies key national goals for ending the HIV epidemic, which include prioritizing the mental health and substance use disorder (SUD) needs of the community. It is [estimated](#) that the prevalence of SUDs among people with HIV is approximately 48%, creating a syndemic in which the interaction of HIV and SUDs exacerbates health challenges and negatively impacts health outcomes.

[Addressing substance use](#) and SUDs is essential to ending the HIV epidemic as they pose significant barriers to engaging and retaining individuals in HIV care and treatment. People with HIV often face barriers, including stigma, discrimination, and the complex burden of managing a chronic condition. For many, these challenges are compounded by, and shared with, co-occurring SUDs which can adversely affect health outcomes and treatment engagement for both HIV and SUD. Substance use behaviors - such as injection drug use, increase the risk of acquiring or transmitting HIV, adversely impact adherence to [antiretroviral therapy](#), and, [perpetuate forward HIV transmissions](#). Addressing these interconnected issues requires building care models that can address the dual challenges of HIV and SUDs and leverage resources that provide comprehensive support.

There is an important opportunity for Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) grant recipients and Substance Abuse and Mental Health Services Administration (SAMHSA)-funded specialty behavioral health service programs through the Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG) to collaborate to form strategic partnerships, [braid funding](#), and advance the health of individuals with HIV with co-occurring substance use disorders. Collaboration across both programs can help address and mitigate interrelated issues and improve health outcomes for people with HIV and SUDs.

Ryan White HIV/AIDS Program

The RWHAP funds states, cities, and community-based organizations to provide critical health care and support services to over half the people with diagnosed HIV in the U.S. to help them get in and stay in HIV care. This includes a range of behavioral health services to support people with HIV, including inpatient and outpatient SUD treatment, mental health services, case management, and psychosocial support as described in [HRSA HAB Policy](#)

[Clarification Notice #16-02 Ryan White HIV/AIDS Program Services: Eligible Individual and Allowable Uses of Funds](#). In addition, RWHAP Part B AIDS Drug Assistance Programs are [encouraged to include medications for SUDs](#), including buprenorphine for opioid use disorder treatment and naloxone for acute opioid overdose reversal, on their formularies. RWHAP Parts A, B, and C employ sound planning and decision-making processes to determine which HIV related services are prioritized and how much to fund them, taking into account the size, demographics, and needs of people with or affected by HIV, including those with SUDs.

Substance Use Prevention, Treatment, and Recovery Services Block Grants

The SUPTRS BG program's objective is to help plan, implement, and evaluate activities that prevent, treat, and provide recovery support services for SUDs across the nation. Funds are distributed annually to the 50 states, all U.S. Territories and one Tribe, and through their sub-recipients, deliver substance use prevention and other services that can prevent or reduce substance use-related harms to individuals and communities impacted by substance use, and provide SUD treatment and recovery support services to individuals and families impacted by SUDs. Services provided can include [a range of SUD treatment options](#), including traditional outpatient, intensive outpatient, residential, and inpatient treatment services as well as a range of individual, family, school, and community prevention services. SUPTRS BG sub-recipients also provide [recovery support services](#) that are based in the community and occur across the lifespan of the individual. SUPTRS BG funds can also be used to purchase [medication for SUD](#), including methadone, buprenorphine, and naltrexone for opioid use disorder treatment; naloxone and other opioid overdose reversal medications for opioid overdose prevention; and medications for alcohol use disorder.

Collaboration Opportunities Examples

Collaboration between RWHAP and SUPTRS BG programs can enhance SUD services for people with HIV by leveraging resources, expertise, and infrastructure while working with partners such as local, tribal, and territorial public health departments, social services agencies (including aging services network and organizations), schools, private sector employers, and housing providers to help meet the health and social needs of persons with SUDs and HIV. Some examples of collaboration opportunities include:

- [Integrated care models](#) that offer co-located HIV care, mental health, SUD services, and psychosocial support such as case management, resource referral, system navigation and recovery support;
- Improving access to medications for the treatment of SUD, [including opioid use disorder](#) and [alcohol use disorder](#), [within HIV clinics](#) to reduce substance use, improve antiretroviral therapy adherence, deliver higher quality of HIV care, and improve quality of life;
- Cross-train providers in SUD management and HIV care;
- Conduct screenings for HIV, SUD and hepatitis and other sexually transmitted infections in clinics and community-based settings to ensure timely identification and treatment;

- Implement innovative interventions such as providing trauma informed care to people with HIV across the behavioral health care spectrum; and
- Jointly respond to HIV outbreaks traced to injection drug use.

The [RWHAP Best Practices Compilation](#) contains effective innovative interventions and best practices that improve health outcomes for people with HIV, including those with SUD. SAMHSA's evidence-based resource guidebook [Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders](#) reviews effective programs and practices to prevent HIV and, for those with HIV, to increase linkage and retention in care in order to improve health outcomes.

HRSA and SAMHSA share a mission to support individuals with HIV and SUDs by promoting accessible, high-quality care. We encourage recipients to explore new partnerships, engage communities, and adopt innovative care models that integrate HIV and SUD services to support comprehensive and client-centered care. Recipients are encouraged to document and share their collaboration activities through their respective reporting requirements to allow HRSA and SAMHSA to identify and amplify successful models that can be replicated across other jurisdictions.

If you have questions, please reach out to your HRSA HAB Project Officer and/or your SAMHSA Center for Substance Abuse Treatment or Center for Substance Abuse Prevention State Project Officer who is responsible for the SUPTRS BG, for more information.

Together, we can strengthen the public health response, improve health outcomes, prevent and reduce SUDs, strengthen recovery, and make significant strides toward ending the HIV epidemic.

Sincerely,

/Carole Johnson/

Carole Johnson
Administrator, Health Resources
and Services Administration

/Miriam E. Delphin-Rittmon, Ph.D./

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



LOS ANGELES COUNTY
COMMISSION ON HIV



Los Angeles County Commission on HIV

2025 TRAINING SCHEDULE

**SUBJECT TO CHANGE*

- All training topics listed below are mandatory for Commissioners and Alternates.
- All trainings are open to the public.
- Click on the training topic to register.
- Certificates of Completion will be provided.
- All trainings are virtual via Webex.
- For questions or assistance, contact: hivcomm@lachiv.org

[Commission on HIV Overview](#)

February 26, 2025 @ 12pm to 1:00pm

[Ryan White Care Act Legislative Overview and Membership Structure and Responsibilities](#)

March 26, 2025 @ 12pm to 1:00pm

[Priority Setting and Resource Allocations Process](#)

April 23, 2025 @ 12pm to 1:00pm

[Service Standards Development](#)

May 21, 2025 @ 12pm to 1:00pm

[Policy Priorities and Legislative Docket Development Process](#)

June 25, 2025 @ 12pm to 1:00pm

[Bylaws Review](#)

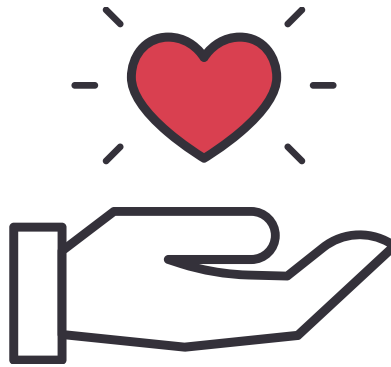
July 23, 2025 @ 12pm to 1:00pm



LOS ANGELES COUNTY
COMMISSION ON HIV



**LOS ANGELES COUNTY COMMISSION ON HIV CAUCUSES
PRESENT:**



2025 Consumer Resource Fair
“Love Begins with Me”
**Empowering Wellness, Advocacy and Community
Beyond HIV**

**THURSDAY, FEBRUARY 13, 2025
12:00PM - 5:00PM**

**THE CALIFORNIA ENDOWMENT
1000 N. ALAMEDA STREET, LOS ANGELES, CA 90012
FREE PARKING ON-SITE [MAP/DIRECTIONS HERE](#)**

Explore a variety of resources, including engaging workshops and presentations, interactive activities like Zumba, free food, exciting giveaways, and more! Don't miss this opportunity to connect with services that support holistic health and wellness beyond HIV.

Are you a vendor or service provider and would like to participate? Register [HERE](#).

For more information, email hivcomm@lachiv.org



2025 COMMISSION ON HIV WORKPLAN
Ongoing 12-26-24

#	DUTY/ROLE	LEAD (S)	NOTES/TIMELINE
1	Conduct ongoing needs assessments	PP&A Shared task with DHSP	<ul style="list-style-type: none"> Review, analyze and hold data presentations (Feb-August COH meetings)
2	Integrated/Comprehensive Planning Comprehensive HIV Plan Development	PP&A Shared task with DHSP	<ul style="list-style-type: none"> Review CDC/HRSA guidance Develop project timeline based on CDC/HRSA guidance CHP Due June 2026 Plan dedicated status-neutral and/or prevention-focused planning summit in collaboration with DHSP.
3	Priority setting	PP&A	<ul style="list-style-type: none"> July-September
4	Resource allocations/reallocations	PP&A	<ul style="list-style-type: none"> July-September Receive and review expenditure data – quarterly
5	Directives	PP&A	<ul style="list-style-type: none"> Complete by February 2025; secure COH approval by March 2025
6	Development of service standards	SBP Shared task with DHSP	<ul style="list-style-type: none"> Housing services Transitional case management
7	Assessment of the Efficiency of the Administrative Mechanism	Operations	<ul style="list-style-type: none"> PY 33 & PY 34 AEAM recipient and subrecipient surveys will be disseminated in January/February 2025. Reports completed by April 2025
8	Planning Council Operations and Support	Operations	<ul style="list-style-type: none"> Membership training Membership recruitment and retention Fill vacancies Mentorship program Bylaws and policies update



9	Complete restructuring framework and key principles and align with bylaws/ordinance updates.	Executive and Operations	<ul style="list-style-type: none">January- April 2025
10	MOU with DHSP	Co-Chairs and Executive Committee	<ul style="list-style-type: none">Complete by March 2025 (awaiting DHSP feedback)
11	Ongoing community engagement and non-member involvement of PLWH	Consumer Caucus and Operations	

Engage all caucuses, committees and subgroups in all functions.

Integrated Plan Components

Cycle Years 2027-2031

Due: June 30, 2026 @ 11:59pm ET

No longer than 100 pages

No smaller than 11 pt font

Update of existing plan or new plan

The Integrated Plan submission should demonstrate an understanding of and considerations for all funding sources, service delivery, and system integration (entire system of HIV prevention and care). It should include the following sections:

1. Introduction
2. Community Engagement and description of Jurisdictional Planning Process
3. Contributing Data Sets and Assessments, including:
 - a. Epidemiologic Snapshot
 - b. HIV Prevention, Care and Treatment Resource Inventory
 - c. Needs Assessment
4. Situational Analysis Overview, including priority populations/groups
5. CY 2027-2031 Goals and Objectives to be organized by the goals in the [NHAS](#) and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See Appendix 2 for examples.
6. Integrated Plan Workplan

Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2027- 2031

Division of HIV Prevention

**National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention**

HIV/AIDS Bureau

Health Resources and Services Administration

December 2024



Executive Summary

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed this guidance to support the submission of the Integrated HIV Prevention and Care Plan (hereafter referred to as Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031 (hereafter referred to as Integrated Plan Guidance). This guidance builds upon the previous guidance issued in 2015 and 2021. That guidance allowed funded health departments and planning groups to submit one integrated HIV plan to lead the implementation of both HIV prevention and care services. As in 2021, the Integrated Plan Guidance for CY 2027-2031 meets all programmatic and legislative requirements associated with both CDC and HRSA funding. It reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. The Integrated Plan Guidance necessitates engagement from a wide range of collaborators and partners including communities disproportionately affected by the HIV epidemic and people with HIV. The Integrated Plan Guidance intends to accelerate progress towards meeting national goals while allowing each jurisdiction to design a HIV services delivery system that reflects local vision, values, and needs.

CDC and HRSA funded recipients will notice several key changes in the Integrated Plan Guidance for CY 2027-2031. These changes reflect feedback from internal and external collaborators, which include recipients and people with HIV as well as priorities detailed in the [National HIV/AIDS Strategy 2022 – 2025 \(NHAS\)](#) published in December 2021 and the implementation strategies outlined in the [Ending the HIV Epidemic in the U.S. \(EHE\) initiative](#). Specifically, recipients who have already conducted extensive planning processes in response to the CDC’s *High-Impact HIV Prevention and Surveillance Programs for Health Departments (PS24-0047)* program or through other jurisdictional efforts (e.g., Getting to Zero plans, Fast Track Cities, HIV Cluster Detection and Response plans) may submit portions of those plans to satisfy this Integrated Plan Guidance as long as the Integrated Plan submission addresses the broader needs of the geographic jurisdiction and applies to the entire HRSA and CDC HIV funding portfolio. To that end, additional details on key changes can be found in the *CY 2027– 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist (See Appendix 1)*. This checklist details submission requirements and allows each jurisdiction to determine which elements may require new content and which elements were developed as part of another jurisdictional plan.

Integrated Plan submissions address the broader needs of the geographic jurisdiction and apply to the entire HRSA and CDC HIV funding portfolio. Additionally, jurisdictions should submit plans that follow the goals and priorities as described in the [NHAS](#) and use data to devise strategies that reduce new HIV infections by 90% by 2030. Proposed strategies should include the implementation of activities that will diagnose all people with HIV as early as possible, treat all people with HIV rapidly and effectively to reach sustained viral suppression, prevent new HIV transmissions by using proven interventions, and respond quickly to potential outbreaks to get appropriate prevention and treatment services to people who need them.

Section I: Introduction

In the United States, we have the tools to end the HIV epidemic and continue to make progress toward that goal. From 2018 to 2022, estimated HIV infections in the U.S. decreased by 12 percent largely attributed to the decrease in new HIV infections among people aged 13 to 24.¹ The work of dedicated individuals across HIV prevention and care delivery systems have contributed to this decrease in HIV diagnoses and the increase in viral suppression rates for clients in the Ryan White HIV/AIDS Program (RWHAP) from 69.5 percent in 2010 to 89.7 percent in 2022.

Although rates of new HIV incidence have decreased overall and viral suppression continue to increase, racial and ethnic differences in diagnoses and treatment outcomes of HIV persist. Health disparities persist among gay, bisexual and other men who have sex with men, particularly Black, Latino, and American Indian/Alaska Native men; Black women; transgender women; youth aged 13-24 years; and people who inject drugs². To reach the national goal of reducing new HIV infections, our systems of HIV prevention and care must work together in unprecedented ways to address health inequities that remain. This includes providing equal access to all available tools so that no population or geographic area is left behind and efforts to end the HIV epidemic are accelerated.

The Integrated Plan Guidance for CY 2027-2031 is the third five-year planning guidance developed by CDC and HRSA. This Integrated Plan Guidance builds on the previous iterations of the Integrated Plan Guidance by allowing each jurisdiction to develop new goals and objectives that align public and private sectors to leverage strengths from the last five years and to add or revise services to address local health inequities that may remain. The Integrated Plan Guidance speaks to the need for aggressive actions necessary to achieve the [NHAS](#) goals and targeted efforts to end the HIV epidemic in the U.S. by the year 2030.

Specifically, the Integrated Plan Guidance was designed to:

1. Coordinate HIV prevention and care activities by assessing resources and service delivery gaps and needs across HIV prevention and care systems to ensure the allocation of resources based on data (e.g., other payors, number of ADAP-eligible clients on health insurance coverage, in-depth analysis of needs assessment of people with HIV and people who can benefit from HIV prevention services or are vulnerable to HIV acquisition);
2. Address requirements for planning, community engagement, and coordination established by the RWHAP legislation as well as programmatic planning and community engagement requirements established by both HRSA and CDC through guidance;

¹ [HIV Surveillance Supplemental Report: Estimated HIV Incidence and Prevalence in the United States, 2018–2022](#)

² Black is defined as African American or Black and Latino is defined as Latino or Hispanic (U.S. Department of Health and Human Services. 2021. [National HIV/AIDS Strategy](#). (pp 19) Washington, DC

3. Improve health outcomes along the HIV care continuum by using data to prioritize those populations where systems of care are not adequately addressing high HIV morbidity and/or lower overall viral suppression rates;
4. Promote a whole-person approach³ to help overcome structural and social barriers to care, eliminate stigma, and improve the health of people with HIV and people who can benefit from prevention services;
5. Reduce recipient burden by allowing jurisdictions to submit portions of other significant planning documents (e.g., EHE Plans, Fast Track Cities, Getting to Zero, or HIV Cluster Detection and Response plans) to meet Integrated Plan requirements and by aligning submission requirements and dates across HIV prevention and care funding;
6. Advance health equity by ensuring that government programs promote equitable delivery of services and engage people with lived experience in service delivery system design and implementation; and,
7. Leverage strategic partnerships to prioritize efforts, and focus resources and evidence informed interventions, to reach those who are diagnosed, but not engaged in care.

Relationship to other National Plans and Initiatives

HRSA and CDC recognize that many jurisdictions have established and implemented extended planning processes as part of other local initiatives including but not limited to EHE funding, Fast Track Cities, locally funded Getting to Zero initiatives, or Cluster Detection and Response Plans. To minimize burden and align planning processes, the jurisdiction may submit portions of these plans to satisfy the Integrated Plan Guidance requirements. Jurisdictions should review the [NHAS](#) or subsequent updates to the current national plan by visiting www.hiv.gov and [subscribing to receive updates](#).

National Framework for Ending the HIV Epidemic

It is important to think about this Integrated Plan Guidance within the framework of national objectives and strategic plans that detail the principles, priorities, and actions that direct the national public health response and provide a blueprint for collective action across the federal government and other sectors (see *Appendix 5*). HRSA and CDC support the implementation of these strategies.

In January 2021, the U.S. Department of Health and Human Services (HHS) released the [NHAS](#) which creates a collective vision for HIV service delivery across the nation. Each jurisdiction should create Integrated Plans that address four goals⁴:

³ A whole-person approach to HIV prevention and treatment considers the multitude of factors affecting a person's health. Source: <https://www.cdc.gov/hiv/policies/strategic-priorities/hiv-and-whole-person-care/index.html#:~:text=A%20whole%2Dperson%20approach%20can,expand%20flexible%20and%20tailored%20interventions.>

⁴ U.S. Department of Health and Human Services. 2021. [National HIV/AIDS Strategy](#) (pp 3-10) Washington, DC.

- Prevent new HIV infections
- Improve HIV-related health outcomes of people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and collaborators

To achieve these goals, the [NHAS](#) identifies key priority populations, focus areas, and strategies. All plans submitted in response to the Integrated Plan Guidance should incorporate the national goals and strategies detailed in the NHAS. This should include activities that:

- Leverage public and private community resources toward meeting the goals;
- Address health inequities for priority populations including inequities related to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral health issues including but not limited to substance use disorders;
- Create strategic partnerships across a broad spectrum of service systems as a means to lessen the impact of social and structural determinants of health such as systemic racism, poverty, unstable housing and homelessness, stigma, and/or under- or un-employment;
- Implement innovative program models that integrate HIV prevention and care with other services and other service organizations as a means to address comorbid conditions and to promote a whole-person approach to care; and,
- Coordinates HIV prevention and care systems around key focus areas to strengthen the local response.

For more information on the NHAS, visit: <https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf>.

In 2020, HHS began implementation of the Ending the HIV Epidemic in the United States initiative coordinated around four strategies – diagnose, treat, prevent, and respond – that leverage highly successful programs, resources, and infrastructure. The EHE initiative aligns with the NHAS plan to reduce new HIV diagnoses in the United States, decreasing the number of new HIV infections to fewer than 3,000 per year. The EHE initiative focuses resources, expertise and technology in jurisdictions hardest hit by the HIV epidemic. For more information on the EHE initiative, visit: <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>.

The Integrated Plan Guidance utilizes the HIV care continuum model and the whole-person approach. The HIV care continuum depicts the stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to reach viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner, thus providing an additional strategy to prevent new HIV infections. Effective strategies to address barriers within HIV prevention, care, and treatment systems are needed to increase the number of people with HIV that reach and maintain viral suppression.

The adoption of a whole-person approach can improve HIV prevention and care service delivery and outcomes. Persons with positive test results should be linked to HIV care, treatment, and other social support services; and persons testing negative should be linked, as needed, to biomedical HIV prevention services, such as PrEP, and other social support services.

The HIV care continuum allows recipients and planning groups to measure progress and to direct HIV resources most effectively. HRSA and CDC encourage jurisdictions to use the HIV care continuum to identify populations for whom the service system may not be adequately engaging in HIV prevention services or may not support improved HIV health outcomes. Additionally, all jurisdictions should include performance measures in their Integrated Plan submission including the core performance measures that measure progress along the HIV care continuum for all priority groups. Please see *Appendix 4* for links to suggested CDC and HRSA data sources, performance measures, and indicators.

Section II: Planning Requirements and Submission Guidelines

Integrated planning is a vehicle for jurisdictions to identify HIV prevention and care needs, existing resources, barriers and gaps, and outline local strategies to address them. The Integrated Plan submission should articulate existing and needed collaborations among people with HIV, service providers, funded program implementers, and other collaborators, including but not limited to other programs funded by the federal government, such as the Housing Opportunity for Persons with AIDS (HOPWA) program and providers from other service systems such as substance use prevention and treatment providers. The Integrated Plan submission should reflect current approaches and use the most recent data available. To ensure coordinated implementation of their Integrated Plan submission, each jurisdiction should include information on the persons or agencies responsible for developing the plan, implementing the plan, coordinating activities and funding streams, and monitoring the plan.

HIV Planning Requirements

All CDC DHP and HRSA HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a system-wide plan for the delivery of HIV prevention and care services and the establishment of an HIV planning group, planning council, or advisory group, also known as a planning body.

By design, the HIV planning body must engage people with different interests, responsibilities, and involvement with HIV to inform and support the development and implementation of an Integrated Plan submission that guides the delivery of HIV prevention and care services. CDC and HRSA recognize and understand the value of individuals who receive services actively participating in the planning process for HIV service delivery, as this drives services that are tailored to the needs of clients in the jurisdiction, and these individuals must be engaged in the development and implementation process.

For the development of the Integrated Plan, jurisdictions should include and use their existing local prevention and care HIV planning bodies, as consistent with CDC and HRSA planning group requirements, and engage traditional collaborators and community members (e.g., people with HIV, people with certain risk factors for acquiring HIV, AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics and local education agencies (LEAs)) to get input. In addition, recipients should broaden their existing group of partners and collaborators to include other federal, state, and local HIV programs, local organizations, and community groups not previously engaged for the purposes of improving data sources, leveraging services, and assisting with key portions of the plan, such as the HIV prevention and care inventories.

When developing the Integrated Plan submission, the planning body should collaborate with the recipient to review and analyze data (e.g., resource inventory, needs assessments, satisfaction surveys, listening sessions) for program action and decisions, prioritize resources to those jurisdictions at highest risk for HIV transmission and acquisition, and address health equity by improving both individual and population-based HIV health outcomes in those jurisdictions. Through strategic collaborations among collaborators, HIV planning is based on the principle that local planning is the best way to respond to local HIV prevention and care service delivery needs and priorities. Please refer to CDC's most recent [HIV Planning Guidance \(HPG\)](#) and the [RWHAP Part A](#) and [Part B Manual](#) for more details about HIV planning processes.

Integrated Plan Components

The Integrated Plan submission should demonstrate an understanding of and considerations for all funding sources, service delivery, and system integration (entire system of HIV prevention and care). It should include the following sections:

1. Introduction
2. Community Engagement and description of Jurisdictional Planning Process
3. Contributing Data Sets and Assessments, including:
 - a. Epidemiologic Snapshot
 - b. HIV Prevention, Care and Treatment Resource Inventory
 - c. Needs Assessment
4. Situational Analysis Overview, including priority populations/groups
5. CY 2027-2031 Goals and Objectives to be organized by the goals in the [NHAS](#) and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See *Appendix 2* for examples.
6. Integrated Plan Workplan

In addition to these sections, please use the checklist attached, as *Appendix 1*, to ensure the jurisdiction submits all of the documents needed to meet submission requirements, including existing materials and newly developed materials needed for each required section.

As part of a complete Integrated Plan submission, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission. In RWHAP Part A jurisdictions that cross state lines, the Part A Planning Councils/Planning Bodies need to submit signed letters to all RWHAP

Part B jurisdictions included in the Part A jurisdiction. As part of the Integrated Plan submission, jurisdictions will need to outline the communities and collaborators represented in the planning and concurrence process (e.g., community members, people with HIV, service providers, governmental entities). Submissions that do not contain the required letters of concurrence will be deemed incomplete and returned for revisions.

See the table below for the required letters of concurrence depending upon the plan submission type. If there are additional planning bodies in the state/territory or jurisdiction, additional letters of concurrence should be submitted. Please see *Appendix 6* for a sample letter of concurrence.

Required Letters of Concurrence			
Planning Body	Type of Plan		
	Integrated State/City Prevention and Care Plan	Integrated State-Only Prevention and Care Plan	Integrated City-Only Prevention and Care Plan
RWHAP Part A Planning Council	✓	✓ ⁵	✓
RWHAP Part B Planning Group	✓	✓	
CDC Prevention Planning Group	✓	✓	✓

Submission

The Integrated Plan submission must include all the components outlined in this guidance and include a completed *CY 2027- 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be comprehensive to ensure that all HIV prevention and care funding work together to reduce new HIV diagnoses and to increase viral suppression among all people with HIV. The new plan should use existing documents such as an epidemiologic profile, if documents are current. Existing versions of documents may be updated or modified if needed during the current integrated planning process.

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan and must include the following:

- Detailed information of who is responsible for developing the Integrated Plan within the jurisdiction (i.e., RWHAP Part A planning councils/body(ies), RWHAP Part B advisory groups, Integrated Planning Bodies and CDC HIV planning bodies).
- Well defined goals and objectives. Each jurisdiction should provide a descriptive detail and process for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the goals of the [NHAS](#).

⁵ RWHAP Part A recipients needed to submit letters of concurrence to all states where 10% or more of the HIV cases in their jurisdiction reside.

All funded jurisdictions (funded by both CDC DHP and HRSA HAB) must submit an Integrated Plan and address all sections as outlined in the guidance. State and/or local jurisdictions (municipalities) have the option to submit to CDC and HRSA:

- Integrated state/city prevention and care plan,
- Integrated state-only prevention and care plan, and/or
- Integrated city-only prevention and care plan.

NOTE: All submissions should demonstrate an integrated prevention and care plan as a method to better coordinate a response to HIV among all partners and collaborators. Per legislative and programmatic requirements, CDC and HRSA expect coordination among funded entities and community collaborators in the development of the Integrated Plan.

The Integrated Plan submission may include several jurisdictions (e.g., the state, the RWHAP Part A jurisdiction(s) in that state, CDC directly funded cities in that state). Each HRSA and CDC-funded jurisdiction must participate in the completion and submission of the Integrated Plan.

- For jurisdictions submitting city-only plan, the city Integrated Plan should complement the state Integrated Plan, including the SCSN.
- Both the city-only and state-only Integrated Plans should describe how the jurisdictions will coordinate actions to prevent duplication.
- Both city-only and state-only plans should include and address the HIV epidemic within its jurisdiction.

The jurisdiction's Integrated Plan submission is due to CDC DHP and HRSA HAB **no later than 11:59 PM ET on June 30, 2026**. Submissions should be no longer than 100 pages, not including the completed checklist, and no smaller than 11pt font.

The submission package must contain the following documents:

- A CY 2027 – 2031 Integrated Plan that includes all components outlined in this guidance;
- A completed *CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* detailing where CDC and HRSA may find each of the required elements; and
- A signed letter from all jurisdictional HIV planning groups/bodies indicating concurrence, concurrence with reservations, or non-concurrence with the plan.

Further detailed instructions on how to submit your jurisdiction's Integrated Plan will be addressed during the upcoming webinar. You may also reach out to your CDC and HRSA project officers for questions or concerns regarding your Integrated Plan.

While there is not a standard template for the Integrated Plan submission, the plan submitted must include all the components outlined in this guidance and include a completed *CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be broad enough to ensure that all HIV prevention and care funding work together to reduce new HIV diagnoses and to increase viral suppression among all people with HIV. The new written plan should not redevelop existing products such as epidemiologic profiles, if these products are current and up-to-date. Existing versions of these documents may be updated or modified if needed for the current integrated planning process.

Workplan Monitoring

The Integrated Plan Workplan provides an overarching vehicle to coordinate approaches for addressing HIV prevention and care needs at the state and local levels. The Integrated Plan Workplan must contain goals, SMART (specific, measurable, achievable, relevant and time-bound) objectives, specific activities, responsible parties, key partners, and performance measures that address both HIV prevention and care needs.

In addition, the goals and objectives must be in alignment with both the NHAS goals and the four EHE strategies, listed below:

- Diagnose all people with HIV as early as possible
- Treat people with HIV rapidly and effectively to reach sustained viral suppression
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs)
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Monitoring the Integrated Plan Workplan will assist recipients and planning bodies with identifying ways to measure progress toward goals and objectives; selecting strategies for collecting information; and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction. Jurisdictions must identify how they will provide regular updates to the planning bodies and collaborators on the progress of plan implementation, solicit feedback, and use the feedback from collaborators for plan improvements. Each jurisdiction also will need to use surveillance and program data to assess and improve health outcomes, health disparities, and the quality of the HIV service delivery systems, including strategic long-range planning.

The Integrated Plan, including the Integrated Plan Workplan, is a “living document” and must be reviewed and updated at least annually or as needed. The process for annual review should include the identification of relevant data and data systems, analysis of data on performance measures, the inclusion of planning bodies in the ongoing evaluation of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process.

To ensure progress on Integrated Plan activities and the Integrated Plan’s alignment with funding strategies, CDC and HRSA will engage in monitoring workplan activities both independently and jointly. Recipients will use established reporting requirements (i.e., applications, annual progress

reports) to document progress on achieving the objectives presented in the Integrated Plan. These reporting updates should include the jurisdiction's plan to monitor and evaluate implementation of the goals, strategies, and objectives included in the Integrated Plan. Project Officers will also utilize the Integrated Plan Workplan as a tool in monitoring and supporting the jurisdiction's progress. Additionally, CDC and HRSA project officers will continue to monitor progress during regularly scheduled calls and will conduct periodic joint monitoring calls with recipients.

CDC DHP and HRSA HAB remain committed to our ongoing partnership and the provision of technical assistance (TA) services. For TA services around integrated planning, please contact your respective project officers.

Appendix 1

CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Section I: Introduction of Integrated Plan and SCSN <i>Purpose:</i> To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission <ul style="list-style-type: none"> • Write a detailed summary: Ensure it shows how you have met the Integrated Plan requirements. • Combining materials: Explain how new and existing materials relate. 			
Requirements	Materials	Title/File Name of materials	Page(s) for this section
1. Introduction Describe the Integrated Plan <ul style="list-style-type: none"> • Include SCSN • Explain how past plans/SCSNs inform this plan/SCSN. • Or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below. 			
a. Approach Describe your approach to preparing the Integrated Plan submission. <ul style="list-style-type: none"> • Update existing plan: Modify and enhance previously submitted plan. • Integrate Existing Documents: Combine sections from current plans and documents. • Develop a New Plan: Create an entirely new plan from scratch. 			
b. Documents submitted to meet requirements. Fill out for each requirement per column provided: <ul style="list-style-type: none"> • New or existing material • Title/File Name for materials • Page numbers within the section 			
Section II: Community Engagement and Planning Process <i>Purpose:</i> To describe how the jurisdiction’s planning approach engaged community members and collaborators, fulfilled legislative and programmatic requirements, and addresses the HIV care and prevention needs of people with HIV and people vulnerable to HIV. Tips for meeting this requirement <ol style="list-style-type: none"> 1. Review of the National HIV/AIDS Strategy. 2. This requirement may include submission of portions of other submitted plans including the EHE plans, and other jurisdictional plans (e.g., Getting to Zero plans, Fast Track Cities, Cluster Detection and Response plans). 3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements, including: 			

- a. SCSN
 - b. RWHAP Part A and B planning requirements including those requiring feedback from key collaborators and people with HIV
 - c. CDC planning requirements
4. The community engagement process should reflect the local demographics.
 5. The planning process should include key collaborators and broad-based communities that include but are not limited to:
 - a. People with HIV,
 - b. People vulnerable to HIV,
 - c. Funded-service providers, and
 - d. Collaborators, especially new collaborators, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of collaborators to be included.
 6. Explain how the jurisdiction will build collaborations including sharing of data and establishing/ maintaining services agreements, among:
 - a. systems of prevention and care
 - b. other service systems relevant to HIV in the jurisdictions (e.g., behavioral health and housing services).
 7. Include community engagement related to “Respond” and support of cluster detection activities. Describe what happens when a potential cluster is detected and how community partners and affected communities are engaged.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
<p>1. Jurisdiction Planning Process Describe Jurisdiction’s approach to planning</p> <ul style="list-style-type: none"> • Planning Steps: explain steps in planning process. • Groups Involved: list involved groups for needs assessment and goal setting. • Usage of Data Sources: detail data sources used. • Representation from Priority Populations: how were they included? <p>Consider sections from other plans, like the EHE plan. Ensure you cover these points.</p>			
<p>a. Entities involved in the process. List and describe the types of entities involved in the planning process. Be sure to include:</p> <ul style="list-style-type: none"> • CDC and HRSA-funded programs, • New collaborators (e.g., new partner organizations, people with HIV, people vulnerable to HIV), and • Other entities such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. <p>See Appendix 3 for list of required and suggested collaborators</p>			
<p>b. Role of the RWHAP Part A Planning Council/Planning Body Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.</p>			

<p>Note: Jurisdictions submitting a State-Only Plan are not required to complete this narrative section; however, letters of concurrence must be submitted.</p>			
<p>c. Role of Planning Bodies and Other Entities <u>Describe how programs and planning bodies contributed.</u></p> <ul style="list-style-type: none"> • CDC Prevention Program • RWHAP Part B • State/territory or jurisdiction prevention and care • EHE • Community members and other entities <p><u>Describe collaboration efforts.</u></p> <ul style="list-style-type: none"> • How did prevention and care bodies work together? <p>Provide documentation of the type of engagement occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.</p>			
<p>d. Collaboration with RWHAP Parts – SCSN requirement Describe how jurisdictions incorporate RWHAP Parts A-D providers and Part F recipients in the planning process. Describe how RWHAP Part A or Part B only plan:</p> <ul style="list-style-type: none"> • Aligns with other Integrated Plans • Avoids service duplication. • Prevents gaps in service delivery systems. 			
<p>e. Engagement of people with HIV – SCSN requirement Describe how jurisdictions engaged people with HIV in all stages of the process:</p> <ul style="list-style-type: none"> • Needs assessment • Priority setting • Development of goals/objectives <p>Describe how people with HIV will be involved in implementing the plan:</p> <ul style="list-style-type: none"> • Implementation • Monitoring • Evaluation • Improvement process 			
<p>f. Priorities List key priorities that arose out of the planning and community engagement process.</p>			

<p>g. Updates to Other Strategic Plans Used to Meet Requirements If the jurisdiction is using portions of another local strategic plan (e.g., EHE, Ending the Epidemic, Getting to Zero) to satisfy this requirement, please describe:</p> <ol style="list-style-type: none"> 1. How the jurisdiction uses annual needs assessment data to adjust that plan’s priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV, people vulnerable to HIV, and collaborators in that plan. 3. Any changes due to updated assessments and community input. 4. Any changes made to that planning process as a result of evaluating the planning process. 			
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Section III: Contributing Data Sets and Assessments
Purpose: To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps across the HIV Prevention and HIV Care Continuums of Care. This section fulfills several legislative requirements including:

1. SCSN
2. RWHAP Part A and B planning requirements including those requiring feedback from key collaborators and people with HIV
3. CDC planning requirements including those requiring feedback from key collaborators and populations vulnerable to HIV acquisition.

Tips for meeting this requirement

1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS24-0047. *Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county.*
2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.
3. Include both narrative and graphic depictions of the health disparities in the area for people with HIV and those vulnerable to HIV including information about HIV outbreaks and clusters.
4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction.
5. Please refer to the [Integrated Guidance for Developing Epidemiologic Profiles \(cdc.gov\)](https://www.cdc.gov/eid/content/2014/vol20/iss12/12-01-integrated-guidance-for-developing-epidemiologic-profiles.html) for HIV Prevention and Ryan White HIV/AIDS Program Planning.
6. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
<p>1. Data Sharing and Use Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose.</p>			
<p>2. Epidemiologic Snapshot Provide a snapshot summary using:</p>			

<ul style="list-style-type: none"> • Current data: by using both narrative and graphic depictions display trends using the most recent 5 years (most available data). • Key descriptors: people diagnosed with HIV (including newly diagnosed), people vulnerable to HIV, and those with HIV who do not know their HIV status. Highlight Priority populations for prevention and care and align with the NHAS. • Types of data: demographic, geographic, socioeconomic, behavioral, and clinical characteristics. • HIV clusters: outline key characteristics of HIV clusters and cases linked to these clusters. <p>Note: Use the HIV prevention and care continuum in your graphic depiction showing burden of HIV in the jurisdiction.</p>			
<p>3. HIV Prevention, Care and Treatment Resource Inventory Develop an inventory that includes a table and/or narrative but must address all of the following information:</p> <p>Providers:</p> <ul style="list-style-type: none"> • Agencies providing HIV care and prevention services in the jurisdiction. • Agencies providing substance use prevention and treatment services: describe the coordination strategy with HIV prevention and care services. <p>Funding Sources:</p> <ul style="list-style-type: none"> • HRSA (all RWHAP parts) and CDC funding sources. Funding amounts not needed. • Additional funding sources: HRSA’s Community Health Center Program, HUD’s HOPWA program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundations. <p>Provided Services:</p> <ul style="list-style-type: none"> • Services and activities by organizations • Priority population served • How services maximize the quality of health and support for those with certain risk factors of acquiring or with HIV 			
<p>a. Assessment of Strengths and Gaps across the HIV Prevention and Care Continuum Assessment of Strengths and Gaps Inventory should include:</p> <ul style="list-style-type: none"> • Health equity • Geographic disparities • Occurrences of HIV clusters/outbreaks 			

<ul style="list-style-type: none"> • Underuse of new HIV prevention tools (e.g., injectable antiretrovirals, environmental impacts) <p>This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on the items listed.</p>			
<p>b. Approaches and partnerships</p> <p>Please describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.</p>			
<p>4. Needs Assessment</p> <p>Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data including:</p> <p>HIV Testing Services:</p> <ol style="list-style-type: none"> 1. Services needed for HIV testing access. 2. Services for staying HIV negative (e.g., PrEP, Syringe Services Programs) 3. Rapid linkage to HIV care after positive diagnosis. <p>HIV Care and Treatment:</p> <ol style="list-style-type: none"> 4. Services for maintaining HIV care and achieving and sustaining viral suppression. <p>Barriers to access:</p> <ol style="list-style-type: none"> 1. HIV testing barriers 2. Challenges with State laws and regulations. 3. HIV prevention, care, and treatment service access issues. 			
<p>a. Priorities</p> <p>List the key priorities arising from the needs assessment process.</p>			
<p>b. Action Taken</p> <p>List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.</p>			
<p>c. Approach</p> <p>Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV and people vulnerable to HIV in the process and how the jurisdiction included entities listed in Appendix 3.</p>			

Section IV: Situational Analysis

Purpose: To provide a snapshot summary that synthesizes information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III that in turn informs the goals and objectives of the Integrated Plan. The situational analysis provides an overview of strengths, challenges, and identified needs across the HIV prevention and care continuum.

Tips

1. New or existing material may be used; however, if existing material is used, it needs to be updated to reflect the most current information.
2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN.
3. Jurisdictions may submit the Situational Analysis requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system.* If using an updated or current version of your EHE plan to fulfill this requirement, be sure to include updates as noted below.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
<p>1. Situational Analysis Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III. Provide a short overview across the HIV prevention and care continuum to include:</p> <ul style="list-style-type: none"> • Strengths • Challenges • Identified needs. • Analysis of structural and systemic issues impacting disproportionately affected populations resulting in health disparities. Analysis should include each of the following areas: <ol style="list-style-type: none"> a. <u>Diagnose</u> all people with HIV as early as possible. b. <u>Treat</u> people with HIV rapidly and effectively to reach sustained viral suppression. c. <u>Prevent</u> new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs) d. <u>Respond</u> quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. <p>Note: Jurisdictions may submit other plans to satisfy this requirement, if they are current and applicable to the entire HIV prevention and care service system across the jurisdiction.</p>			
<p>a. Priority Populations Based on the Community Engagement and Planning Process in Section II and the</p>			

Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction			
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Section V: 2027-2031 Goals and Objectives
Purpose: To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a comprehensive, coordinated approach for all HIV prevention and care funding.
 Tips for meeting this requirement:
 2. Recipients may submit plans (e.g., EHE, Getting to Zero, HIV Cluster Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care continuum and geographic area.
 3. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following:
 a. Diagnose all people with HIV as early as possible
 b. Treat people with HIV rapidly and effectively to reach sustained viral suppression
 c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs)
 d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.
 4. The plan should include goals that address both HIV prevention and care needs and health disparities.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
<p>1. Goals and Objectives Description List and describe goals and objectives for the jurisdiction. Include 3 goals/objectives for each area:</p> <ul style="list-style-type: none"> • Diagnose • Treat • Prevent • Respond to HIV <p>Ensure goals address any barriers or needs identified during the planning process. See Appendix 2 for examples. Note: Jurisdictions may submit other updated plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and care service delivery system and geographic area.</p>			
<p>a. Updates to Other Strategic Plans Used to Meet Requirements If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.</p>			

Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up

Purpose: To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases:

1. Implementation
2. Monitoring
3. Evaluation
4. Improvement
5. Reporting and Dissemination

Tips for meeting this requirement

1. This requirement may require the recipient to create some new material or expand upon existing materials.
2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process.
3. If you are submitting portions of a different jurisdictional plan to meet this requirement, you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
<p>1. 2027-2031 Integrated Planning Implementation Approach</p> <p>1. Describe the infrastructure, procedures, systems and/or tools that will be used to support the 5 key phases (see phases above) of integrated planning to ensure goals and objectives are met</p>			
<p>a. Implementation</p> <p>2. To achieve the jurisdictions Integrated Plan goals and objectives. Describe the process for coordinating partners:</p> <ul style="list-style-type: none"> • New partners • People with HIV • People vulnerable to HIV • Providers and administrators from different funding streams <p>Include how the plan will influence, leverage, and coordinate funding streams including but not limited to HAB and CDC funding.</p>			
<p>b. Monitoring</p> <p>3. Describe the process for monitoring progress on the Integrated Plan goals and objectives. Include how the jurisdiction will:</p> <ul style="list-style-type: none"> • Coordinate different collaborators. • Use different funding streams to implement plan goals. 			

<ul style="list-style-type: none"> • Collaborate/coordinate monitoring of multiple different plans (e.g., city-only, state-only) to avoid duplication of effort and potential gaps in service provision. • Coordinate activities and timelines. <p>Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.</p>			
<p>c. Evaluation</p> <p>4. Describe performance measures and methodology used to evaluate progress on goals and objectives.</p> <p>Include how often the jurisdiction:</p> <ul style="list-style-type: none"> • Conducts analysis of the performance measures • Presents data to the planning group. 			
<p>d. Improvement</p> <p>5. Describe how the jurisdiction will:</p> <ul style="list-style-type: none"> • Continue to use data. • Use community input to make revisions and improvements to the plan. • How revision decisions will be made and how often. 			
<p>e. Reporting and Dissemination</p> <p>6. Describe the process for informing collaborators, including people with HIV, about progress made to the plan. (implementation, monitoring, evaluation and improvements).</p>			
<p>f. Updates to Other Strategic Plans to Meet Requirements</p> <p>If using portions of another local strategic plan to satisfy this requirement, please describe:</p> <ol style="list-style-type: none"> 1. Steps the jurisdiction has already taken to: <ul style="list-style-type: none"> • Implement • Monitor • Evaluate • Improve • Report/disseminate plan activities. 2. Describe Achievements/challenges in implementing: <ul style="list-style-type: none"> • Strategies to resolve challenges. • Plan to replicate successes. 3. Revisions made based on work completed. 			

Section VII: Letters of Concurrence

Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. Please note, a letter of concurrence is required from Planning Councils regardless of the type of plan submitted. See *Appendix 6* for a sample Letter of Concurrence.

Requirements	New/existing Materials	Title/File Name of materials	Page(s) for this section
1. CDC Prevention Program Planning Body Chair(s) or Representative(s) Required letter of concurrence			
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s) Required letter of concurrence			
3. RWHAP Part B Planning Body Chair or Representative Required letter of concurrence unless City-Only Plan is submitted			
4. Integrated Planning Body Optional letter of concurrence			
5. EHE Planning Body Optional letter of concurrence			

Appendix 2

Examples of Workplan Components

Note: A workplan template is available on TargetHIV under the Integrated HIV/AIDS Planning & Technical Assistance Center (IHAP TAC) as a part of the Integrated Plan Toolkit.

Diagnose (EXAMPLE)

Goal 1: Diagnose all people with HIV as early as possible.

Objective: To increase the number of HIV tests conducted by XX% within the jurisdiction by 2031.

Key Activities/Strategies:

- 1) Increase capacity of health care delivery systems to offer routine testing in XX ERs, acute care settings, etc.
- 2) Plan and develop a wide dissemination of self-testing kits through system partners across the jurisdiction to improve access for testing.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, people with lived experience and those with certain risk factors for acquiring HIV, sexual health clinics, women's health services/prenatal services providers, hospitals, etc.

Performance Measures:

- # of HIV tests
- # of newly identified persons with HIV

Progress towards NHAS Goals: Increase the number of people who know their HIV diagnosis by XX% to prevent new HIV infections.

Treat (EXAMPLE)

Goal 1: Treat HIV timely and effectively.

Objective: To engage and provide access to care for XX people with HIV by 2028.

Key Activities/Strategies:

- 1) Identify and address mental health barriers for people who have never engaged in care or who have fallen out of care by partnering with mental health providers
- 2) Develop and implement at least one effective, evidence-based, or evidence-informed interventions that improve retention in care

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient

Key Partners: FQHCs, medical care providers, hospitals, people with lived experience and those with certain risk factors for acquiring HIV, community-based organizations, mental health providers, various professional health care associations, etc.

Performance Measures:

- # of newly identified persons with HIV linked to care within 30 days
- # of persons with HIV identified as not in care linked to care within 30 days

Progress towards NHAS Goals: Increase the number of people receiving care by XX% to improve HIV-related health outcomes.

Prevent (EXAMPLE)

Goal 1: Prevent new HIV transmissions.

Objective: To increase access to PrEP by X% for priority populations by 2031.

Key Activities/Strategies:

- 1) Increase number of providers trained each year by X% to prescribe PrEP
- 2) Increase PrEP prescriptions among priority populations to reduce health disparities

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

Key Partners: Community-based organizations, people with lived experience and those with certain risk factors for acquiring HIV, FQHCs, sexual health clinics, hospitals, private providers, social service providers, primary care providers, etc.

Performance Measures:

- # of providers trained
- # of prescriptions for PrEP

Progress towards NHAS Goals: Reduce HIV-related disparities and health inequities by reducing new HIV infections

Respond (EXAMPLE)

Goal 1: Respond quickly to potential HIV clusters and/or outbreaks.

Objective: To develop a Cluster Detection and Response (CDR) Plan that can be executed effectively by 2028.

Key Activities/Strategies:

- 1) Identify and engage all key collaborators in the plan development process, including people with lived experience and those with certain risk factors for acquiring HIV
- 2) Convene existing communities of practice to share outbreak best response practices and known gaps to guide development and key strategies in the plan

Responsible Parties: CDC Recipient

Key Partners: Community members, community-based organizations, HIV care providers, FQHCs, correctional facilities, hospitals, social services providers, people with HIV, health departments, public health professionals, etc.

Performance Measures: Completion of CDR plan

Progress towards NHAS Goals: Achieve integrated and coordinated efforts that address the HIV epidemic

Appendix 3

Examples of Key Collaborators and Community Members

Community engagement is a key requirement of the Integrated Planning Guidance. Community engagement involves the collaboration of key collaborators and broad-based communities who work together to identify strategies to increase coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. Each community should select collaborators including persons with HIV who reflect the local demographics of the epidemic with lived experience and can best help align resources and set goals that promote equitable HIV prevention and health outcomes for priority populations. This should include not only traditional collaborators but engagement with new partners and non-traditional organizations. While the Integrated Plan submission should be done in collaboration with identified Integrated Planning body(s), community engagement may also include assessment processes (e.g., focus groups, population-specific advisory boards) that take place outside of or in conjunction with the Integrated HIV Care and Prevention body(s) and to inform the Integrated Plan submission.

Please Note: Persons or groups with a “*” must be included in the planning process to meet HRSA and/or CDC’s legislative or programmatic requirements.

Key Collaborators to Consider for Planning Group Membership

- Health department staff*
- Community- based organizations serving populations affected by HIV as well as HIV services providers*
- People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C*
- Populations with certain risk factors for acquiring HIV or with HIV representing priority populations
- Behavioral or social scientists
- Epidemiologists
- HIV clinical care providers including (RWHAP Part C and D)*
- STD clinics and programs
- Non-elected community leaders including faith community members and business/labor representatives*
- Community health care center representatives including FQHCs*
- Substance use treatment providers*
- Hospital planning agencies and health care planning agencies*
- Intervention specialists
- Jurisdictions with CDC- funded local education agencies/academic institutions (strongly encouraged to participate).
- Mental health providers*
- Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*
- Representatives from state or local law enforcement and/or correctional facilities

- Social services providers including housing and homeless services representatives*
- Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners
- Area Agencies on Aging and other aging oriented organizations

Examples of Key Collaborators to Consider for Community Engagement

- Existing community advisory boards
- Community members resulting from new outreach efforts
- Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.)
- Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC
- STD clinics and programs
- Other key informants
- City, county, tribal, and other state public health department partners
- Local, regional clinics, and school-based healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners and private payors
- Correctional facilities, juvenile justice, local law enforcement and related service providers
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions
- Area Agencies on Aging and other aging oriented organizations
- Other key informants

Examples of Community Engagement Activities

- Focus groups or interviews
- Town hall meetings
- Topic-focused community discussions
- Community advisory group or ad hoc committees or panels
- Collaboration building meetings with new partners
- Public planning body(s) meetings or increased membership
- Meetings between state and local health departments
- Social media events

Appendix 4

Suggested Data Sources

Suggested Data Sources:

- Behavioral surveillance data, including databases such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)
- HIV surveillance data, including clinical data (e.g., CD4 and viral load results) and HIV cluster detection and response data. HIV Surveillance Report, Supplemental Reports, and Data Tables: <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>
- STI surveillance data
- HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees; CDC HIV testing data)
- NCHHSTP AtlasPlus (HIV, STD, Hepatitis, TB, and Social Determinants): https://www.cdc.gov/nchhstp/about/atlasplus.html?CDC_AAref_Val=https://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=ss_AtlasPlusUpdate001
- Medical Monitoring Project: https://www.cdc.gov/hiv-data/mmp/?CDC_AAref_Val=https://www.cdc.gov/hiv/statistics/systems/mmp/index.html
- Ryan White HIV/AIDS Program data (Ryan White HIV/AIDS Program Services Report; ADAP Data Report): <https://ryanwhite.hrsa.gov/data/reports>
- AHEAD: America's HIV Epidemic Analysis Dashboard: <https://ahead.hiv.gov/>
- Other relevant demographic data (i.e., Hepatitis B or C surveillance, tuberculosis surveillance, and substance use data)
- Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)
- Vital statistics data (e.g., state office of vital statistics, National Death Index, Social Security Death Master File)
- Other Federal Data Sources (e.g., Medicaid Data, HOPWA Data, VA Data)
- Local Data Sources (e.g., Department of Corrections, Behavioral Health services data including information on substance use and mental health services)
- Other Relevant Program Data: (e.g. Community Health Center program data).

References for CDC DHP and HRSA HAB Performance Measures:

- HRSA HAB Performance Measure Portfolio: <https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio>
- Core Indicators for Monitoring the Ending the HIV Epidemic: <https://ahead.hiv.gov/>

Appendix 5

Federal Strategic Plans and Resources

Federal Strategic Planning Documents

- [Healthy People 2030](#): Sets data-driven national objectives to improve health and well-being over the next decade.
- [National HIV/AIDS Strategy \(2022 - 2025\)](#): Roadmap to accelerate efforts to end the HIV epidemic in the country by 2030.
- [Sexually Transmitted Infections National Strategic Plan for the United States \(2021 - 2025\)](#): Groundbreaking, first ever five-year plan that aims to reverse the recent dramatic rise in STIs in the United States
- [Viral Hepatitis National Strategic Plan: A Roadmap to Elimination \(2021 - 2025\)](#): Provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030.
- [HHS Ending the HIV Epidemic \(EHE\): A Plan for America Initiative](#): EHE aims to reduce the number of new HIV infections in the United States by at least 90% to fewer than 3,000 per year.

Federal HIV Funding Resources

This non-exhaustive list provides web sites to assist with identifying federal HIV funding resources in U.S. jurisdictions.

General

- [USA Spending](#)
- [Federal HIV Budget](#)

Health Resources and Services Administration (HRSA)

- [HRSA HIV/AIDS Programs – Grantee Allocations & Expenditures](#)
- [HRSA Bureau of Primary Health Care Health Center Recipients Locator](#)
- [HRSA Federal Office of Rural Health Policy, Rural Assistance Center, Rural HIV and AIDS Funding & Opportunities](#)

Centers for Disease Control and Prevention (CDC)

- [CDC Division of HIV Prevention \(DHP\) Funding and Budget](#)
- [High-Impact HIV Prevention and Surveillance Programs for Health Departments \(PS24-0047\) State and Local HIV Planning to End the HIV Epidemic](#)
- [Ending the Epidemic \(EHE\): Scaling Up HIV Prevention Services in STD Specialty Clinics](#)
- [CDC DIS Workforce Development Funding](#)

U.S. Department of Housing and Urban Development (HUD)

- [HUD Community Planning and Development Program Listing](#)
- [HUD Community Planning and Development – Cross-Program Funding Matrix and Dashboard Reports](#)

Substance Abuse and Mental Health Services Administration (SAMHSA)

- [SAMHSA Grant Awards by State](#)
- [SAMHSA's Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders](#)

National Institutes of Health

- [Centers for AIDS Research \(CFAR\) program](#)

Appendix 6

Sample Letter of Concurrence or Concurrence with Reservations between Planning Body and State or Local Health Department or Funded Agency

Dear (Name):

The [insert name of Planning Body, e.g. planning council, advisory council, HIV planning group, planning body] [insert ***concur*** or ***concur with reservations***] with the following submission by the [insert name of State/Local Health Department/ Funded Agency] in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

The planning body (e.g. planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [insert ***concur*** or ***concur with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

[Insert the process used by the planning body to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process.]

The signature(s) below confirms the [insert ***concurrence*** or ***concurrence with reservations***] of the planning body with the Integrated HIV Prevention and Care Plan.

Signature:

Planning Body Chair(s)

Date:



Get Ready for Co-Chair Open Nominations & Elections: Your Questions Answered!

Greetings! It's that time of year again—election season is upon us, not just for general elections, but also for our Commission, Committee and Caucus Co-Chairs. The nomination and election process for COH, Committee, and Caucus Co-Chairs is underway. Below is a quick FAQ to help you prepare and make an informed decision about becoming a Co-Chair.

Am I Eligible?

**Per COH Bylaws, Policies #08.1102 and #08.1104*

Commission Co-Chairs (Nominations remain open until the January 9, 2025, COH meeting)

(2) Commission Co-Chairs have two-year staggered terms – one co-chair seat is up for election which will serve the Jan 2025-Dec 2026 term.

- Only voting Commissioners can serve as Commission Co-Chairs.
- Candidates must have at least one year of service on the Commission to ensure leadership diversity and representation.
- At least one Co-Chair must be HIV-positive, and at least one must be a person of color. It is also preferred that at least one Co-Chair is female.

Committee Co-Chairs (Nominations will open by December, with elections in January 2025)

(2) Committee Co-Chairs serve one-year terms – all co-chair seats are up for election which will serve the Jan-Dec 2025 term.

- The Commission does not impose specific requirements, though one year of experience on the Committee is strongly encouraged.
- Nominees must be primary members of the Committee, not serving in alternate or secondary roles.
- Only Commissioners can serve as Co-Chairs.

Caucus Co-Chairs (Nominations will open by December, with elections in January 2025)

Caucuses typically have two Co-Chairs serving one-year terms, except the Consumer Caucus, which has three seats, including a prevention representative. All co-chair seats are up for election which will serve the Jan-Dec 2025 term.

- One Co-Chair must be a Commissioner to ensure that the Caucus activities are aligned with the COH's scope, goals and objectives
- Note: Caucuses are not subject to Brown Act requirements but work with COH consent to set their own leadership structure, guidelines, membership, and activities.

****All Co-Chair candidates will be asked to provide a brief statement before the election.***

What Are the Co-Chair Roles & Responsibilities?

- Lead COH/committee/caucus activities and meetings.

- Set agendas for meetings in collaboration with staff.
- Develop work plans with the Executive Director and staff.
- Facilitate meetings, guiding discussion and ensuring effective workflow.
- Summarize discussions and assist in developing work products.
- Act on behalf of the group and communicate with stakeholders.

How Should I Prepare?

- Honestly assess your accessibility, bandwidth, and time to ensure you are able to show up fully and prepared. *Co-Chair roles require at least 10-12 commitment hours per month.*
- Review the [COH Co-Chair training slides](#) to understand the role's expectations
- Familiarize yourself with the:
 - [Ryan White Program Part A Planning Council Primer](#),
 - [COH bylaws](#),
 - [COH Co-Chair Duty Statement](#) (if applicable),
 - [Committee Co-Chair Duty Statement](#) (if applicable)
 - [Required Commissioner trainings](#).

Ready to take on a leadership role? Nominate yourself or a colleague and help guide our collective work toward meaningful community impact! If you have questions, please reach out to your respective staff lead.

2025 STRATEGIC PRIORITIES - PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)			Co-Chairs: Kevin Donnelly & Felipe Gonzalez	
Committee Adoption Date: 1.21.25			Revision Dates: xx.xx.xxxx	
<p>GOAL: To focus and prioritize key activities for Planning, Priorities and Allocations Committee for 2025</p> <p>Objective: Reduce the number of new HIV and STD infections while increasing HIV care outcomes for PLWH in LA County.</p>				
#	TASK	ACTIVITIES/DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Review PY35 expenditures and conduct reallocation for PY35, as needed.	1. Quarterly review PY35 Expenditure Reports	Quarterly	Input from consumers (all caucuses)
2	Conduct needs assessment focusing on all women living with HIV.	<ol style="list-style-type: none"> 1. Collaborate with the Women’s Caucus and the Transgender Caucus to conduct a needs assessment focusing on all women living with HIV. 2. Develop assessment questionnaire(s) with input from WC and TC 3. Conduct needs assessment. 4. Identify unique challenges and needs of WLWH. 5. Utilize information gathered to inform PSRA process and program directives. 	Feb - May	Women’s Caucus and Transgender Caucus
3	Conduct priority setting and resource allocation.	<ol style="list-style-type: none"> 1. Review all data reports including unmet needs, utilization reports, expenditure reports, needs assessments and MMP data from DHSP. 2. Identify additional data needed to inform planning process. 	July – Sept	Target months may change depending on when Notices of Funding Opportunity are released.

2025 STRATEGIC PRIORITIES - PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		<ol style="list-style-type: none"> 3. Harness input from Caucuses, workgroups, and Committees. 4. Reassess and prioritize service rankings for PY35, if needed. 5. Allocate RWP funds for PY36. 6. Review program directives and incorporate revisions/additions, if needed. 		<p>Resources: Unmet need estimates, service utilization report for prevention and care programs/services,</p>
4	Lead the development of the 2027-2031 Integrated Plan.	<ol style="list-style-type: none"> 1. The Committee will work with DHSP and various partners to plan and develop the 2027-2031 Integrated Plan. 	June - Dec	<p>Resources: Consultant, CHP and EHE plans, DHSP updates, County departments, CDPH,</p>
5	Monitor the implementation of the 2021-2026 Integrated Plan.	<ol style="list-style-type: none"> 1. The Committee will work with DHSP and various partners to implement and monitor progress toward meeting the goals and objectives of the CHP. 2. Develop progress report. 	Ongoing; Report in Dec 2025	<p>Resources: CHP and EHE plans, DHSP updates, County departments, CDPH,</p>
ONGOING ACTIVITIES				
	<ol style="list-style-type: none"> 1. Continue to track expenditures and service needs as reallocation RW and CDC funding as needed. 2. Continue to monitor status of program directives, service utilization, Part A, MAI, and other funding sources. 3. Continue to collaborate with PPW to strengthen integrated prevention and care planning. 4. Monitor and discuss systems of care changes and impact on care and prevention planning. 			



LOS ANGELES COUNTY
COMMISSION ON HIV



PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE 2025 MEETING CALENDAR

MEETING DATES & TIME	
Jan. 21, 2025 1pm – 3pm	Jul. 15, 2025 1pm – 3pm
Feb. 18, 2025 1pm – 3pm	Aug. 19, 2025 1pm – 3pm
Mar. 18, 2025 1pm – 3pm	Sep. 16, 2025 1pm – 3pm
Apr. 15, 2025 1pm – 3pm	Oct. 21, 2025 1pm – 3pm
May 20, 2025 1pm – 3pm	Nov. 18, 2025 1pm – 3pm
Jun. 17, 2025 1pm – 3pm	Dec. 16, 2025 1pm – 3pm

Antelope Valley: A Community Rising to End HIV

A World AIDS Day Event sponsored by
Supervisor Kathryn Barger and the
Los Angeles County Commission on HIV

Bartz-Altadonna Community Health Clinic
Lancaster, CA 93535

December 3, 2024





HIV Research to Practice in Los Angeles County

3rd National EHE Partnerships for Research Meeting
University of California at Los Angeles
April 16, 2024

Mario J. Pérez, MPH
Director, Division of HIV and STD Programs
Los Angeles County Department of Public Health





Key Takeaways

We must end multiple epidemics to End the HIV Epidemic.

We must transform healthcare delivery systems and adapt to changes in health care consumption patterns (beyond health care settings); we can't expect our priority pops to adjust to these systems.

We must start a 10-year national MH/SW/SUD Specialist workforce recruitment, development and training program (e.g., Teach for America, Peace Corps). HIV is increasingly concentrated among persons MH and SU disorders.

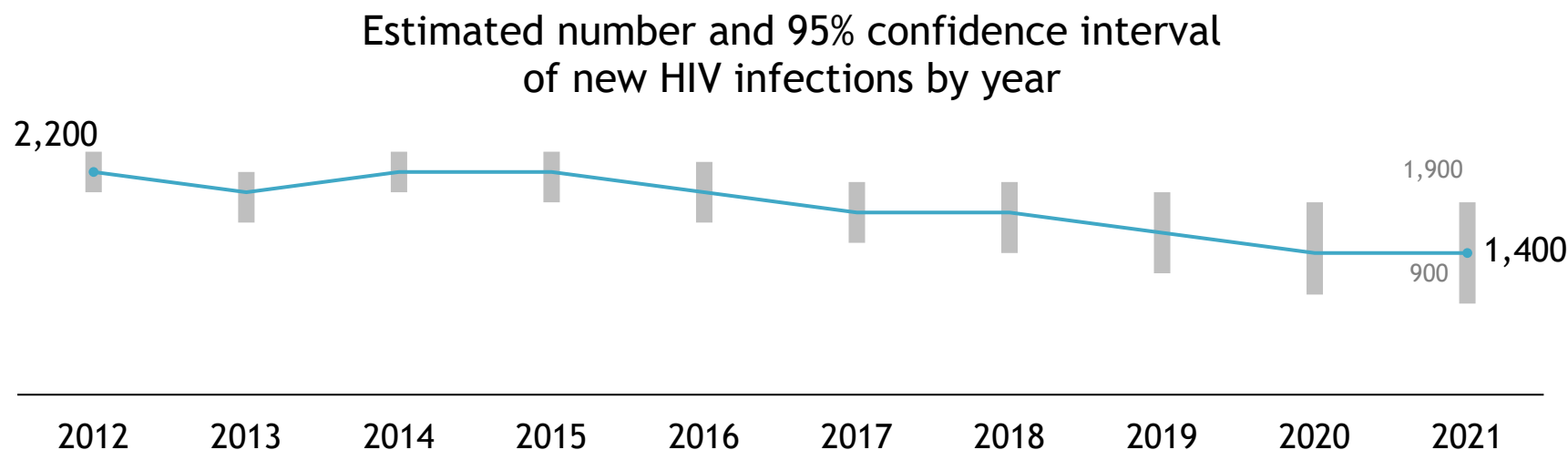
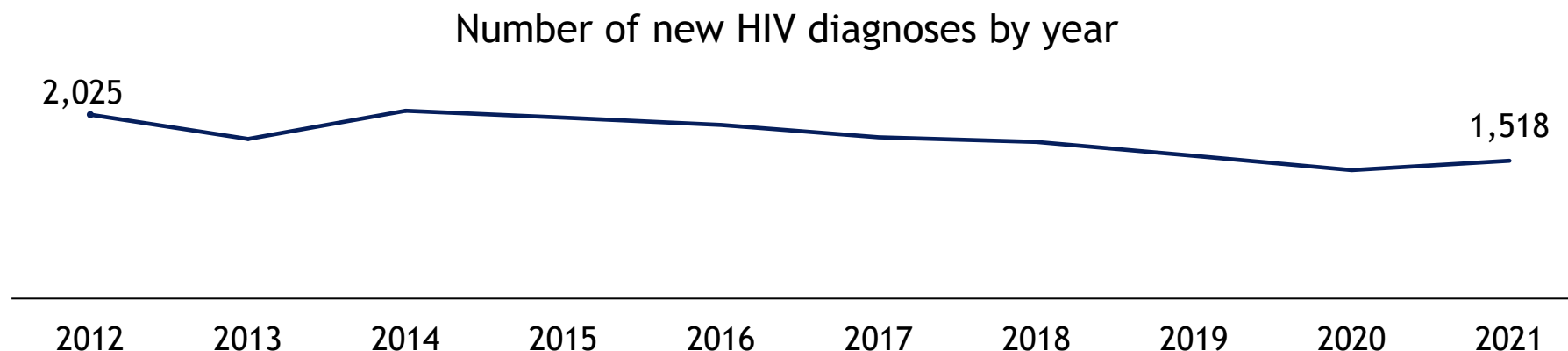
We must change the way we collect data, use data (integrated surveillance systems), and share data with frontline providers (e.g., D2C).

We must expand partners, train partners (detailing, learning collabs, action kits), retain partners.

We must change financing schemes, broaden list of allowable expenses (e.g., CM, EFA, GBI) and coordinate categorical investments and performance expectations between local, State and federal partners. We must push boundaries and disrupt dysfunctional systems of care.



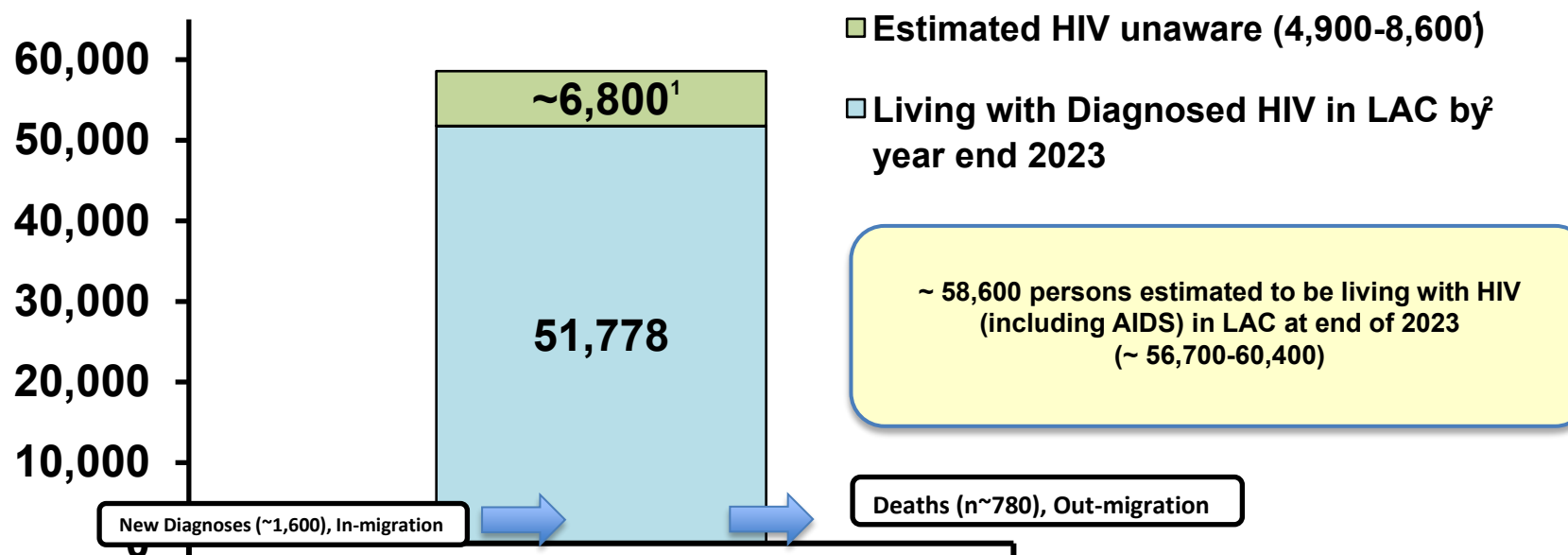
Number of persons newly diagnosed with HIV compared with the estimated number of persons with new HIV infection among PLWH aged ≥ 13 years, LAC 2012-2021^{1,2}



Abbreviation: PLWH = persons living with HIV

¹ Estimates based on the CD4-Based Model v4.1 developed by CDC, which derived by using HIV surveillance and CD4 data for persons aged ≥ 13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of $>1,000$ and to the nearest 10 for estimates of $\leq 1,000$ to reflect model uncertainty.

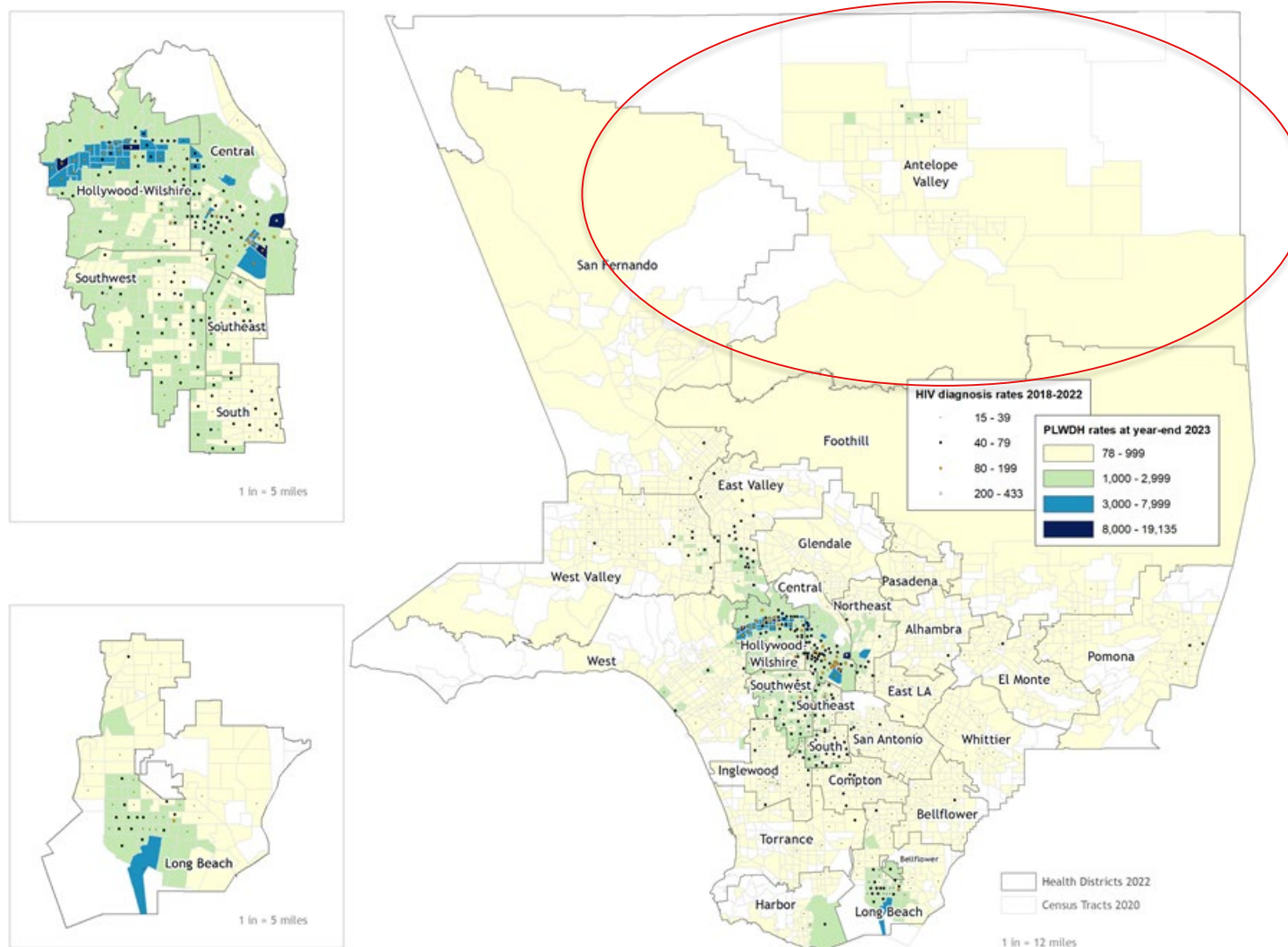
Estimated Number of Persons aged 13+ years Living with HIV in LAC at Year end 2023



¹ Estimates derived from CDC's CD4 depletion model, Song R, Hall HI, Green TA, SzwarcwaldCL, PantazisN. Using CD4 data to estimate HIV incidence, prevalence, and percent of undiagnosed infections in the United States. J AcquirImmune DeficSyndr2017;74(1):3-9. doi:10.1097/QAI.0000000000001151. Estimate is for 2021 but is being used until the 2023 estimate is available.

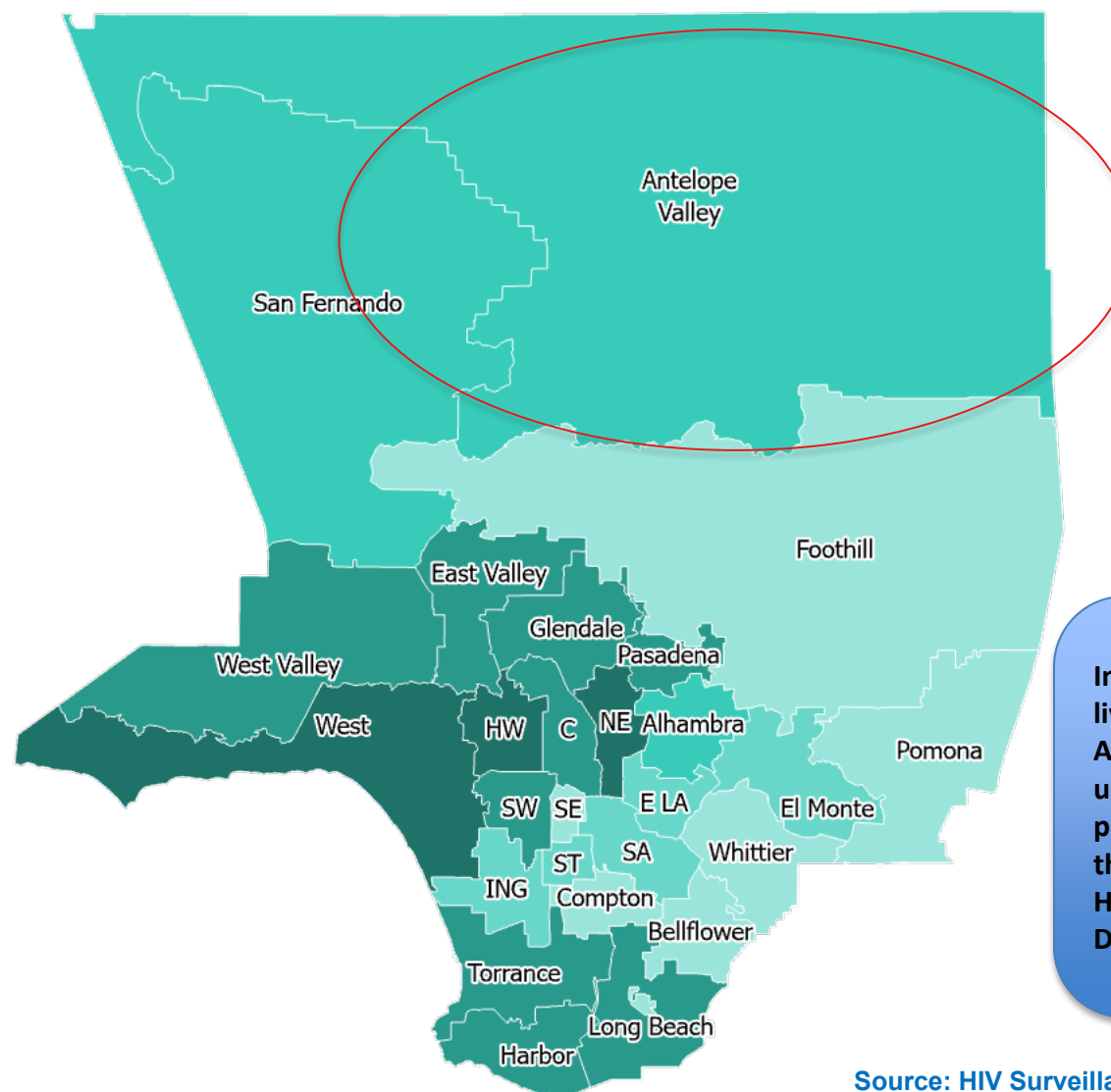
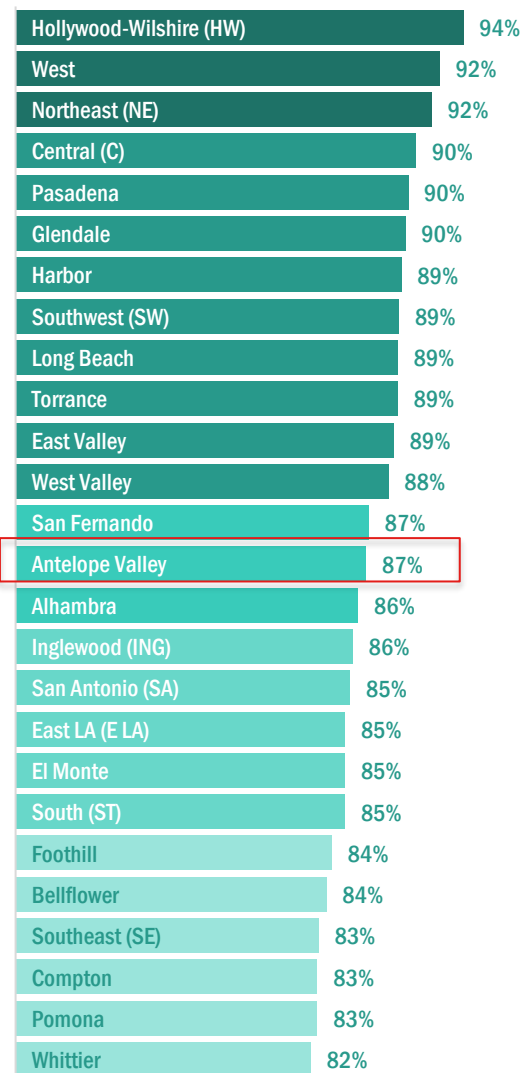
² Includes persons diagnosed with HIV and living in LAC based on most recent known address as of 12/31/2023.

Geographic distribution of rates per 100,000 population for PLWDH aged ≥ 13 years at year-end 2023 and persons newly diagnosed with HIV in 2018-2022, LAC



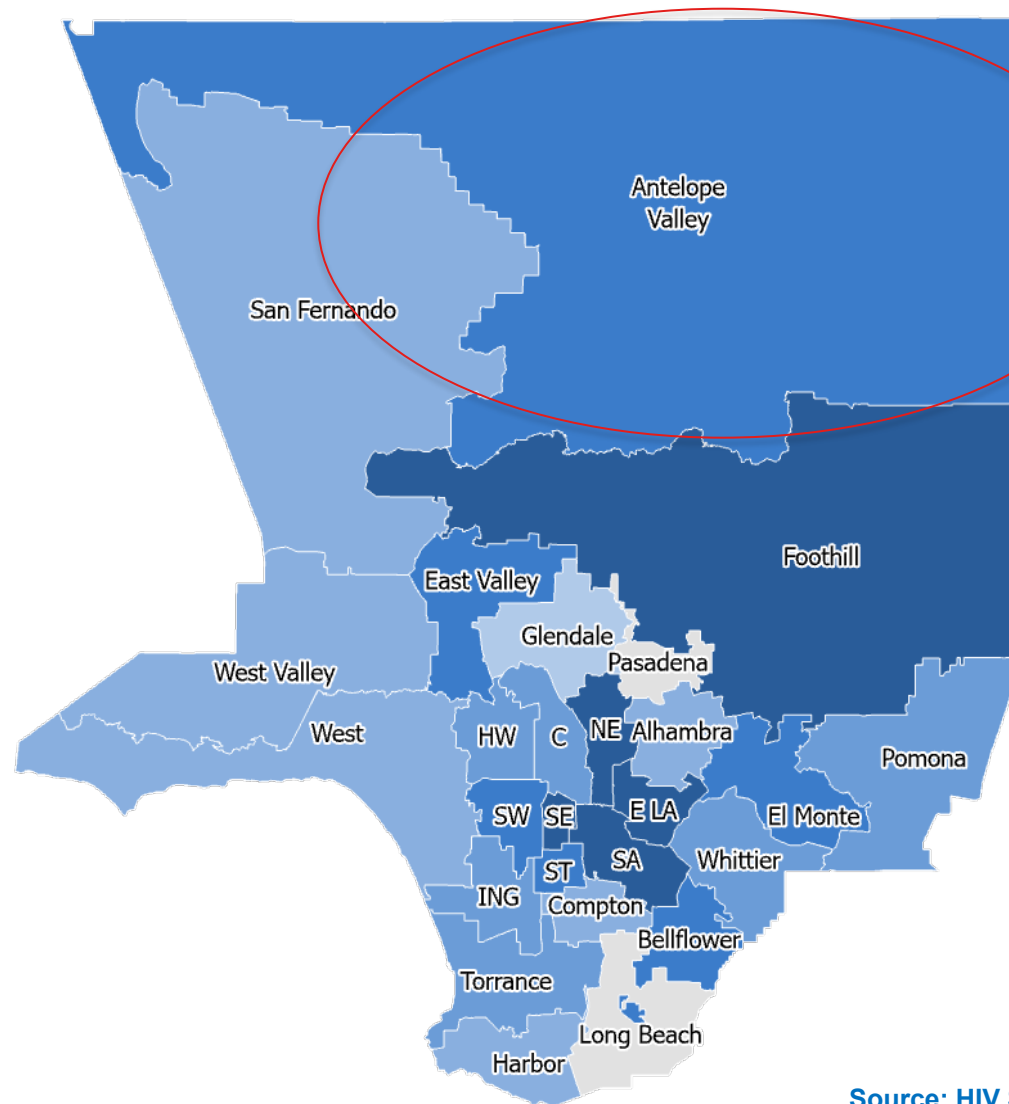
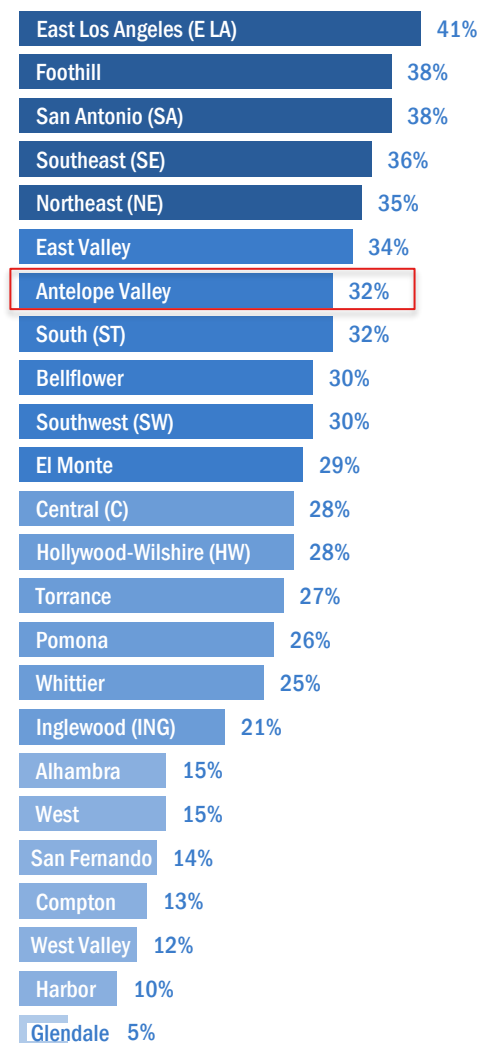
2023 Rates of PLWDH in Antelope Valley HD are markedly lower compared with the LAC HDs with the highest HIV rates (Antelope Valley HD: 358/100,000 vs Hollywood Wilshire HD 2,138/100,000)

Percentage of PLWH aged ≥ 13 years who were aware of their HIV-positive status by Health District, LAC 2022



In 2022, 13% of persons living with HIV in the Antelope Valley were unaware of their HIV-positive status, over double the percent unaware in the Hollywood-Wilshire Health District (6%).

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis in the same calendar year as HIV diagnosis by Health District, LAC (excluding Long Beach and Pasadena) 2022



In 2022, in the Antelope Valley, nearly 1 in 3 persons newly diagnosed with HIV was also diagnosed with syphilis, compared to only 1 in 20 persons in the Glendale Health District.

Early Syphilis Rates by Health District and SPA Los Angeles County, 2021

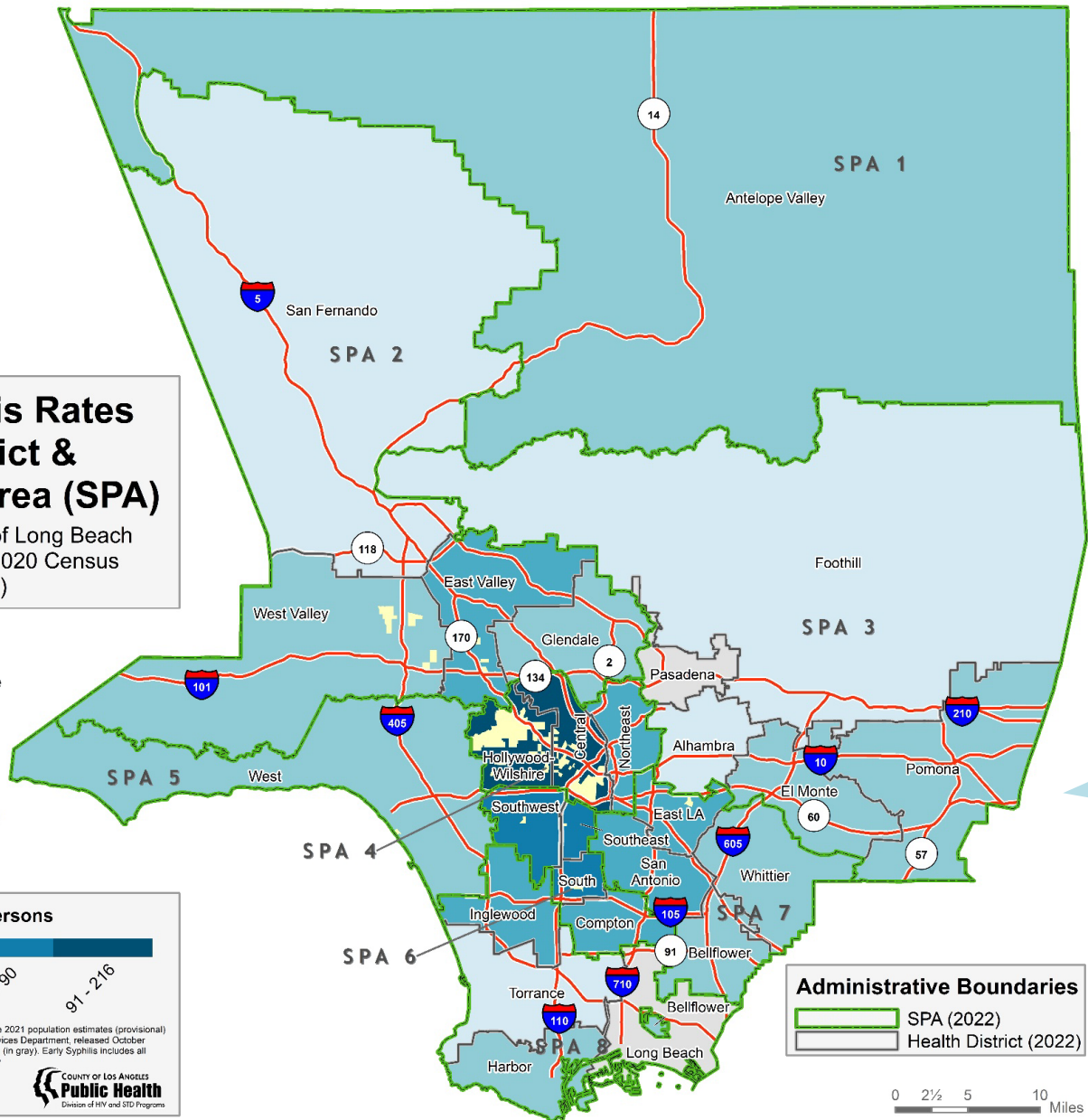
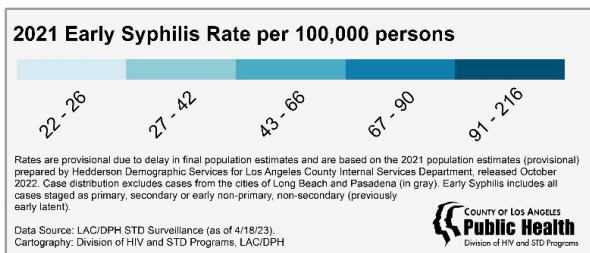


Revised: 7/24/2023

2021 Early Syphilis Rates by Health District & Service Planning Area (SPA)
(excludes data from the cities of Long Beach and Pasadena and includes 2020 Census Tracts of interest*)

* Census tracts with ≥ 12 cases and a population > 100 are symbolized by pale yellow. These areas in SPA 4, 2 and 6 should be prioritized when designing geographic-based interventions.

Census tract with stable rates (Range: 198 - 1,948 per 100,000 persons)



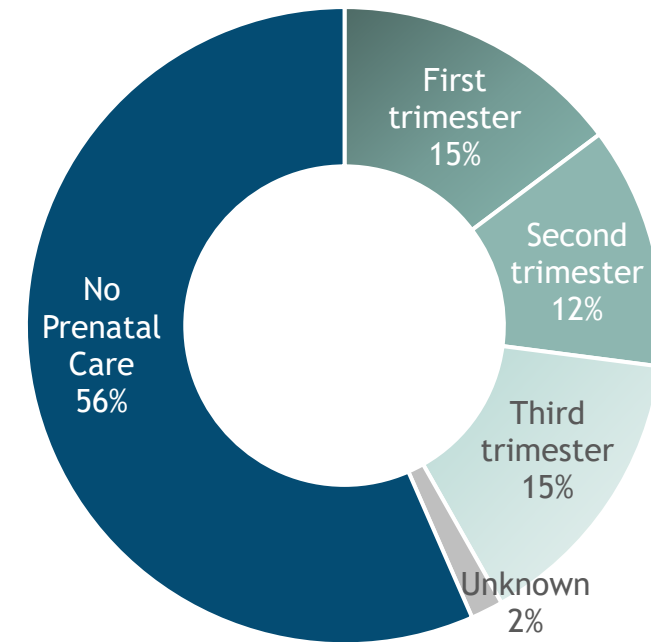
During 2021, rates of early syphilis were highest in Hollywood-Wilshire, Central, South, and Southwest.

Administrative Boundaries
 SPA (2022)
 Health District (2022)

0 2 1/2 5 10 Miles

- 124 Congenital syphilis cases
 - 18 stillbirths
- 40% reported unstable housing
- 34% history of incarceration
- 62% reported substance use
 - methamphetamine most common
- >2/3 had late or no prenatal care

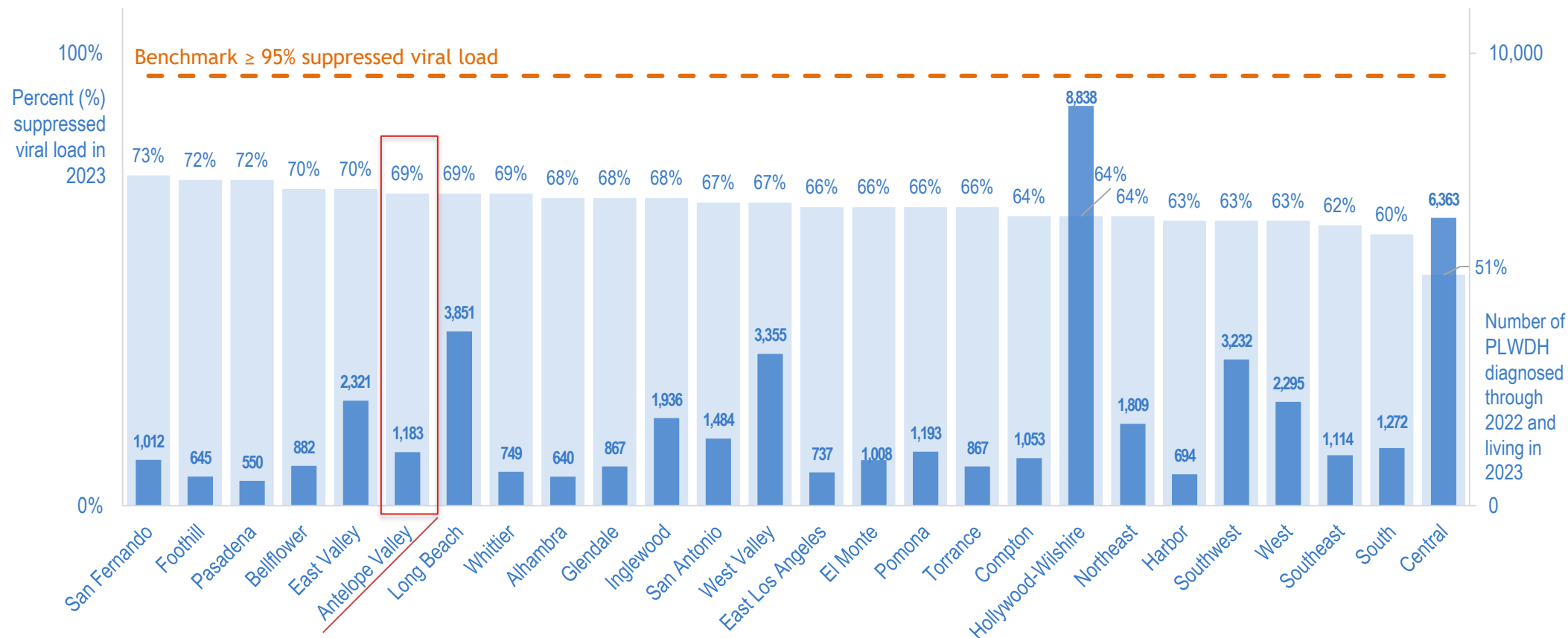
Entry into Prenatal Care



- Interventions must extend beyond healthcare settings



Suppressed viral load by Health District among persons aged ≥ 13 years diagnosed through 2022 and living in LAC at year-end 2023,^{1,2} LAC 2023



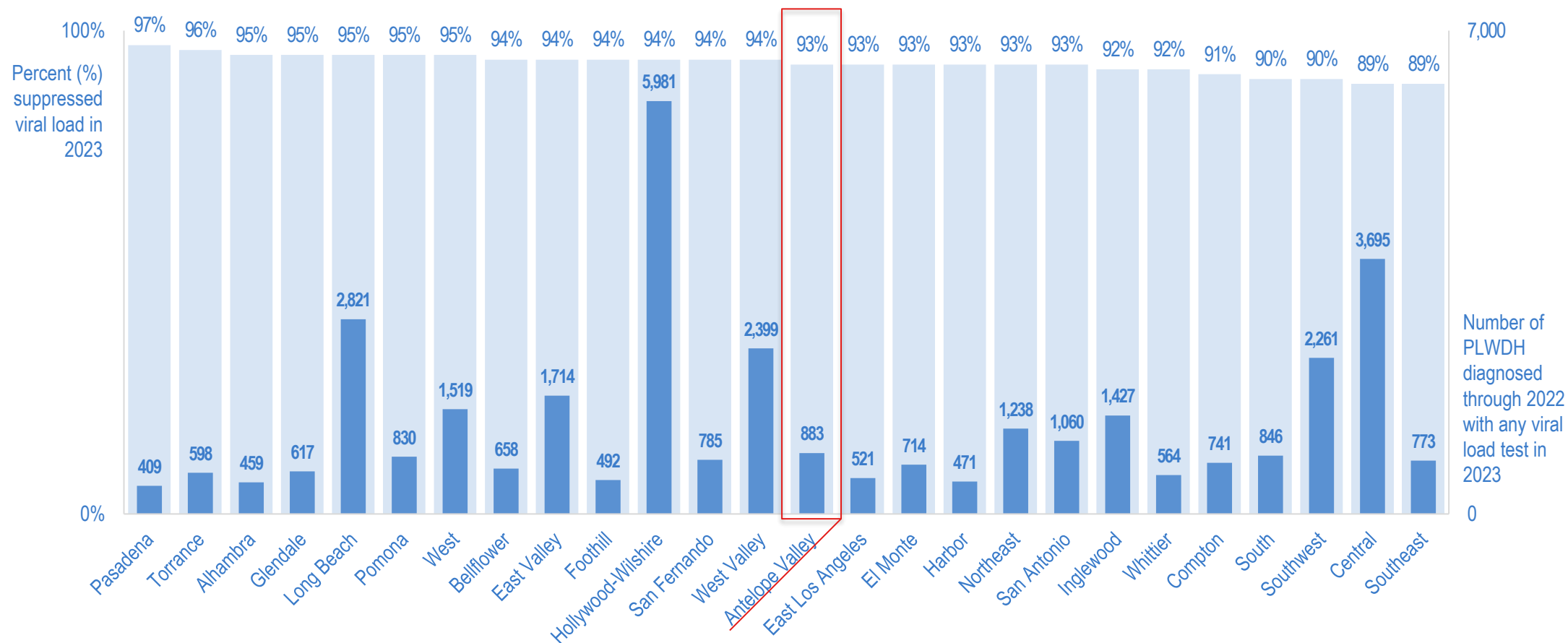
Abbreviation: PLWDH = persons living with diagnosed HIV

¹Suppressed viral load: numerator includes PLWDH whose last VL test in 2023 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2022 and living in LAC at year-end 2023 based on most recent residence. PLWDH without a VL test in 2023 were categorized as having unsuppressed viral load.

²Health Districts are based on 2022 boundaries. Persons are assigned a Health District using their geocoded residence at diagnosis joined to census tract 2020, followed by their ZIP Code if no valid residence at diagnosis was available. The correspondence tables were provided by LAC DPH Information Management and Analytics Office, Office of Health Assessment and Epidemiology, GIS Unit team.



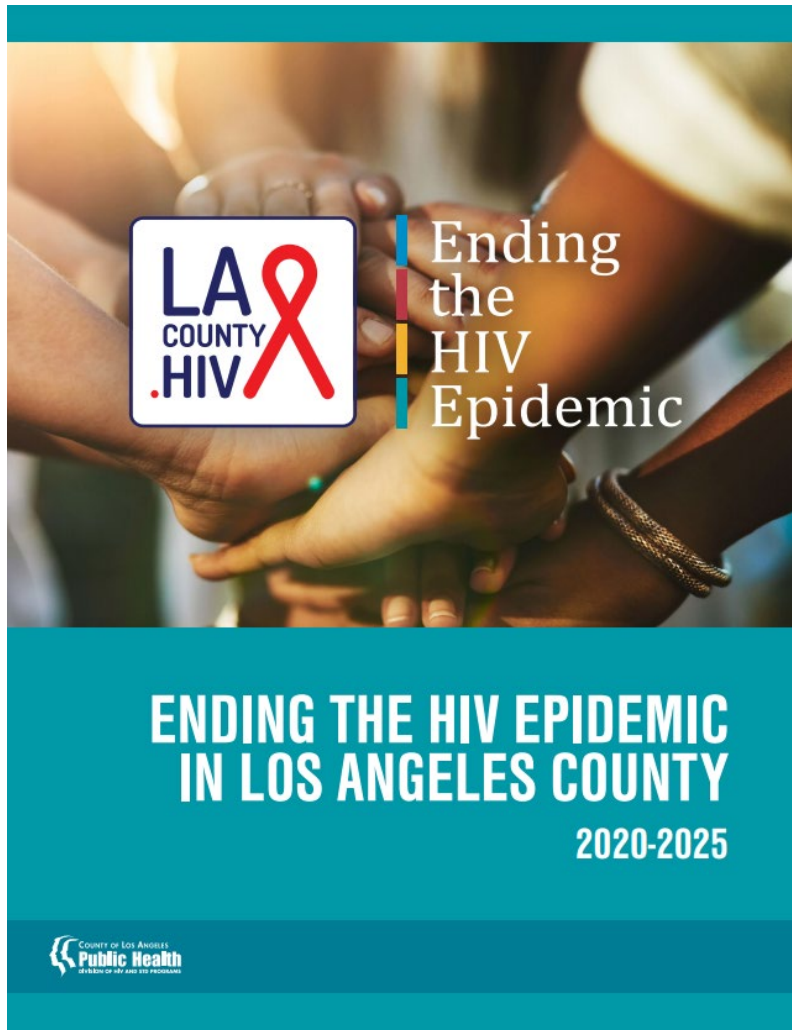
Suppressed viral load among persons aged ≥ 13 years receiving HIV care and who had any viral load test in 2023 by Health District, LAC 2023^{1,2}



Abbreviation: PLWDH = persons living with diagnosed HIV

¹Suppressed viral load: numerator includes PLWDH whose last VL test in 2023 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2022 and living in LAC at year-end 2023 based on most recent residence who had any viral load test in 2023. PLWDH without a VL test in 2023 were categorized as having unsuppressed viral load.

²Health Districts are based on 2022 boundaries. Persons are assigned a Health District using their geocoded residence at diagnosis joined to census tract 2020, followed by their ZIP Code if no valid residence at diagnosis was available. The correspondence tables were provided by LAC DPH Information Management and Analytics Office, Office of Health Assessment and Epidemiology, GIS Unit team.



Priority Populations

- Black/African American men who have sex with men (MSM)
- Latinx MSM
- Ciswomen of color
- People who inject drugs and/or with substance use disorder
- People of trans experience
- Youth under 30 years of age

EHE website: www.LACounty.HIV

Snapshot of EHE Strategies and Programs



Diagnose

- HIV self-testing
- Increased HIV testing in non-healthcare settings
- Routine testing in healthcare settings



Treat

- Rapid and Ready Program
- iCARE Program (Contingency Management)
- Mental health/trauma informed services
- Intensive case management for pregnant persons with HIV
- Evidence based interventions



Prevent

- Expand PrEP service delivery
- TelePrEP
- Provider education
- Media campaigns
- Pharmacies as PrEP access points



Respond

- Cluster Detection and Response
- Statewide Community Advisory Board
- Data to Action efforts
- Community Health Ambassador Program

Cross
Cutting
Strategies

- Community mobilization and engagement
- Social media influencer partnerships
- HIV workforce development (skills building, leadership development, self-care)
- Mini-grants & Innovation awards
- Financial assistance programs

Antelope Valley Community-Based Partner Overview



Tarzana Treatment Centers

- Substance Abuse Transitional Housing: 1 house
- MCC Services: Palmdale
- AOM Services: Palmdale



Wesley Health Centers (also known as JWCH Institute)

- Oral Health: Lancaster and Palmdale
- Biomedical HIV Prevention
- Data to Care (EHE)

Antelope Valley Community-Based Partner Overview (continued)



AHF (AIDS Healthcare Foundation)

- AOM Services: Lancaster
- MCC Services: Lancaster



Bartz-Altadonna Community Health Center

- Ending the HIV Epidemic (EHE) Innovation Grant: Lancaster



Thank You!



Suggestions for Multi-Year (PY 35-37) Program Directives For Discussion Purposes Only*

1. Patient Navigation and Support – to support consumers as they navigate the various services available to them (whether RWP related or not); needs to go beyond referral by providing assistance in making calls, attending appointments, encouragement during difficult periods, etc.
2. Increase workforce capacity by providing ongoing training for frontline staff to reduce stigma and improve cultural competency/sensitivity and create more welcoming physical environments that celebrate all populations (waiting rooms). Incorporate methods to ensure client confidentiality and desire for privacy.
3. Increase use of long-acting injectable (LAI) antiretroviral therapy (ART) and injectable PrEP to address issues with medication adherence (forgetting or pill fatigue), inability to store medications due to being unhoused, active substance use, etc.
4. Increase awareness of available services throughout the County and from various providers. Increase partnerships with non-traditional partners to expand messaging and awareness and explore the feasibility of offering testing with non-traditional providers.
5. ~~All funded core medical providers~~ The recipient must create marketing and social awareness campaigns using print materials and digital media, including social media to raise awareness of HIV risk and available services.
 - o ~~Funded providers~~ The recipient must develop measurable, culturally responsive print and digital marketing campaigns specifically tailored to the Black community.
- 5-6. Increase access to appointments outside of traditional business hours (evenings and weekends). May need to increase service availability in a specific geographic area(s).
- 6-7. Address the unique needs of people who use substances.
- 7-8. Core medical and support service providers must Increase opportunities to hire individuals with lived experience (within various capacities) that reflect the populations being served particularly women, people of a trans experience, Black/AA MSM, Latine/x MSM, formerly incarcerated, former substance users.
- 8-9. Increase training and ensure staff are periodically screening clients for Medi-Cal eligibility, including dental providers. Counsel clients with undocumented status, or mixed status families, to dispel Public Charge inaccuracies and encourage enrollment in Medi-Cal.
- 9-10. Recipient to formally report the status of all directives issued by the Planning Council
- 10-11. Recipient must share all COH communications with all funded providers and encourage -participate in Commission on HIV meetings, events and other COH-related

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Commented [LM1]: Every funded ambulatory outpatient medical (AOM) services provider and every medical care coordination (MCC) provider must offer services at least one evening a week and one weekend day a month.

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* Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.



LOS ANGELES COUNTY
COMMISSION ON HIV



activities. Providers must share information on the COH and encourage consumers to participate on the COH, whether formally or informally.

Transgender Caucus Recommendations:

- 11.12. Housing service providers must have policies in place that protect the rights of Transgender, Gender Non-Confirming, and Intersex (TGI) People Living with HIV (PLWH).
- 12.13. Housing service providers must have staff trained in Trauma-Informed Care strategies.
- 13.14. Core Medical and Support service providers must have staff qualified to provide gender-affirming/ appropriate services to Transgender, Gender non-conforming, and Intersex people.

Commented [LM2]: Forwarded to Standards and Best Practices Committee on 12.2.24 for incorporation into service standards.

Women's Caucus Recommendations:

- Recipient to work with the Women's Caucus to develop services that meet the needs of women including, women who are pregnant or have children. Services will be developed in collaboration with the Women's Caucus and the recipient and must be approved by both parties. At least 2 funded core medical providers must offer women's-centered services.

Aging Caucus Recommendations:

- Benefits Specialty services must be available to PLWH within each Service Planning Area (SPA). Benefits Specialty services must also expand to include services available for aging populations (50+) within Los Angeles County. The recipient must work with the local Area on Aging to identify services.

Black Caucus Recommendations:

- Develop pilot community engagement activities, e.g., incentivized coalition-building and ambassador programs that engage trusted influencers from diverse Black subpopulations, including transgender individuals, MSM, women, and youth. These initiatives will aim to foster connection, build trust, and raise HIV awareness by promoting available services and encouraging community-driven advocacy and support beyond traditional providers and spaces.

** Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.*



**Mult-Year Program Directives for Ryan White Part A and MAI Funds for Program Years (PY) 35, 36, and 37
and Centers for Disease Control and Prevention (CDC) Funding**

(Final Draft for PP&A Approval 1.16.25)

Approval Dates:

Purpose: These program directives approved by the Los Angeles County Commission on HIV (COH) on **{Insert date}** articulate instructions to the Division of HIV and STD Programs (DHSP), Los Angeles County Department of Public Health on how to meet the priorities established by the Commission on HIV. The Ryan White PY Years **35, 36, and 37 service rankings and allocations table are found in Attachment A. {Insert allocations table as an attachment}**. The Commission looks forward to receiving formal reports on the status of the directives issued by the Commission at least twice a year from DHSP.

#	DIRECTIVE
	ACCESS AND SERVICE IMPROVEMENTS
1	Provide ongoing patient navigation support for clients as they navigate the various services available to them (whether Ryan White Program (RWP) related or not). Patient navigation services are a support system designed to help patients navigate the complexities of the healthcare system by identifying and overcoming barriers to accessing timely and appropriate care, often including assistance with scheduling appointments, understanding medical information, finding financial resources, and coordinating transportation, all with the goal of improving overall health outcomes. Patient navigation services should guide patients through the continuum of healthcare and social services process and ensure timely receipt of services.
2	Incentivize the use of long-acting injectable (LAI) antiretroviral therapy (ART) and injectable PrEP to address issues with medication adherence such as forgetting or pill fatigue, inability to store medications due to being unhoused, substance use, and other factors that hinder optimal viral suppression.
3	<ul style="list-style-type: none"> A. Expand promotion of <u>Get Protected LA The Ryan White Program</u> to foster broader community awareness of local Ryan White-funded services. B. Enhance the Get Protected LA website to include available services throughout the County and from various providers.

** Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.
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	C. Increase county-wide awareness of the I'm Positive LA website through partnerships with non-traditional and new partners outside of the HIV sphere.
4	Based on clinic capacity, geographic need and patient demand, instruct contracted providers to increase access to appointments outside of traditional business hours (i.e., evenings and weekends).
5	Expand services that address the unique needs of people living with HIV who use substances such as syringe service programs, offering free naloxone and drug testing resources, medication assisted treatment (MAT), referrals for mental/behavioral health, and support consistent antiretroviral therapy (ART) use. Additional examples include increased training for staff to avoid potential adverse drug reactions, case management services to facilitate coordinated care and timely referrals for additional services needed such as housing assistance, legal services, food assistance, Hepatitis C testing, contingency management, and peer support services to ensure ART adherence.
WORKFORCE CAPACITY AND TRAINING	
6	Increase workforce capacity by providing ongoing training for frontline staff on reducing stigma in clinical settings such as creating more welcoming and inclusive physical environments. Examples include culturally, age, and gender-appropriate visuals and health education materials in waiting rooms and reception areas; text-based customer service satisfaction surveys to preserve anonymity; and offering language, reading and comprehension assistance (interpretation and translation services) to clients.
7	Instruct core medical and support service providers to increase opportunities to hire individuals with lived experience that reflect the populations being served particularly women, people of a trans experience, Black/AA MSM, Latine/x MSM, formerly incarcerated, former substance users.
8	Increase training on Medi-Cal eligibility, enrollment, and re-enrollment process and ensure staff are periodically screening clients for Medi-Cal and Denti-Cal eligibility. Counsel clients with undocumented status, or mixed status families, to dispel Public Charge inaccuracies and encourage enrollment in Medi-Cal.
COMMUNITY ENGAGEMENT AND COLLABORATIONS	
10	A. Encourage contracted providers participate in Commission on HIV meetings, events and other COH-related activities.

* Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.

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	<p>B. Encourage contracted providers to support their clients and/or community advisory board members to participate on the local planning process, whether formally or informally.</p>
POPULATION-SPECIFIC DIRECTIVES	
11	<p>Transgender:</p> <ul style="list-style-type: none">A. Housing service providers must have policies in place that protect the rights of Transgender, Gender Non-Conforming, and Intersex (TGI) People Living with HIV (PLWH).B. Housing service providers must have staff trained in trauma-informed care strategies and practices.C. Core medical and support service providers must have staff qualified to provide gender-affirming/ appropriate services to Transgender, Gender non-conforming, and Intersex people. <p><i>*These transgender-specific directives are already in approved Universal service standards or care</i></p>
	<p>Women:</p> <ul style="list-style-type: none">• Recipient to work with the Women’s Caucus to develop services that meet the needs of women including, women who are pregnant or have children. Explore feasibility and process for funding at least two core medical providers that would offer comprehensive women’s-centered services.
12	<p>Older Adults/Aging:</p> <ul style="list-style-type: none">• Ensure that Benefits Specialty services are available within each Service Planning Area (SPA). Benefits Specialty services must also expand to include non-Ryan White services available for aging populations (50+) within Los Angeles County.• Develop formal partnership agreements with the local Area on Aging agencies to identify and promote services for older adults living with HIV.
13	<p>Black/African American:</p> <ul style="list-style-type: none">• Develop pilot community engagement activities, e.g., incentivized coalition-building and ambassador programs that engage trusted influencers from diverse Black subpopulations, including transgender individuals, MSM, women, and youth. These initiatives will aim to foster connection, build trust, and raise HIV awareness by promoting available services and encouraging community-driven advocacy and support beyond traditional providers and spaces.

** Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.*

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FOR IMMEDIATE RELEASE

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Biden-Harris Administration Announces \$60 Million Investment for Adding Early Morning, Night, and Weekend Hours at Community Health Centers

Health centers see patients regardless of ability to pay; early morning, late night, and weekend hours will provide new options for getting care for patients who lack sick leave or struggle with transportation, child care and other issues during typical

business hours

Today, the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services (HHS), announced a \$60 million investment in 125 HRSA-funded community health centers that serve nearly 4.2 million people to expand their hours of operation to improve access to health care services. Health centers receiving this new funding will add an additional 20 hours of operation a week on average to support the critical clinical and administrative staff necessary to add early morning (before work), night and weekend hours.


Since health centers see patients regardless of their ability to pay, this expansion of operating hours will be particularly critical for people who are uninsured, underinsured, or have Medicaid coverage and struggle to find affordable care outside of traditional business hours and cannot afford expensive visits to urgent care, retail clinics or emergency departments. This funding will also help health center patients with common challenges in accessing health care – for example, taking a child to the doctor after work or getting a timely appointment when you are not feeling well on the weekend – and help connect patients to preventive services and resources for health-related social needs to improve health outcomes. Many patients currently forgo care altogether in these circumstances, putting their health at greater risk and leading to more expensive visits to emergency departments when conditions get more serious.

“No one should have to delay or skip a trip to the doctor because of work or school. The millions of Americans who can’t miss their daytime work shift, whose kids are in school, who have limited child care, or who face transportation challenges deserve the same access to quality care,” said HHS Secretary Xavier Becerra. “These investments will help to extend operating hours, especially for patients in rural or underserved communities nationwide. I’m proud to be part of an Administration that leaves nobody behind.”

“Today’s action is another example of the Biden-Harris Administration taking action to address the challenges families face in getting health care services,” said HRSA Administrator Carole Johnson. “Having the option to get to the doctor before or after work or on the weekend not only helps families get the care they need, but it also

helps relieve some of the stress and burden on families trying to arrange care. HRSA’s investment is expanding access to care in a way that recognizes the day-to-day realities of working families across the country.”



HRSA-supported health centers provide access to primary care services—regardless of an individual’s ability to pay—for over 31 million patients at more than 15,000 service sites in high need communities. More than 90 percent of health center patients have incomes below 200 percent of the Federal Poverty Level.

For a list of today’s awardees, visit: <https://bphc.hrsa.gov/funding/funding-opportunities/expanded-hours/fy-25-awards> <<https://bphc.hrsa.gov/funding/funding-opportunities/expanded-hours/fy-25-awards>> 

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