LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE

TUESDAY, AUGUST 16, 2022, 2022|1:00 PM – 3:45 PM

To Join by Computer:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/onstage/g.php?MTID=eed3953837a4a0130c31b82cfe0f3477b
**Link is for non-committee members only*
To Join by Phone: 1-415-655-0001
Access code: 2595 298 6203

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA, Co-Chair	Felipe Gonzalez	Joseph Green
Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW	Anthony M. Mills, MD
Derek Murray	Jesus “Chuy” Orozco	LaShonda Spencer, MD	Michael Green, PhD
QUORUM:	7		

AGENDA POSTED: August 11, 2022

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

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 hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. 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 Commission on HIV 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 Comisión en HIV al (213)

738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 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, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Committee leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

Call to Order | Introductions | Statement – Conflict of Interest 1:00 PM – 1:02 PM

I. ADMINISTRATIVE MATTERS 1:02 PM – 1:04 PM

1. Approval of Agenda **MOTION #1**
2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:04 PM – 1:14 PM

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

III. COMMITTEE NEW BUSINESS 1:14 PM – 1:19 PM

4. 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

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:19 PM – 1:25 PM
   a. Operational Update
6. CO-CHAIR REPORT 1:25 PM – 1:40 PM
   a. Committee Workplan Review

b. Prevention Planning Workgroup (PPW) Updates
i. PPW Workplan

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:40 PM – 2:30 PM
a. Fiscal and Program Updates
i. FY 23 Non-Competing Continuation Progress Report Preparation
ii. Comprehensive Review of Funding Streams
b. Ryan White Program and DHS Clinics
i. Number of Patients Affected
ii. Number of Patients at DHS Clinics
iii. Anticipated Fiscal Impact

V. DISCUSSION

8. Comprehensive HIV Plan 2022-2026 2:30 PM – 3:30 PM
a. Proposed Goals and Objectives

VI. NEXT STEPS 3:30 PM – 3:35 PM
9. Task/Assignments Recap
10. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 3:35 P.M. – 3:45 P.M.
11. Opportunity for Members of the Public and the Committee to Make Announcements

VIII. ADJOURNMENT 3:45 P.M.
12. Adjournment for the Meeting of August 16, 2022.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve meeting minutes as presented or revised.

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/11/22

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CAO	**Michael**	Golden Heart Medical	No Ryan White or prevention contracts
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
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)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

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

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

DRAFT

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

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

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

July 19, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	EA
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	P
Joseph Green	P	Derek Murray	EA
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	EA
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Sonja Wright, AJ King			
DHSP STAFF			
Jane Rohde Bowers, Pamela Ogata, Victor Scott, Anait Arsenyan			

*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.

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST
Kevin Donnelly, Committee Co-Chair, called the meeting to order at approximately 1:05 PM. Members and attendees introduced themselves and declared their conflicts of interest.

I. ADMINISTRATIVE MATTERS

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

2. **Approval of Meeting Minutes**
   MOTION #2: Approve meeting minutes as presented **(✓Passed by Consensus)**

II. PUBLIC COMMENT

3. **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

4. **Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agenized 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 were no new business items.*

IV. REPORTS

5. **Executive Director/Staff Report**
   a. **Operational Updates**
      - Cheryl Barrit reminded d the PP&A Committee that an updated memorandum from the Executive Office of the Board of Supervisors for Commissioners was provided in the July 14 Commission on HIV (COH) meeting packet. The memo reminded Commissioners that the COVID-19 vaccination mandate applies to Commissioners. Consistent with this mandate, Commissioners are encouraged to get vaccinated against COVID-19 before in-person meetings resume. However, once in-person meetings resume, members who have not provided proof of vaccination against COVID-19 will be required to submit a negative COVID-19 test taken within 24 hours for an antigen test or within 48 hours for a PCR test before attending an in-person meeting. Joe Green inquired if additional booster vaccines are needed as well. C. Barrit responded that only the first two vaccines are required.
6. **Co-Chair Report**
   a. **Prevention Planning Workgroup Updates**
      i. **Prevention Knowledge, Attitudes and Beliefs Survey Framework**
         - Miguel Martinez informed the group that the Prevention Planning Workgroup (PPW) is in the final stages of developing a survey to capture the knowledge, attitudes, and beliefs toward HIV prevention among Commissioners. Their last meeting was dedicated to finalizing the survey.
         - Starting in August, the PPW will be meeting from 4:00-5:30 PM.
         - Dr. William King will hold a presentation on injectable PrEP at the August PPW meeting.
         - K. Donnelly suggested providing an update on the PPW workplan at the August PP&A meeting.
   b. **Topics and Discussion Items for Future Meetings**
      - K. Donnelly asked the group for suggestions on potential topics and discussion items for future meetings. He suggested the following topics may have a potential impact on the PP&A planning efforts and Ryan White service delivery system: 1) California

Advancing and Innovating Medi-Cal (CalAIM); 2) decrease in spending power due to inflation; 3) expansion of Medi-Cal to include individuals 50 years old and above, regardless of immigration status; and 4) status neutral planning.

- AJ King suggested giving him some time to go over the draft goals and objectives for the Comprehensive HIV Plan.
- Al Ballesteros recommended discussing 1) the impact of additional Ryan White (RW) Program and Ending the HIV Epidemic initiative funding for Los Angeles County (LAC); 2) dollars saved from the migration of people over 50 years old to Medi-Cal, and 3) the decision by the Department of Health Services (DHS) to no longer use RW funds to support HIV services in their clinics. A. Ballesteros noted that specific dollars saved and available need to be quantified, emphasizing that a full understanding of all available funding streams is a part of the priority setting and resource allocations process. A. Ballesteros also recommended holding a comprehensive review of all of the County's funding streams (i.e., RWP, CDC, HRSA, NCC and Maintenance of Effort (MOE)). He inquired how is the MOE affected by the DHS decision to move away from using RW funds. He noted that the Committee will need to hear recommendations from DHSP for PP&A to weigh in on how to best use and maximize funding for HIV services in the County.
- Committee members suggested planning the PP&A Committee's agenda for the next 3 months to agendize the suggested topics.
- Dr. A. Mills inquired about the number of patients affected at DHS clinics.
- K. Donnelly commented that there is also a significant Minority AIDS Initiative (MAI) rollover funds that must be considered on top of savings from DHS funding source shift, Medi-Cal expansion, and CalAIM.
- P. Ogata noted that DHSP can provide the final 2021 fiscal report and DHS PLWH client data at the August PP&A Committee meeting. P. Ogata stated that due to COVID, HRSA is allowing grantees (in this case DHSP) to roll over unspent Part A funds. Notification of this policy was sent to grant recipients in April 2022. She added that DHSP still has the core medical services waiver approved for 2022 and DHSP is planning to submit another core medical services waiver with the 2023 Non-Competing Continuation Progress Report to HRSA.
- The PP&A Committee suggested extending their August meeting to discuss these major changes in funding.

7. Division of HIV and STD Programs (DHSP)

a. Fiscal and Program Updates – *No report provided.*

V. <u>DISCUSSION</u>

8. Comprehensive HIV Plan 2022-2026

AJ King, Comprehensive HIV Plan (CHP) Consultant, provided a presentation titled, "Overview of Data Used to Inform the LA County Comprehensive HIV Plan, 2022-2026." The presentation covered the use of data for planning purposes, people living with HIV, people

newly diagnosed with HIV, HIV care continuum, pre-exposure prophylaxis (PrEP) coverage, STDs, priority populations, and social determinants. The presentation slides can be found in the meeting packet.

a. **Epidemiology and Surveillance Data Analysis**
   - In LAC, an estimated 59,400 persons aged 13 years or older were living with HIV in 2020. This includes an estimated 6,800 persons (11%) who were unaware of their infection.
   - The top three epicenters for HIV in LAC by Health District (HD) are Central, Hollywood-Wilshire, and Long Beach.

b. **Description of PLWH and Populations at Risk**
   - Priority populations include Black/African American men who have sex with men (MSM), Latinx MSM, women of color, transgender persons, persons 50 years of age and older, persons under 30 years of age, and people who inject drugs.

c. **Syndemic Analysis**
   - Syndemics relative to HIV discussed in the presentation include homelessness, methamphetamine use, syphilis/congenital syphilis, gonorrhea, and chlamydia.

VI. NEXT STEPS

9. Task/Assignments Recap

- ➢ Request data from Pamela Ogata, DHSP, regarding projected savings resulting from the decision for DHS to no longer bill DHSP for Ryan White services and the number of PLWH patients using DHS clinics.

10. Agenda Development for Next Meeting

- The August PP&A meeting will be extended by one hour to allow time for a discussion on funding changes within LAC and review the draft goals and objectives for the CHP.
- The PPW will provide a presentation on their updated PP&A and PPW workplan.

VII. ANNOUNCEMENTS

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

- J. Green announced that the American Red Cross is participating in a study with the Food and Drug Administration (FDA) regarding potential changes for regulations for blood donations by MSM. More information can be found at www.advancestudy.org.

VIII. ADJOURNMENT

12. Adjournment for the Meeting of July 19, 2022

The meeting was adjourned by K. Donnelly at approximately 3:00 PM.

Planning, Priorities, and Allocations (PP&A) Committee
Follow-up to WebEx Chat Questions from July 19, 2022 Meeting

CD4-based Method:
The CD4-based method is used to estimate the following:

- **Incidence of HIV infection (diagnosed and undiagnosed)**
- **Prevalence of HIV infection (diagnosed and undiagnosed)**
- **Undiagnosed infections among adults and adolescents**
- **Percentage of diagnosed infections among adults and adolescents**

The estimates are obtained in 5 steps:

1. The date of HIV infection is estimated for each person with a CD4 test by using a CD4 depletion model. Not all persons with diagnosed HIV have a CD4 test. The number of persons with CD4 test results are weighted to account for those without a CD4 test result; weighting is based on the year of HIV diagnosis, sex, race/ethnicity, transmission category, age at diagnosis, disease classification, and vital status at the end of the specified year. Because the CD4 model is based on transmission categories for adults and adolescents, persons classified in a pediatric category or age <13 years at diagnosis are excluded. If the age at the estimated date of infection for a person was less than 13, the estimated date of infection is set to the date when the person reached the age of 13.
2. The distribution of delay (from HIV infection to diagnosis) is then estimated and used to estimate the annual number of HIV infections, which includes persons with diagnosed and persons with undiagnosed infection.
3. The number of persons with undiagnosed HIV infection is estimated by subtracting cumulative diagnoses from cumulative infections.
4. HIV prevalence, which represents counts of persons with diagnosed or undiagnosed HIV infection who were alive at the end of a given year, is estimated by adding the diagnosed prevalence (based on year specific PITA) and the estimated number of persons with undiagnosed infections.
5. The percentage of diagnosed (or undiagnosed) infections is determined by dividing the number of persons living with diagnosed (or undiagnosed) infections by the total HIV prevalence for each year.

After estimates are produced, confidence intervals are constructed. To reflect model uncertainty, numbers are rounded to the nearest 100 for estimates of more than 1,000 and to the nearest 10 for estimates ≤1,000. Numbers of persons living with diagnosed HIV infection are calculated based on cases reported to the jurisdiction. These numbers are not estimates.

Additional information from AJ:

Based on information above, provided by Dr. Green, and a little research on my part (*Estimating the First 90 of the UNAIDS 90-90-90 Goal: A Review, Sohail, et al.)* I've tried to describe the CD4 Depletion Model a bit more:

CD4 Depletion Model
The CD4 depletion method relies on a newly diagnosed person's CD4 count to reflect when the individual was most likely infected, provided ART was not initiated.

Lodi et al estimated the time from infection to a particular CD4 count by using data on 21,240 individuals from Concerted Action on Seroconversion to AIDS and Death in Europe. The study included individuals from Europe, Australia, Canada, and Sub-Saharan Africa whose dates of HIV infection were well estimated.

The results indicated that CD4 depletion without ART could be used to estimate time from diagnosis, for example:

- 1.19 years post-infection CD4 was 350 to 500 cells/mm
- 4.19 years was 200 to 350 cells/mm
- and 7.93 years was <200 cells/mm

This estimated time from the infection to a particular CD4 cell level allows us to identify when the person most likely became infected, demonstrated by the dashed line in Figure 3 which shows CD4 count of 500 cells/mm after about 1.19 years of being infected.

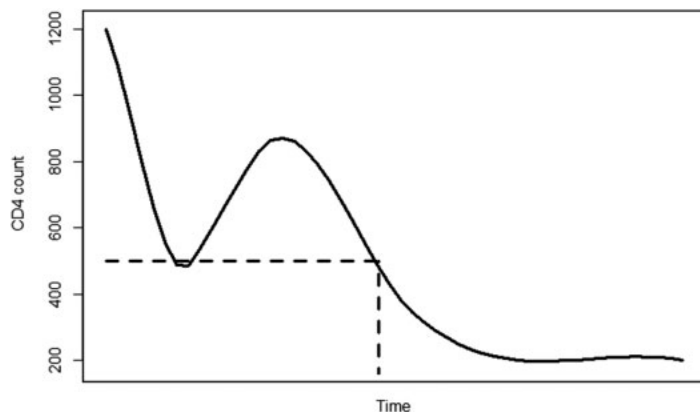


Figure 3. Hypothetical schematic figure of the CD4 depletion model.
Time since infection estimated using CD4 count.

A major drawback to this method is that an initial CD4 count prior to initiation of ART is required and may not be readily available. If an individual's CD4 count is reported after the initiation of the ART, the validity of the estimated time since infection will be reduced. In the United States, most *but not all* states have implemented the mandatory reporting of initial CD4 counts to the CDC. Furthermore, the current CD4 depletion model does not include individuals <13 years of age. Moreover, since CD4 counts deplete drastically in the initial stage followed by

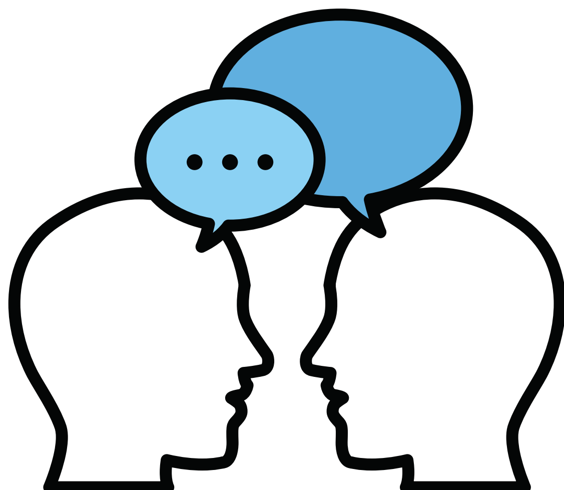
a temporary recovery, CD4 count profiles captured at this initial period can lead to an overestimation of the duration of infection, and therefore, should not be used alone in acute/early infection, but methods such as a biomarker method that accurately distinguishes acute infection should be used in supplement. This method has been used by the CDC to estimate the national and state level number of undiagnosed PLWH and to estimate the undiagnosed PLWH by demographic characteristics and HIV risk factors.

LOS ANGELES COUNTY
COMMISSION ON HIV

Los Angeles County Commission on HIV Training Schedule 2022

Come learn with us!
All trainings are open to the public. Virtual study hours will be available for all commissioners and members of the public who have any questions about the purpose and functions of the Commission on HIV.

Trainings are mandatory for all Commissioners.



March 29
General Orientation
Commission on HIV Overview
3:00 - 4:30 PM - Register here.

April 12
Virtual Study Hour
3:00 - 4:00 PM - Register here.

July 21
Ryan White Care Act Legislative Overview
Membership Structure and Responsibilities
3:00 - 4:30 PM - Register here.

August 17
Virtual Study Hour
3:00 - 4:00 PM - Register here.

September 15
Priority Setting and Resource Allocation Process
Service Standards Development
3:00 - 4:30 PM - Register here.

October 20
Virtual Study Hour
3:00 - 4:00 PM - Register here.

November 16
Policy Priorities and Legislative Docket Development Process
4:00 - 5:00 PM - Register here.

November 17
Co-Chair Roles and Responsibilities (Virtual live)
4:00 - 5:00 PM - Register here.

December 13
Virtual Study Hour
3:00 - 4:00 PM - Register here.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly
Committee Adoption Date: 1/18/22	Revision Dates:
Purpose of Work Plan: To focus and prioritize key activities for COH 2022	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Develop the Comprehensive HIV Plan 2022-2026	The Committee will gather, discuss, develop and provide planning priorities for inclusion in the plan.	10/2022	PP&A will continue to agendize the CHP. The Committee is the conduit for information obtained from all Commission Committees and subgroups. ***In progress.***
2	Address Areas of Improvement from the HealthHIV Planning Council Effectiveness Assessment	The Committee will engage the broader community in developing and shaping the CHP. in	***Ongoing***	PP&A is discussing activities to enhance community representation/engagement of underserved populations impacted by HIV in LAC.
3	Strengthen Core Planning Council Responsibilities	The Committee will continue to improve the Commission's prevention and care multi-year planning process and decision-making	***Ongoing***	PP&A has increased the scope and frequency of data reviewed in the decision-making process to optimize services offered.
4	Develop Strategies for Maximizing Part A and MAI Funding	Monitor, assess and create directives for DHSP to effectively expend Part A and MAI funds to meet the needs of the underserved with specific focus on minority communities.	03/2022 - ***Ongoing***	The Committee has used data provided by DHSP, Ending the HIV Epidemic (EHE) Plan, Transgender, Women and Consumer Caucuses; Black African American Community (BAAC) and Aging Taskforces (TF) recommendations in multi-year planning efforts. ***Program Directives for PY 32, 33, and 34 approved by the COH on 6/9/22***

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

				PP&A will create specific DHSP Directives for the use of MAI funding to fully expend funds within the allocation program year.
5	Review, discuss and understand financial information from DHSP	Review and monitor fiscal reports on all HIV funds supporting LAC HIV Care and Prevention services.	**Ongoing**	The Committee has requested DHSP provide this information on a monthly basis.
6	Annual Progress Report (APR)	Review progress report prepared for Health Resources and Services Administration (HRSA) by DHSP	08/2022	
7	Rank Service Categories for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Rank (HRSA) Ryan White services numerically and obtain Commission approval to provide service rankings to DHSP for program implementation.	08-2022	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before ranking services. ***PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY 32 allocations approved by the COH 7/14/22***
8	Allocations for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Determine financial resource allocation percentages for HRSA ranked services and obtain Commission approval to provide to DHSP for program implementation.	08/2022	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission. PP&A dedicates several meetings to reviewing data and deliberating on findings before determining funding allocations. ***PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY***

				32 allocations approved by the COH 7/14/22
9	Prevention Planning	Develop integrated prevention and care planning strategies. Participate in the CDC prevention application process by recommending strategies for inclusion in the CDC prevention plan.	Ongoing	The committee established a Prevention Planning Workgroup to prepare short- and long-term prevention activities for recommendation to DHSP; DHSP to provide prevention data ****See PPW Workplan for details*****
10	Discuss systems of care changes and impact on care and prevention planning.	Agendize the following topics for Committee discussion: 1. Medi-Cal expansion to 50+ individuals regardless of documentation status. 2. CalAIM (California Advancing and Innovating Medi-Cal) 3. Decrease in purchasing power of grant funds due to inflation 4. Making status neutral planning the norm for PP&A and COH	August-December 2022	P. Ogata (DHSP) presented "Medi-Cal Expansion: Preliminary Analysis on the Impact to Los Angeles County's Ryan White Program" 6/21/22. ***Ongoing***

LOS ANGELES COUNTY COMMISSION ON HIV 2022 PREVENTION PLANNING WORKGROUP WORK PLAN
DRAFT/FOR REVIEW (07.13.22; Revised 7.27.22; 08.8.22; 08.15.22)

<table>
<tr><td colspan="4">Prioritization Considerations: Select activities that are feasible and within the influence/capacity of the Prevention Planning Workgroup (PPW). PPW was established to infuse and strengthen prevention efforts in the Commission on HIV's planning and priority setting processes and discussions.</td></tr>
<tr><td># of Votes</td><td>Approval Date:</td><td colspan="2">Revision Dates:</td></tr>
<tr><td colspan="3">TASK/ACTIVITY</td><td>TARGET COMPLETION DATE</td></tr>
<tr><td>5</td><td colspan="2">Engage in conversations around syringe exchange. Expand conversations beyond syringe exchange related to harm reduction. Increase access to syringe exchange and other harm reduction programs and services. Include STIs and hepatitis c screening, education and treatment in harm reduction programs. Combined all syringe access/harm reduction activities together.
I'm looking at "harm reduction" in this context broadly. So, what does harm reduction look like for people engaged in survival sex? What about for people using drugs or iv drug use? People who attend sex parties or CSVs?</td><td></td></tr>
<tr><td>4</td><td colspan="2">How do we truly target populations/create standards or focus on populations that cannot access organizations based on hours.
Proposed Revision:
Discuss standards/guidelines for prevention contracts/services to be accessible to target populations that also address social determinants of health.
Include but not limited to hours of operation, geographic locations, mental health, housing.</td><td></td></tr>
<tr><td>4</td><td colspan="2">Address unique prevention and health and wellness needs of youth and aging populations</td><td></td></tr>
<tr><td>4</td><td colspan="2">Provide wrap-around services for high-risk negative individuals</td><td></td></tr>
<tr><td>4</td><td colspan="2">Marketing campaign to support awareness of resources about HIV-related services (including influencers)</td><td>In progress
12/30/22</td></tr>
<tr><td>4</td><td colspan="2">Identify primary and secondary prevention efforts and develop layered interventions. Any layered intervention should include situational factors and social determinants of health, including homelessness, employment, supportive social networks, etc.</td><td></td></tr>
<tr><td>3</td><td colspan="2">Identify strategies to increase ~~encourage~~ in-person HIV testing and self HIV testing overall</td><td></td></tr>
<tr><td>3</td><td colspan="2">Merge mental health and biomedical prevention efforts/programs</td><td>12/30/22</td></tr>
<tr><td>3</td><td colspan="2">Navigating sex for high-risk negative individuals</td><td>12/30/22</td></tr>
<tr><td>3</td><td colspan="2">Address housing needs of high-risk negative individuals</td><td>12/30/22</td></tr>
</table>

2	Conduct a thorough evaluation of existing directives to infuse prevention focus. *We should include quantitative data so that as we infuse new prevention focus, we're moving towards directives that are empirically-based and against which we can measure progress*	
2	Request data regarding HIV/STD testing, diagnosing, and PrEP for aging population. *I'm not prioritizing this separately, but as part of creating dashboards, we should break out data for the highest risk populations, including, if appropriate, ageing individuals.*	12/30/22
2	Advocate for a minimum number of prevention-focused presentations each year. *These topics should be dictated in part by the results of the KAB survey and include dashboard data to provide a quantitative foundation for the presentations.*	
1	Review B/AA Task Force recommendations to identify prevention-focused items.	
1	Injectable PrEP information/education focused on navigators at organizations	
1	Recenter conversations and planning back to health districts including requesting prevention indicators (HIV and STD testing, PrEP uptake) by health district. *I think this would necessarily involve our developing a dashboard of prevention metrics that we can use to establish a baseline and against which we measure progress.*	
1	*Identify ways to increase PrEP uptake. Based on data from the AHEAD dashboard, PrEP update is low in LAC.*	
1	Look at creating space for supporting the assessment of readiness for injectable PrEP (at the provider level).	
0	Develop and implement a survey of Commission members to look at knowledge, attitudes, and beliefs (KAB) regarding prevention to guide further activities.	In progress
0	Support PrEP Center(s) of Excellence for women (in line with recommendations with B/AA task force). -- **Contracts have been awarded although no agencies selected to serve women exclusively.**	~~In progress~~ *Completed. No one applied to serve women.*
0	Look at ways to support the development of resources to build the capacity of smaller orgs to respond to RFAs/WOS.	In progress
0	Efforts to target monolingual populations regarding prevention information	

County of Los Angeles Public Health

Changing Healthcare Landscape in Los Angeles County: Impact to Local Ryan White Program in FY 2022

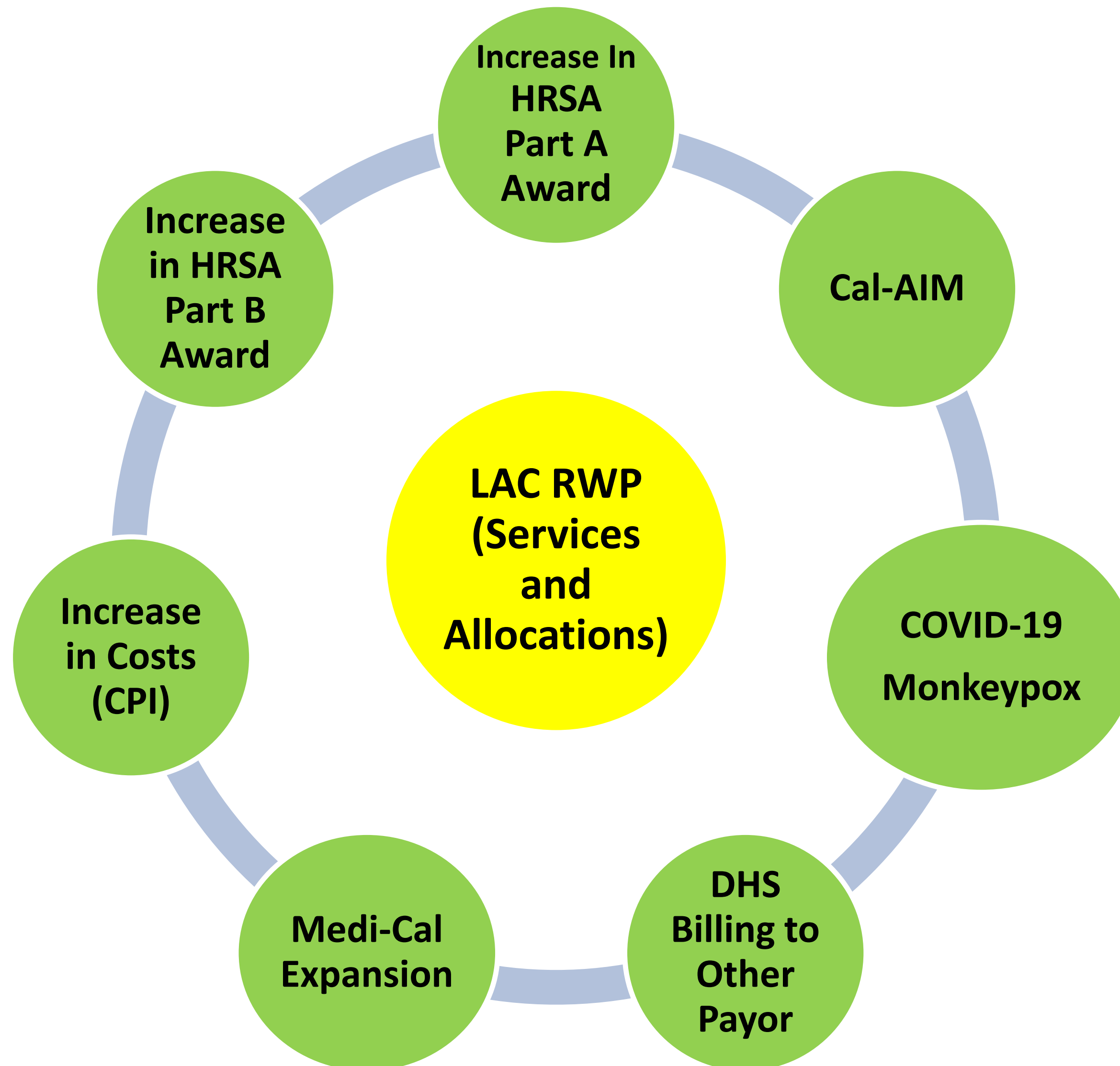
August 16, 2022 PP&A Meeting

Dr. Michael Green, Chief
Planning, Development and Research
Division of HIV and STD Programs

COUNTY OF LOS ANGELES Public Health

Background

Expected and Unexpected Changes



Overview of Previous Re-Allocation Estimate

Issue	Estimate or Actual	Notes
Increase in FY 2022 HRSA Part B Award	$446,809 actual increase	Part B covers HRSA approved fee-for-service (FFS) service categories
Increase in Costs (CPI)	Assessment in progress	Overall increase in past 12-months- appx. 8%
Medi-Cal Expansion	Up to $4 million (estimate)	Low income persons 50 years old and older (regardless of immigration status) are eligible to receive full Medi-Cal coverage as of May 1, 2022. Thus, the RWP will not pay for these clients' AOM, MCC, and general oral health services anymore because RWP must be the payor of last resort

Overview of Previous Re-Allocation Estimate (cont.)

Issue	Estimate or Actual	Notes
Increase in FY 2022 HRSA Part A Award	$1,945,224 actual increase	Received full Notice of Award (NOA) on May 19, 2022. Requesting approval to carryover $1,747,329 from FY 2021 to FY 2022
Cal-AIM	Pending additional information from State	Cal-AIM program will be rolled out in stages. State is soliciting feedback on Cal-AIM plan.
COVID-19 and Monkeypox	Assessments in progress	Service utilization and impact on expenditures will be closely monitored by DHSP staff.
HS Billing to Other Payor Source	$11.7 million (estimated/projected)	In FY 2021 DHS provided Emergency Financial Assistance (EFA), Housing, Medical Care Coordination (MCC), Ambulatory Outpatient Medical (AOM), Mental Health (MH), transportation, and Transitional Case Management (TCM)-Jails services.

Current Re-Allocation Projection

Current Re-Allocation Projection and Plan

Current Re-Allocation Estimate: **$5 million - $6 million**

Plan:

- DHS will continue to bill the RWP for Emergency Financial Assistance and Housing services in FY 2022. (New estimated DHS amount to be reallocated=$7.2 million)
- DHSP is in the process of augmenting nutritional support contracts
- DHSP is in the process of increasing AOM rates based on change in the Consumer Price Index (CPI)
- DHSP will be billing HIV partner services to RWP (Early Intervention Services) as of July 1, 2022 (appx. $800,000)
- DHSP is working with the Housing for Health program to procure motel vouchers for unstably housed PLWDH for the Linkage and Reengagement Program (LRP)

Current Re-Allocation Projection and Plan (cont.)

Current Re-Allocation Estimate: $5 million - $6 million

Plan:

- HRSA announced that RWP funds can be used to support Monkeypox screening and laboratory costs
- DHSP can carryover approximately $2 million from FY 2022 MAI award to FY 2023
- DHSP is closely monitoring the impact of Medi-Cal expansion on the RWP. Not enough time has elapsed to see if there is a difference in expenditures compared to last year. Based on invoices received for May 2022, there was no change in expenditures for AOM and MCC services. It is highly unlikely that the financial impact of Medi-Cal expansion will be $4 million in FY 2022.
- DHSP has met, and will continue to meet with State OA and HRSA to discuss the changing healthcare landscape in Los Angeles County and the impact on the RWP

Contingency Planning

Plan B

The current estimate that needs to be re-allocated to maximize the HRSA Part A/MAI and Part B grants is approximately $5 to $6 million. This can probably be covered by implementing the changes listed in the previous slides. However, additional issues may arise. One possible contingency plan is to

- Carryover FY 2022 Formula funds into FY 2023 without penalty (HRSA announced waiver opportunity)

Questions and Discussion

How many clients does DHS serve?

- In CY 2021, 5,678 PLWDH got lab work done at a DHS site.
- In FY 2021, 16,963 PLWDH received one or more RWP services.
  - 5,351 RWP clients received AOM services; approximately 28% received services from a DHS site (n=1,476)
  - 8,244 RWP clients received MCC services; approximately 13% received services from a DHS site (n=1,036)
- Retention in care and viral suppression measures were higher at DHS RWP sites compared to the overall RWP data (2019).

Outcome	Overall RWP	RWP DHS Sites
Retention in Care	79%	87%
Viral Suppression	82%	86%

Q. Will the MOE be impacted if DHS does not bill for AOM/MCC services?

- The costs DHS incurs for AOM and MCC services will count towards meeting the MOE requirement

Q. How can DHSP and or COH monitor DHS' performance if DHS is no longer a RWP provider?

Q. Can HRSA Part A/MAI funds be used for STD services?

Additional Questions?

thank you!

Funding Source	Amount	Description
HRSA Ryan White Program Parts A (March 1-February 28/29) Year 1 of 3-year award	$42,142,230	Grant must fund at least one or more core or support service for people living with HIV/AIDS per policy clarification notice 16-02. The Ryan White Program is the payor of last resort. AOM, Oral Health, Early Intervention Services, Emergency Financial Assistance Services, Home and Community Based Health Services, Mental Health Services, Medical Case Management (MCC), Non-medical Case Management (Benefits Specialty), Food Bank and Home Delivered Meals, Housing Services (RCFCI, TRCF), Legal Services, Linguistic Services, Medical Transportation, Substance Abuse Residential Services
HRSA Ryan White Program Part B April 1- March 31 (year 4 of 5-year cycle)	$5,446,809	Grant must fund at least one or more core or support service for people living with HIV/AIDS per policy clarification notice 16-02. The Ryan White Program is the payor of last resort. Housing Services (RCFCI and TRCF. Mental health portion of these contracts is covered under Part A. Substance Use Residential services for one agency is also supported with RWP Part B)
HRSA Ryan White Program Minority AIDS Initiative (March 1-February 28/29) Year 1 of 3-year award	$3,780,205	Grant must fund at least one or more core or support service for HIV-positive racial or ethnic or sexual minorities. The Ryan White Program is the payor of last resort. Outreach (LRP), Housing (Permanent Supportive Housing), and Non-medical Case Management (Transitional Case Management) is supported with RWP MAI.
HRSA Ending the HIV Epidemic March 1-February 28/29 (Year 3 of a 5-year cycle)	$6,168,850	Grant supports 1) Data system infrastructure development and systems linkages; 2) Surveillance improvements and building organizational capacity, 3) Emerging practices, evidence-informed and evidence-based interventions for diagnosis and rapid linkage to care; 4) Reengagement in care and viral suppression; and 5) Community engagement, information dissemination specifically calling attention to the activities for PLWH who are not virally suppressed.
CDC Ending the HIV Epidemic August 1-July 31 (Year 3 of a 5 year cycle)	$3,360,658	Grant supports HIV prevention strategies, including 1) HIV self-testing; 2) Community engagement; 3) Increaed access to syringe services; 4) Increased screening for PrEP; 5) HIV prevention media campaigns; and 6) Improved surveillance data for real-time HIV cluster detection and response.
CDC Integrated HIV Surveillance and Prevention (January 1-December 31)-year 5 of a 5 year cycle	$17,950,095	Grant supports 11 HIV surveillance and prevention strategies including active and passive surveillance; outbreak investigation; data management, analysis and reporting; comprehensive individual-level and community-level HIV-related prevention services; and data-driven planning.
State Block Grant - HIV Surveillance (July 1-June 30)	$1,972,378	Grant supports active and passive HIV surveillance, data management, analysis and reporting
CDC HIV Treatment Improvement Demonstration Project (January 1-December 31)-year 5 (1-year extension in 2022) of a 4-year cycle	$597,083	The two goals of this project are 1) increase infrastructure to improve classification of provider-level HIV surveillance data and 2) provide technical assistance on quality improvement to increase viral suppression, retention in care, and durable viral suppression among low performing providers in Los Angeles County.
CDC National HIV Behavioral Survey & TG supplement (January 1-December 31) - year 1 of a 5-year cycle)	$637,802 + $78,366 for Hep suppl.	Grant supports Los Angeles County's participation in this four-cycle national survey (MSM, IDU, Heterosexuals, and TG). Survey findings are used for the Los Angeles County HIV/AIDS Strategy, program development, and resource allocation.
CDC Medical Monitoring Project (June 1-May 31) - year 3 of a 5-year cycle	$728,648	Grant supports Los Angeles County's participation in the national surveillance project designed to learn more about the experiences and needs of PLWH (in and out of care).
CDC Strengthening STD Prevention and Control for Health Departments (January 1-December 31) - year 4 of a 5-year cycle	$3,356,049	Grant must be used to support 5 strategy areas: STD surveillance, disease investigation and intervention, screening and treatment, promotion and policy, and data management and utilization. No more than 10% of grant funds can support contracts.
CDC STD Prevention and Control for Health Departments – Disease Investigation Specialist (DIS) Workforce Development Infrastructure (January 1-December 31) – year 2 of a 5-yr cycle	$6,598,516	Grant supports expanding, training, and sustaining local DIS workforce to support icreased capacity to conduct disease investigation, linkage to prevention and treatment, case management and oversight, and outbreak response for COVID-19 and other infectious diseases.
CDC Gonococcal Isolates Surveillance Project (August 1, 2019-July 31, 2020)	$15,000	ELC Grant supports participation in the national sentinel surveillance system to monitor trends in antimicrobial susceptibilities of Neisseria gonorrhoeae strains in the US among selected STD clinics and covers salary, fringe benefits and supplies
State STD General Funds Allocation July 1-June 30 (year 4 of 5-year cycle)	$547,050	Grant funds support CT/GC Patient Delivered Partner Therapy (PDPT) Distribution Project, condom distribution, training for PHNs and PHIs and DHSP staff.
State STD Management and Collaboration Project (July 1-June 30) - year 4 of 5-year cycle	$497,400	Grant funds support Los Angeles LGBT Center, Entercom for condom distribution, and rapid Syphilis test kits
SAPC Non-Drug Medi-Cal (July 1-June 30)	$3,249,000	Grant supports HIV risk reduction interventions that contain a substance abuse component.
Total	**$97,126,139**	

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 31 AND PART B YR 31 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by July 19, 2022

1	2	3	4	5	6	7	8
SERVICE CATEGORY	YR 31 EXPENDITURES PART A	YEAR 31 EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	PART A + MAI EXPENDITURES %	YEAR 31 EXPENDITURES PART B	TOTAL YEAR 31 DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+6)	COH YR 31 ALLOCATIONS %
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 7,478,232	$ -	$ 7,478,232	20.28%	$ -	$ 7,478,232	24.13%
MEDICAL CASE MGMT (Medical Care Coordination)	$ 9,652,814	$ -	$ 9,652,814	26.17%	$ -	$ 9,652,814	31.73%
ORAL HEALTH CARE	$ 6,699,203	$ -	$ 6,699,203	18.16%	$ -	$ 6,699,203	13.81%
MENTAL HEALTH	$ 362,699	$ -	$ 362,699	0.98%	$ -	$ 362,699	0.69%
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,318,710	$ -	$ 2,318,710	6.29%	$ -	$ 2,318,710	7.02%
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 1,403,115	$ -	$ 1,403,115	3.80%	$ -	$ 1,403,115	3.49%
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ 527,592	$ 242,484	$ 770,076	2.09%	$ -	$ 770,076	0.79%
HOUSING-RCFCI, TRCF	$ 235,329	$ -	$ 235,329	0.64%	$ 3,859,442	$ 4,094,771	1.05%
HOUSING-Temporary and Permanent Supportive with Case Management	$ 1,695,682	$ 1,279,626	$ 2,975,308	8.07%	$ -	$ 2,975,308	7.73%
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	0.00%	$ 744,825	$ 744,825	--
MEDICAL TRANSPORTATION	$ 446,195	$ -	$ 446,195	1.21%	$ -	$ 446,195	2.06%
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 2,504,284	$ -	$ 2,504,284	6.79%	$ -	$ 2,504,284	7.27%
EMERGENCY FINANCIAL ASSISTANCE	$ 1,051,759	$ -	$ 1,051,759	2.85%	$ -	$ 1,051,759	--
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 614,470	$ -	$ 614,470	1.67%	$ -	$ 614,470	--
LEGAL	$ 369,106	$ -	$ 369,106	1.00%	$ -	$ 369,106	0.23%
SUB-TOTAL DIRECT SERVICES	$ 35,359,190	$ 1,522,110	$ 36,881,300	100.00%	$ 4,604,267	$ 41,485,567	100.00%
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 4,034,450	$ 363,270	$ 4,397,720		$ 395,733	$ 4,793,453	
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 950,862	$ -	$ 950,862		$ -	$ 950,862	
TOTAL EXPENDITURES	$ 40,344,502	$ 1,885,380	$ 42,229,882		$ 5,000,000	$ 47,229,882	
TOTAL GRANT AWARD			43,977,211				
VARIANCE			1,747,329				
MAI Carryover from YR 21 to YR 22	**$**	**1,747,329**					

APPROVED REVISIONS TO THE PY 32 (FY 2022) RW Part A and MAI ALLOCATIONS-- LOS ANGELES COUNTY DIVISION OF HIV AND STD PROGAMS
Approved by Planning, Priorities, and Allocations Committee on 6/21/22; Exec. Committee Approved 6.23.22; COH Approved 7.14.22

PY 32 Priority #	Service Category	COH Part A Percent	COH MAI Percent	COH Part A and MAI Percent	Proposed Part A Percent	Proposed MAI Percent	Proposed Part A and MAI Percent	Notes
1	Housing Services	1.0%	87.39%	8.33%	0.97%	88.18%	8.30%	
2	Case Management (Non-Medical)	2.4%	12.61%	3.30%	2.47%	11.82%	3.26%	
3	Outpatient/Ambulatory Health Services	25.5%	0.00%	23.33%	25.87%	0.00%	23.70%	
4	Emergency Financial Assistance (EFA)	0.0%	0.00%	0.00%	4.05%	0.00%	3.70%	EFA was previously supported by HRSA Ending the HIV Epidemic grant. However, this service is a better fit under HRSA Part A
5	Psychosocial Support	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
6	Medical Case Management (Medical Care Coordination)	28.9%	0.00%	26.41%	23.87%	0.00%	21.87%	The difference between the proposed allocation and the original COH allocation is due to 1) addition of EFA service category and 2) minor changes because our final award was not exactly the same as the requested amount on the application.
7	Mental Health Services	4.1%	0.00%	3.72%	4.13%	0.00%	3.78%	
8	Outreach (Linkage and Re-engagement Program)	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
9	Substance Abuse Outpatient	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
10	Early Intervention Services	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
11	Medical Transportation	2.2%	0.00%	1.99%	2.20%	0.00%	2.01%	
12	Nutrition Support-Food Bank and Home Delivered Meals	9.0%	0.00%	8.19%	9.07%	0.00%	8.31%	
13	Oral Health	17.6%	0.00%	16.30%	17.86%	0.00%	16.36%	
14	Child Care Services	1.0%	0.00%	0.87%	0.96%	0.00%	0.88%	
15	Legal Services	1.0%	0.00%	0.92%	1.02%	0.00%	0.93%	
16	Substance Use Residential	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
17	Health Education Risk Reduction	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
18	Home and Community Based Case Managem	6.8%	0.00%	6.21%	6.87%	0.00%	6.30%	
19	Home Health Care	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
20	Referral	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
21	Health Insurance Premium	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
22	Language Services	0.7%	0.00%	0.60%	0.66%	0.00%	0.60%	
23	Medical Nutritional Therapy	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
24	Rehabilitation	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
25	Respite Care	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
26	Local Pharmacy Assistance	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
27	Hospice	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
		100.0%	100.00%	100%	100.00%	100.00%	100.00%	

County of Los Angeles
Public Health

Medi-Cal Expansion: Preliminary Analysis on the Impact to Los Angeles County's Ryan White Program

Medi-Cal Eligibility

Prior to May 1, 2022

- Persons 65 years or older *
- Child/ Youth (under age 26)
- Pregnant woman
- Other (in a skilled nursing or intermediate care home*, blind, disabled, etc.)

*** Must have legal residence status & Earn less than or equal to 138% FPL**

Beginning May 1, 2022

- **Persons 50 years or older***
- Child/Youth
- Pregnant woman
- Other (in a skilled nursing or intermediate care home, blind, disabled, etc.)

***Earn less than or equal to 138% FPL**

Methodology/Approach

Methodology/Approach

Data Source: RW utilization data for March 1, 2020 to February 28, 2021 as reported in HIV Casewatch and paid for by the Division of HIV and STD Programs (DHSP)

1. Describe utilization and expenditures for the three RW service categories that will be most impacted by the 2022 Medi-Cal expansion; Ambulatory Outpatient Medical (AOM), Oral Health (general), and Mental Health services.
2. Estimate average cost per client for each RW service.
3. Estimate the number of RW clients aged 50 and older with income at or below 138% FPL.
4. Estimate savings by multiplying the number of clients that may transfer out of the RWP to Medi-Cal by the average per client cost for each RW service.

Review of 2020 RW Utilization Data

- 16,960 persons living with HIV (PLWH) accessed one or more RW service
  - 27% (n=4,639) were 50 to 59 years of age
  - 15% (n=2,491) aged 60 and older
  - 43% (n=7,272) were not born in the US
  - 60% (n=10,211) had an income at or below the FPL.

Step 1: Review of 2020 RW Utilization Data

Table 1. Overview of Service Utilization and Expenditures for Ryan White Program AOM, Oral Health, and Mental Health Services, Los Angeles County, March 1, 2020 to February 28, 2021.

RW Service Category	Number of Clients	Number of Service Units	Part A/ MAI	Part B	HIV NCC	Total FY 2020 Expenditures
AOM	5,653	16,973 visits	$8,252,137	$0	$0	$8,252,137
Mental Health	312	3,168 sessions	$408,834	$0	$1,072	$409,906
Oral Health General	3,119	18,752 procedures	$5,005,012	$0	$0	$5,005,012
Specialty	2,698	10,672 procedures	$1,582,509	$0	$0	$1,582,509

Step 2: Estimation of Average Cost per Client

Table 2. Average Cost per Client for Ryan White Program AOM, Oral Health, and Mental Health Services, Los Angeles County, March 1, 2020 to February 28, 2021.

RW Service Category	Number of Clients	Total FY 2020 Expenditures	Average Cost per Client
AOM	5,653	$8,252,137	$1,460
Mental Health	312	$409,906	$1,314
Oral Health General	3,119	$5,005,012	$1,605
Specialty	2,698	$1,582,509	$587

Step 3: Estimation of Number of Clients 50 years or older and <= 138% FPL

Table 3. Number of Clients aged 50 to 64 Years and Percent FPL for AOM, Oral Health, and Mental Health Services March 1, 2020 to February 28, 2021.

RW Service Category	Number of Clients Age 50-64	Less than or equal to 138% FPL	Greater than 138% FPL
AOM	1,734	1,174 (67.7%)	559 (32.2%)
Mental Health	111	87 (78.4%)	24 (21.6%)
Oral Health General	1,389	936 (67.4%)	453 (32.6%)
Specialty	1,243	837 (67.4%)	405 (32.6%)

Clients may receive one or more service so the total of clients now eligible for Medi-Cal may be less than 2,197. More assessment is needed to determine the impact of Medi-Cal or Denti-Cal expansion on RW specialty oral health services. Some specialty services such as implants are not covered by Denti-Cal

Step 4: Estimation of Potential RWP Cost Savings

Table 4. Estimated Savings from Medi-Cal Expansion among Clients Aged 50 and older (estimated using 2020 data and expenditures)

RW Service Category	Number of Clients age 50-64, <=138% FPL	Number of non-legal immigrants age 65 and older, <=138% FPL	Number of Clients Transitioning to Medi-Cal	Average Cost per Client	Total EstimatedSavings per RW Service
AOM	1,174	91	1,265	$1,460	$1,846,900
Mental Health	87	7	94	$1,314	$123,516
Oral Health General	936	215	1,251	$1,605	$2,007,855

Total Estimated Savings= $3,978,271

County of Los Angeles Public Health

Limitations of Forecasting Analysis

Limitations and Next Steps

- More information is needed on Medi-Cal covered behavioral health services and specialty oral health
- RW will need to cover some costs for Medi-Cal expansion eligible clients while Medi-Cal eligibility is being verified in FY 2022
- Legal immigration status is not collected in Casewatch
- Analysis used FY 2020 RW Casewatch data and expenditures. RW utilization patterns in FY 2020 may be different compared to FY 2021 or 2022 due to the impact of COVID-19.
- Changes in the cost of services will affect total estimated savings
- Re-run analysis using FY 2021 RW Care Utilization Data and Expenditures in July 2022
- How can WE (OA, DHSP, COH, PP&A, service providers, etc.) help or support clients through this transition?
- Need to assess how CalAIM changes will impact RWP utilization and expenditures. Continued collaboration and open communication with OA is critical.

Questions and Discussion

Ending the HIV Epidemic (EHE) Awards to Federally Qualified Health Centers (FQHCs) in Los Angeles County (LAC) from Health Resources Administration (HRSA) Health Center Program

FY 2020 (Contract Term: 2 years)

ORGANIZATION NAME	CITY	AWARD AMOUNT
ALTAMED HEALTH SERVICES CORPORATION	LOS ANGELES	$417,912
APLA HEALTH & WELLNESS	LOS ANGELES	$261,233
BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	LANCASTER	$256,071
BEHAVIORAL HEALTH SERVICES INC	GARDENA	$252,468
CENTRAL CITY COMMUNITY HEALTH CENTER, INC.	ROSEMEAD	$268,231
CLINIC INC, THE	LOS ANGELES	$263,355
EAST VALLEY COMMUNITY HEALTH CENTER INC	WEST COVINA	$264,715
EL PROYECTO DEL BARRIO, INC	ARLETA	$268,099
JWCH INSTITUTE, INC.	COMMERCE	$289,548
LOS ANGELES LGBT CENTER	LOS ANGELES	$278,196
NORTHEAST VALLEY HEALTH CORPORATION	SAN FERNANDO	$329,066
ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.	LOS ANGELES	$305,039
VALLEY COMMUNITY HEALTHCARE	NORTH HOLLYWOOD	$274,893
VENICE FAMILY CLINIC	VENICE	$264,541
WATTS HEALTHCARE CORPORATION	LOS ANGELES	$270,534
TOTAL		**$4,263,901**

FY 2021 (Contract Term: 2 years)

ORGANIZATION NAME	CITY	AWARD AMOUNT
ALL-INCLUSIVE COMMUNITY HEALTH CENTER	BURBANK	$342,098
CENTER FOR FAMILY HEALTH & EDUCATION, INC.	PANORAMA CITY	$345,137
CENTRAL NEIGHBORHOOD HEALTH FOUNDATION	LOS ANGELES	$348,808
EISNER PEDIATRIC & FAMILY MEDICAL CENTER	LOS ANGELES	$365,537
HARBOR COMMUNITY CLINIC	SAN PEDRO	$341,063
HEALTH ACCESS FOR ALL, INC.	LOS ANGELES	$344,157
LOS ANGELES CHRISTIAN HEALTH CENTERS	LOS ANGELES	$347,216
MISSION CITY COMMUNITY NETWORK, INC.	NORTH HILLS	$342,198
POMONA COMMUNITY HEALTH CENTER DBA PARKTREE CHC	POMONA	$345,963
SAN FERNANDO COMMUNITY HOSPITAL	SAN FERNANDO	$340,405
SOUTH CENTRAL FAMILY HEALTH CENTER	LOS ANGELES	$353,475
SOUTHERN CALIFORNIA MEDICAL CENTER, INC.	EL MONTE	$346,672
THE LOS ANGELES FREE CLINIC	LOS ANGELES	$348,195
UNIVERSAL COMMUNITY HEALTH CENTER	LOS ANGELES	$342,870

ORGANIZATION NAME	CITY	AWARD AMOUNT
VIA CARE COMMUNITY HEALTH CENTER, INC.	LOS ANGELES	$346,411
WESTSIDE FAMILY HEALTH CENTER	SANTA MONICA	$345,390
YEHOWA MEDICAL SERVICES	CARSON	$338,781
TOTAL		**$5,884,376**

FY 2022 | Awards Pending

- Estimated award amount $325,000 per year subject to availability of funds
- Eligible health centers in LAC

COMMUNITY CLINIC, INC.	ALHAMBRA
FAMILY HEALTH CARE CENTERS OF GREATER LOS ANGELES, INC.	BELL GARDENS
THE R.O.A.D.S. FOUNDATION, INC.	COMPTON
THE ACHIEVABLE FOUNDATION	CULVER CITY
ALL FOR HEALTH, HEALTH FOR ALL, INC.	GLENDALE
COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.	GLENDALE
COMMUNITY MEDICAL WELLNESS CENTERS USA	LONG BEACH
THE CHILDREN'S CLINIC 'SERVING CHILDREN AND THEIR FAMILIES'	LONG BEACH
ARROYO VISTA FAMILY HEALTH FOUNDATION	LOS ANGELES
ASIAN PACIFIC HEALTH CARE VENTURE, INC.	LOS ANGELES
BENEVOLENCE INDUSTRIES, INC.	LOS ANGELES
CHINATOWN SERVICE CENTER	LOS ANGELES
CLINICA MSR. OSCAR A ROMERO	LOS ANGELES
COMPLETE CARE COMMUNITY HEALTH CENTER, INC.	LOS ANGELES
KEDREN COMMUNITY HEALTH CENTER, INC.	LOS ANGELES
KOREAN HEALTH, EDUCATION, INFORMATION, AND RESEARCH CENTER	LOS ANGELES
QUEENSCARE HEALTH CENTERS	LOS ANGELES
ST. ANTHONY MEDICAL CENTERS	LOS ANGELES
UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC.	LOS ANGELES
AAA COMPREHENSIVE HEALTHCARE, INC.	NORTH HOLLYWOOD
COMMUNITY HEALTH ALLIANCE OF PASADENA	PASADENA
HERALD CHRISTIAN HEALTH CENTER	SAN GABRIEL
SAMUEL DIXON FAMILY HEALTH CENTER, INC.	VALENCIA
WILMINGTON COMMUNITY CLINIC	WILMINGTON

Centers for Disease Control and Prevention (CDC)

PS22-2209: Transgender Status-Neutral Community-to-Clinic Models to End the HIV Epidemic

- St. John’s Community Health
- 4 years; approximately $500,000 one year award amount

PS22-2203: Comprehensive High-Impact HIV Prevention Programs for Young Men of Color Who have Sex with Men and Young Transgender Persons of Color; 5 Year Contract Term

Organization Name	Funding Amount
AltaMed Health Services	$400,000
APLA Health & Wellness	$400,000
Los Angeles LGBT Center	$400,000
Special Services of Groups, Inc	$400,000

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

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

Footnotes:

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

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

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

Development of Goals & Objectives for the CHP

PP&A Committee Meeting

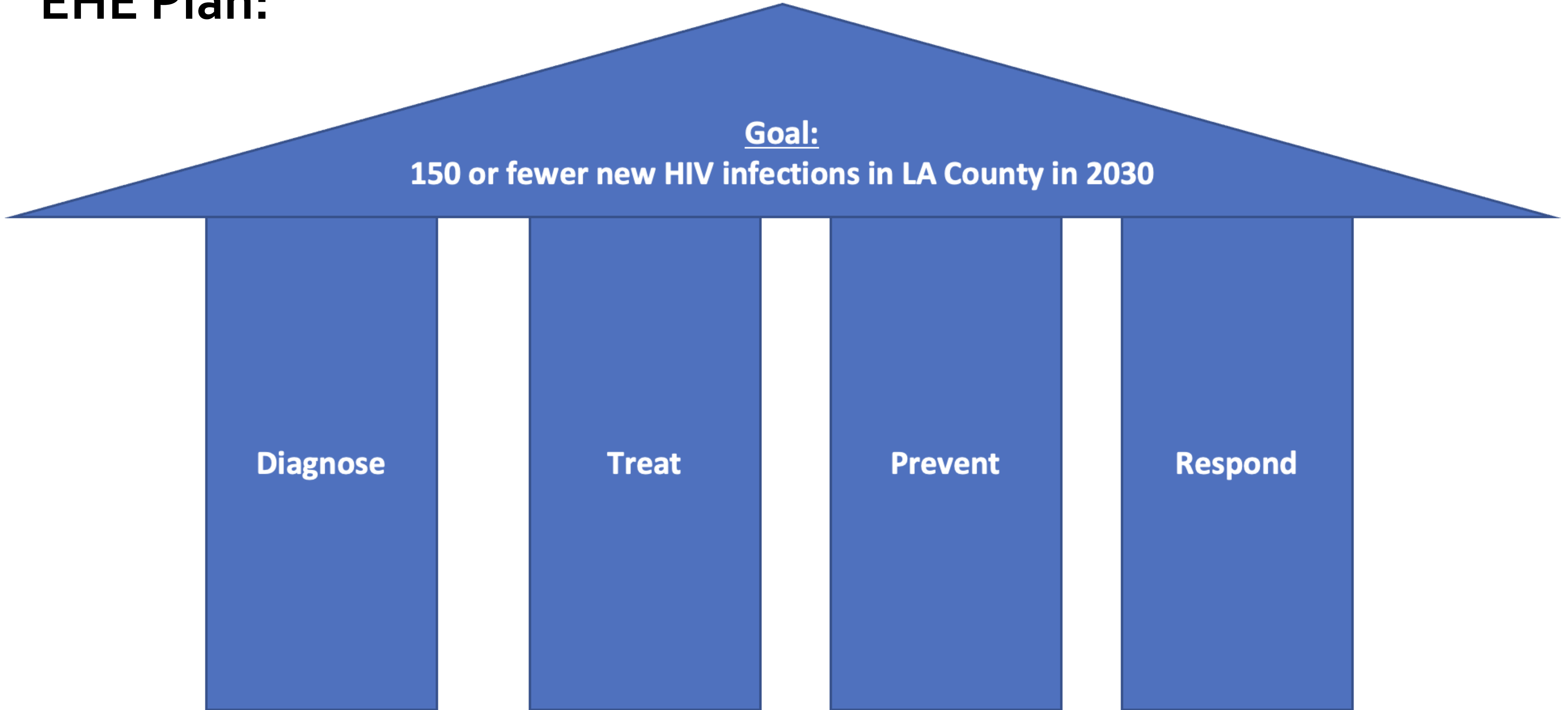
August 16, 2022

Instructions from the Guidance

Purpose: To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding.

- May submit plans (e.g., EHE Plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area
- Goals and objectives should be in SMART format and structured to include strategies that accomplish…Diagnose/Treat/Prevent/Respond
- Include goals that address HIV prevention and care needs and health equity
- There should be at least 3 goals and objectives for each of these four areas.

EHE Plan:



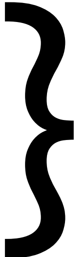
Goal:
150 or fewer new HIV infections in LA County in 2030

Diagnose	Treat	Prevent	Respond

Address "Across Pillar" Issues

Build HIV Workforce Capacity

Address social and structural drivers of HIV/STD/HCV disparities and risk



New Additions

Pillar I: Diagnose

Goal: Diagnose all people with HIV as early as possible

Objectives: Increase the percentage of PLWH who are aware of their HIV status to 95%.
Reduce the number of undiagnosed persons living with HIV.

Strategy 1A: Expand or implement **routine opt-out HIV screening in healthcare and other settings** (such as emergency departments and community health centers) in high prevalence communities.

- **Activity 1A.1:** **Assess and monitor** the degree that HIV testing is occurring County-wide. **Identify infrastructure and healthcare system issues to determine the feasibility of expanding** routine opt- out testing.
- **Activity 1A.2:** **Expand the number of emergency departments and community health centers** in high prevalence communities performing routine opt-out HIV screening.
- **Activity 1A.3:** **Identify additional opportunities in healthcare and non-healthcare settings** where HIV testing can be included, such as **routine STD screening sites and substance use treatment centers**, among others.

Strategy 1B: Develop locally tailored HIV testing programs to **reach persons in non-healthcare settings including home and/or self-testing**.

- **Activity 1B.1:** Assess and monitor the degree that HIV testing is occurring County-wide (see Strategy 1A). Identify infrastructure and healthcare system issues to determine the **feasibility of launching a county-wide rapid HIV self-test program**.
- **Activity 1B.2:** Develop **guidance on HIV home testing**, including a quality assurance protocol, and **assess readiness of providers** to implement home testing.
- **Activity 1B.3:** Expand use of HIV home testing among at risk individuals unlikely to receive traditional in-person HIV testing.

Strategy 1C: Increase the rate of **annual HIV re-screening among persons at elevated risk** for HIV in both healthcare & non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening & increase ways of maintaining communication with clients.

- **Activity 1C.1:** Develop **provider-to-patient communication tools to support providers identify at risk clients** who are due for HIV re-screening and increase systematic ways of maintaining communication with clients.
- **Activity 1C.2:** Develop a plan for evaluating impact of the provider-to-patient communication tools on client re-screening.
- **Activity 1C.3:** Expand implementation & use of provider-to-patient communication tools among LAC DPH funded HIV prevention providers.

Pillar II: Treat

Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression

Objectives: Increase the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95%.
Increase the proportion of diagnosed PLWH who are virally suppressed to 95%.

Strategy 2A: Ensure **rapid linkage to HIV care and antiretroviral therapy (ART) initiation** for all persons newly diagnosed with HIV.

- **Activity 2A.1:** Increase county-wide **capacity to provide same-day rapid linkage to care during expanded hours and days** for persons newly diagnosed with HIV.
- **Activity 2A.2:** Develop a **network of HIV care providers who offer same day appointments with rapid ART disbursement**.

Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, **especially for persons who are not eligible for Ryan White Program-supported services, persons with mental illness, and persons with substance use disorders**.

- **Activity 2B.1**: Comprehensively **assess unmet mental health needs** of PLWH and **identify gaps and areas of improvement in the mental health provider network** in LAC.
- **Activity 2B.2: Develop partnerships to meet the SUD (particularly meth use disorder) needs** of persons at risk for HIV or PLWH and improve the **capacity of SUD providers** to address the sexual health needs of clients and ensure access to HIV-related services, as needed.
- **Activity 2B.3:** Develop a report that summarizes critical gaps in the current system and makes recommendations for improvement and investment of County resources, including Ryan White Program funds.

Strategy 2C: Expand the promotion of Ryan White Program services to increase awareness, access to, and utilization of available medical care and support services for PLWH.

- **Activity 2C.1: Assess** how clients are currently learning about available RWP services. **Identify existing and new resources to assist with promotion** and educational outreach including, but not limited to, print materials and online resources.

Strategy 2D: Improve the delivery of HIV services and client satisfaction rates by **supporting strategies to address workforce burnout, improve staff capacity to better meet the needs of PLWH, and expand the availability of staff training** tied to trauma informed care, stigma reduction, implicit bias, and medical mistrust.

- **Activity 2D.1: Conduct assessment** to identify factors contributing to staff burnout and attrition as well as gaps in skills or knowledge around trauma informed care, stigma reduction, implicit bias, and medical mistrust.
- **Activity 2D.2: Support programs or provide technical assistance** in response to identified needs.

Strategy 2E: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH.

- **Activity 2E.1**: Determine processes and program operations for housing assistance that are aligned with federal funding guidance and restrictions.
- **Activity 2E.2**: Identify potential housing partners positioned to serve PLWH and implement an expanded housing program.

Strategy 2F: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH.

- **Activity 2F.1:** Develop processes and program operations for a pilot program that is acceptable to clients and is aligned with federal funding guidance and restrictions.
- **Activity 2F.2:** Identify potential clinical sites, train staff on pilot processes, and implement program.
- **Activity 2F.3:** Develop a robust evaluation plan to determine continued use of financial incentives and potential for expansion to other populations.

Strategy 2G: RFP: EHE Priority Populations Interventions

- **Activity 2G.1:** Develop and release **RFP to fund 7-10 contracts** for identified interventions.

Pillar III: Prevent

Goal: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs)
Objectives: Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% from a 2017 baseline of 21.5%. Increase the number of syringe service programs by 50%.
Strategy 3A: Accelerate efforts to **increase PrEP use** (particularly for populations with the highest rates of new HIV diagnoses and low PrEP coverage rates) by adopting **new strategies at LAC funded PrEP Centers of Excellence** tied to client retention, PrEP navigation, community education, supporting alternatives to daily PrEP, and expanding PrEP support groups.
Activity 3A.1: Conduct an **in-depth landscape analysis** of current PrEP resources and services among primary care providers in high morbidity areas, **among providers who serve transgender persons, women's health providers, and SUD providers**.
Activity 3A.2: Implement systematic and innovative strategies at LAC DPH-funded PrEP Centers of Excellence for **enhanced client communication** to promote retention in PrEP and sexual health services.
Activity 3A.3: Increase **capacity of LAC DPH staff to provide more robust PrEP navigation services** to clients served through County STD clinics, Partner Services, and those receiving PrEP/PEP at community pharmacies.
Activity 3A.4: Disseminate simple fact-based **social marketing** PrEP messaging to increase knowledge and awareness of PrEP, alternatives to daily PrEP, and help combat misinformation regarding cost, access, and safety.
Activity 3A.5: Work with local stakeholders to identify the **potential role for PrEP support groups or PrEP ambassadors** to support new and continued PrEP use in affected communities.
Strategy 3B: Increase availability, use, and access to **comprehensive syringe services programs (SSPs).**
Activity 3B.1: Collaborate with the Los Angeles County **Substance Abuse Prevention and Control Program** to identify opportunities to **increase the capacity of SSPs, improve the provision or linkage of SSP clients to HIV and STD prevention and treatment services, and expand the availability of contingency management services** to persons with substance use disorder, including meth use.
Activity 3B.2: Explore ideas for **alternate models of prevention service delivery** (e.g., vouchers which can be taken to pharmacies in exchange for clean syringes and home HIV test kits).

Pillar IV: Respond

Goal: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them
Objectives: Develop and maintain capacity for cluster and outbreak detection and response. Increase the proportion of people newly diagnosed with HIV that are interviewed for Partner Services within 7 days of diagnosis to at least 85%.
Strategy 4A: Refine processes, data systems, and policies for robust, real-time cluster detection, time- space analysis, and response
Activity 4A.1: Develop a protocol, training materials, and standard operation plan.
Activity 4A.2: Continue community engagement regarding the use of HIV molecular surveillance for cluster detection to inform its best use and identify and mitigate any unintended consequences.
Activity 4A.3: Expand routine epidemiological analysis of recent infection by person, place, and time to identify hot-spot locations and sub-populations associated with recent infection to inform rapid investigation and intervention.
Strategy 4B: Refine current processes to **increase capacity of Partner Services** to ensure people newly diagnosed are interviewed and close partners are identified and offered services in a timely and effective manner.
Activity 4B.1: Increase capacity of LAC DPH to provide Partner Services to all newly diagnosed persons in LAC.
Activity 4B.2: Implement **new STD surveillance system** to enhance the identification and assignment of new HIV cases to LAC DPH staff for timely follow-up and Partner Services.
Strategy 4C: Data to Care RFP
Activity 4C.1: Develop and release RFP to fund up to 5 contracts for Data to Care activities.

Pillar I: Diagnose

Goal: Diagnose all people with HIV as early as possible
Objectives: Increase the percentage of PLWH who are aware of their HIV status to 95%. Reduce the number of undiagnosed persons living with HIV.
Strategy 1A: Expand or implement **routine opt-out HIV screening in healthcare and other settings** (such as emergency departments and community health centers) in high prevalence communities.
Strategy 1B: Develop locally tailored HIV testing programs to **reach persons in non-healthcare settings including home and/or self-testing**.
Strategy 1C: Increase the rate of **annual HIV re-screening among persons at elevated risk** for HIV in both healthcare & non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening & increase ways of maintaining communication with clients.

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Strategy 1C: Increase the rate of **annual HIV re-screening among persons at elevated risk** for HIV in both healthcare & non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening & increase ways of maintaining communication with clients.

- Add objective: Increase proportion of newly diagnosed who are in early stage of HIV disease (from 15% to X); or decrease late-stage from 24% of all diagnosis to 18% of all diagnosis. – Activities include cluster detection & PS
- Work on streamlining access to testing/screening – low barrier
- Increase integrated screening – **especially syphilis -** Incentivize providers that screen for syphilis?
- Advertise/promote options for testing
- Make testing sites more discreet/change names of STD Clinics
- Testing via **street medicine/mobile clinics** for unhoused
- Have a testing month rather than day
- Make even more convenient – learn from COVID response
- Focus on rapid STI testing
- Evaluate Take Me Home – improve upon
- Target testing in geographic hot spots – with other STD/SDH
- Normalize/integrate into primary care settings – via PH detailing by DHSP?
- Ensure that all SSPs provide testing/screening
- Increase health literacy – Promotoras/CHW model

Pillar II: Treat

Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression
Objectives: Increase the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95%. Increase the proportion of diagnosed PLWH who are virally suppressed to 95%.
Strategy 2A: Ensure **rapid linkage to HIV care and antiretroviral therapy (ART) initiation** for all persons newly diagnosed with HIV.
Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, **especially for persons who are not eligible for Ryan White Program-supported services, persons with mental illness, and persons with substance use disorders**.
Strategy 2C: Expand the promotion of Ryan White Program services to increase awareness, access to, and utilization of available medical care and support services for PLWH.
Strategy 2D: Improve the delivery of HIV services and client satisfaction rates by **supporting strategies to address workforce burnout, improve staff capacity to better meet the needs of PLWH, and expand the availability of staff training** tied to trauma informed care, stigma reduction, implicit bias, and medical mistrust.
Strategy 2E: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH.
Strategy 2F: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH.
Strategy 2G: RFP: EHE Priority Populations Interventions

Pillar II: Treat

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Objectives: Increase the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95%. Increase the proportion of diagnosed PLWH who are virally suppressed to 95%.
Strategy 2A: Ensure **rapid linkage to HIV care and antiretroviral therapy (ART) initiation** for all persons newly diagnosed with HIV.
Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, **especially for persons who are not eligible for Ryan White Program-supported services, persons with mental illness, and persons with substance use disorders**.
Strategy 2C: Expand the promotion of Ryan White Program services to increase awareness, access to, and utilization of available medical care and support services for PLWH.
Strategy 2D: Improve the delivery of HIV services and client satisfaction rates by **supporting strategies to address workforce burnout, improve staff capacity to better meet the needs of PLWH, and expand the availability of staff training** tied to trauma informed care, stigma reduction, implicit bias, and medical mistrust.
Strategy 2E: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH.
Strategy 2F: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH.
Strategy 2G: RFP: EHE Priority Populations Interventions

- Add objective: increase LTC within 1 week?
- Add objectives: decrease time from Dx to Treat (now 54% in 1 month) and from Dx to Viral Suppression (now 51% in 3 months)
- Leverage and monitor CalAIM – transforming Medi-Cal system to support/advance our work
- Train all providers on long acting injectables – increase community awareness
- Expand capacity to provide whole-person care to older adults and LT survivors - ID best practices/models of care for older PLWH
- Street medicine/mobile clinics for unhoused

- More incentives – Contingency Management
- Transportation barriers
- Evaluate iCARE for young people
- Incentives for providers who increase VS? for undetectable people?
- Create list/network of clinical providers of color/culturally competent doctors

Pillar III: Prevent

Goal: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs)
Objectives: Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% from a 2017 baseline of 21.5%. Increase the number of syringe service programs by 50%.
Strategy 3A: Accelerate efforts to **increase PrEP use** (particularly for populations with the highest rates of new HIV diagnoses and low PrEP coverage rates) by adopting **new strategies at LAC funded PrEP Centers of Excellence** tied to client retention, PrEP navigation, community education, supporting alternatives to daily PrEP, and expanding PrEP support groups.
Strategy 3B: Increase availability, use, and access to **comprehensive syringe services programs (SSPs).**

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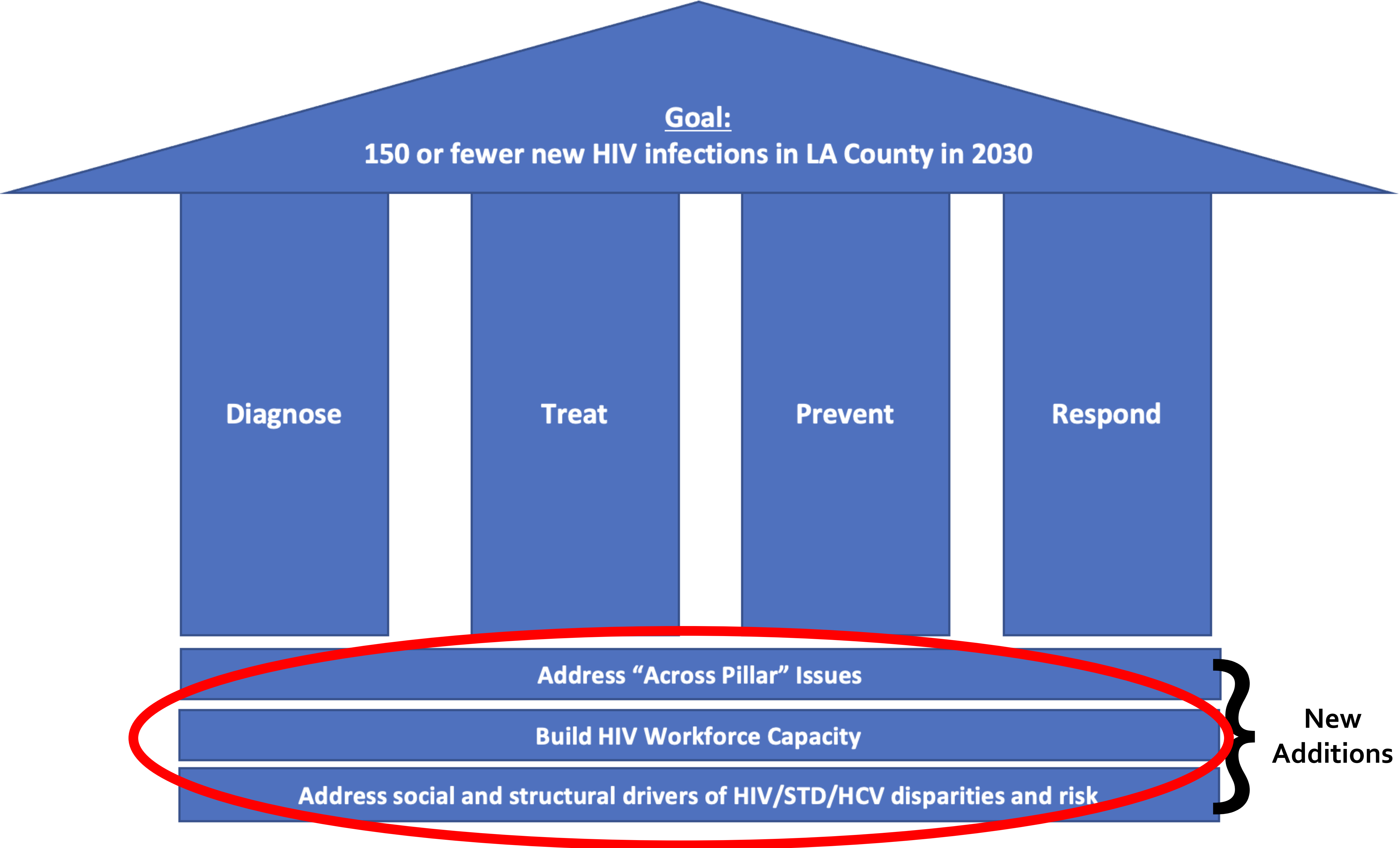
Strategy 3B: Increase availability, use, and access to **comprehensive syringe services programs (SSPs).**

- Add as objective?: Reduce new infections from 1400 to 380 by 2025 (73%) and to 334 in 2026; reduce new dx from 1401 to 450 in 2025 and 396 in 2026
- Train all providers on long acting injectables – increase community awareness – train navigators
- Destigmatize SSPs and providers
- Promote safe consumption/injection sites
- Build capacity of SSPs
- We need more data on PrEP – PrEP AP/Are pharmacies prescribing? /How many prescriptions from Gilead
- Sexual health support groups – promote resilience and protective factors
- Increase awareness of PrEP/PEP in communities and among HC providers – PrEP detailing
- Extend hours of pharmacists since they can prescribe
- Marketing campaign to support awareness of resources about HIV related services (including influencers)
- How do we truly target populations/create standards or focus on populations that cannot access organizations based on hours.
- Efforts to target monolingual populations regarding prevention information
- Expand conversations beyond syringe exchange related to harm reduction
- Draft a one-pager on the efficacy of SSPs

Pillar IV: Respond

Goal: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them
Objectives: Develop and maintain capacity for cluster and outbreak detection and response. Increase the proportion of people newly diagnosed with HIV that are interviewed for Partner Services within 7 days of diagnosis to at least 85%.
Strategy 4A: Refine processes, data systems, and policies for robust, real-time cluster detection, time- space analysis, and response
Strategy 4B: Refine current processes to **increase capacity of Partner Services** to ensure people newly diagnosed are interviewed and close partners are identified and offered services in a timely and effective manner.
Strategy 4C: Data to Care RFP

- Connect Partner Services and Cluster Detection to other goals
- Increase community engagement related to cluster detection
- How promote partner services?


Goal:
150 or fewer new HIV infections in LA County in 2030
Diagnose
Treat
Prevent
Respond
Address "Across Pillar" Issues
Build HIV Workforce Capacity
Address social and structural drivers of HIV/STD/HCV disparities and risk
New Additions

Workforce Capacity: Issues

- Critical shortage of qualified staff – both clinical and non-clinical
- No clear pipelines or educational training programs
- The scope of work and job duties from DHSP agreements are complex and require advanced skills. Those with these skills have opportunities in other fields which have better career paths and ladders and pay better. HIV jobs are dead-end jobs for some.
- Because it's costly and time-consuming to train new employees, we often recruit from other agencies. Thus, the field is not being replenished.
- Non-licensed staff need higher salaries to attract talent and stay in the field
- RNs and LCSWs are extremely difficult to recruit and retain, yet these positions are the core of the MCC program.

Workforce Capacity: Ideas

- The extent of what is needed now and in the future needs to be assessed including an extensive assessment of what the cost of these services truly are and how might the financing of these services be approached.
- Explore pipeline programs and leadership development initiatives
- Implement pilot program – e.g., AETC fellowship program for medical doctors – use as framework?
- Succession planning/leadership – CBAs? PAETC?
- Explore and promote Promotoras and HIV Model
- HS level not implementing CHYA – first window into HIV fields – opens door to pipeline – HS-college – grad school
- Revisit our service standards – BS required?
- SBP: Explore building in cross-training into our standards

Across Pillar Issues

- Harm reduction approach
- Health district lens (e.g., see Strategy)
- Monkeypox = need to have a voice in pandemic planning and response
- Address stigma – WeHo model?
- Review recommendations from Black/AA Task Force and Aging Task Force and update in plan

Across Pillar Issues

- Empowerment for women of color
- Reproductive Rights
- Telehealth
- **Integration**: HIV-SUD/ HIV-HCV/ Syph – PrEP
- Fund low-barrier MH services in partnership with SAPC/DMH
- Increase capacity of SSPs to test and link to care and increase capacity of FQHCs to treat HCV
- Encourage HIV programs to interact with HCV programs

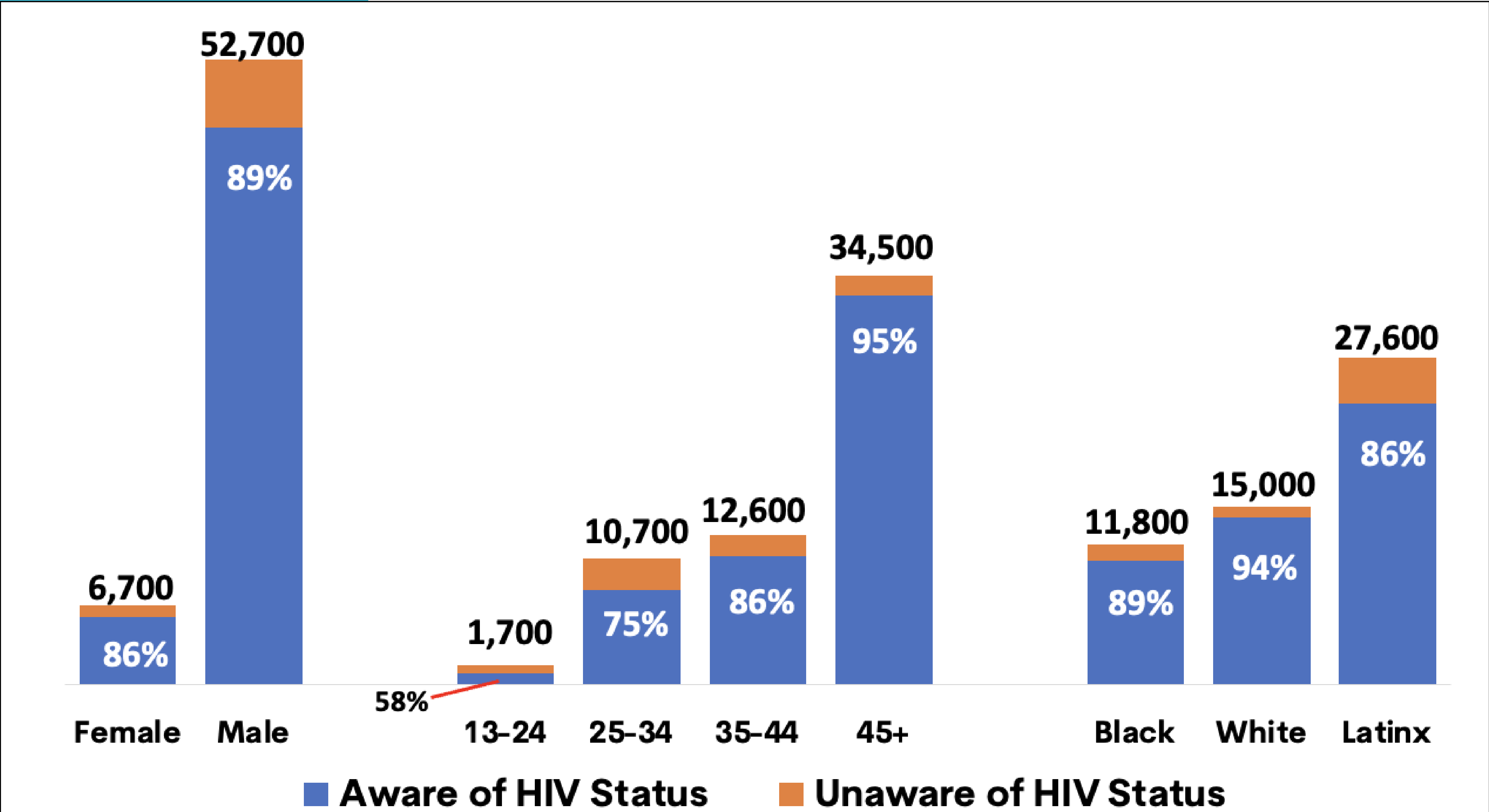
Addressing Meth: Ideas from ANAM

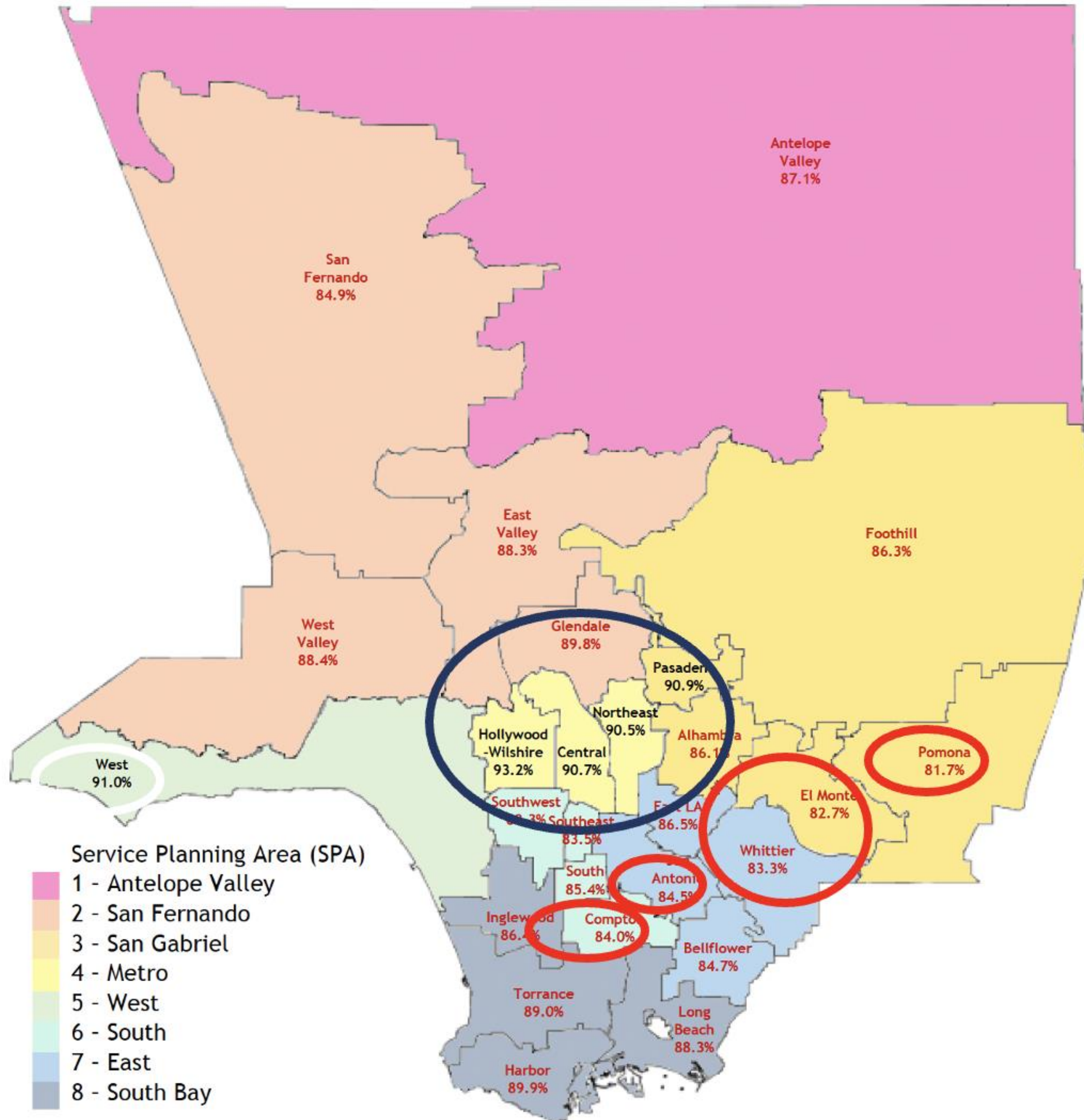
- Increase awareness of SUD services and harm reduction among HIV/STD/HCV providers
- Support collaborations between DMH, SAPC and DHSP
- Funded orgs address meth and other SUD; provide refs to SU services; navigation
- Assess providers ability to address Meth
- Incorporate HIV/STI/HCV screening and PrEP/PEP navigation services in SUD services
- Navigation for re-entry population
- Harm reduction principles and trauma-informed care incorporated across provider trainings
- Support efforts to decriminalize drug possession
- Support a meth awareness day

Structural/ Policy Ideas

- Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g. Commercial Sex Work).
- Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through the reduction in funding for policing and incarceration. (MCJ Closure Report)
- Improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS
- Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
- Promote Family housing and emergency financial assistance as a strategy to maintain housing.
- Increase mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.
- Support the building of community-based mental health services to account for the nearly 4,000+ individuals currently incarcerated in need of mental health services and support closing of Men's Central Jail.

Percentage of PLWH who were Aware of their HIV-Status, 2020



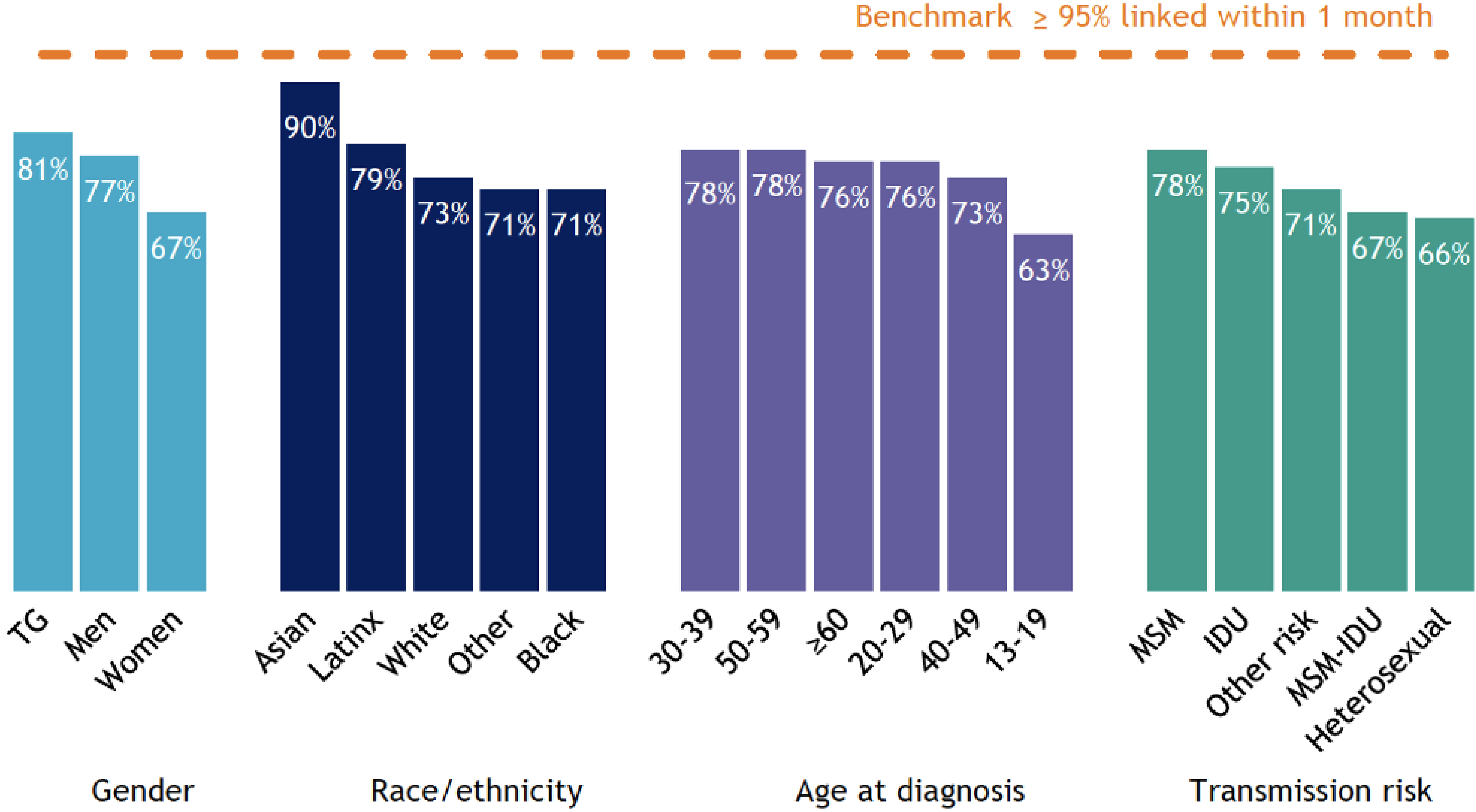


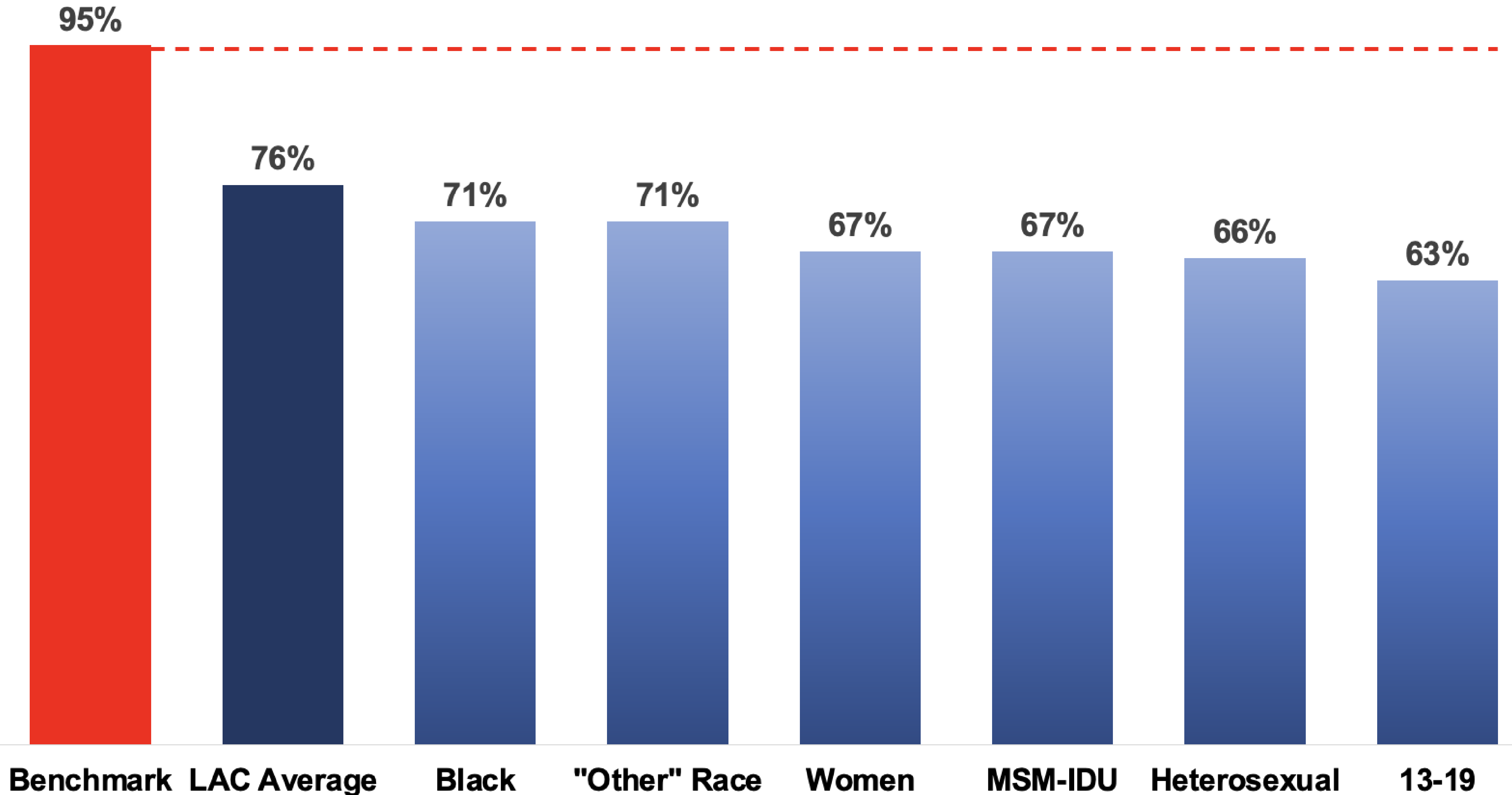
Percentage of PLWH aged ≥ 13 years who were aware of their HIV-positive status by Health District, LAC 2020

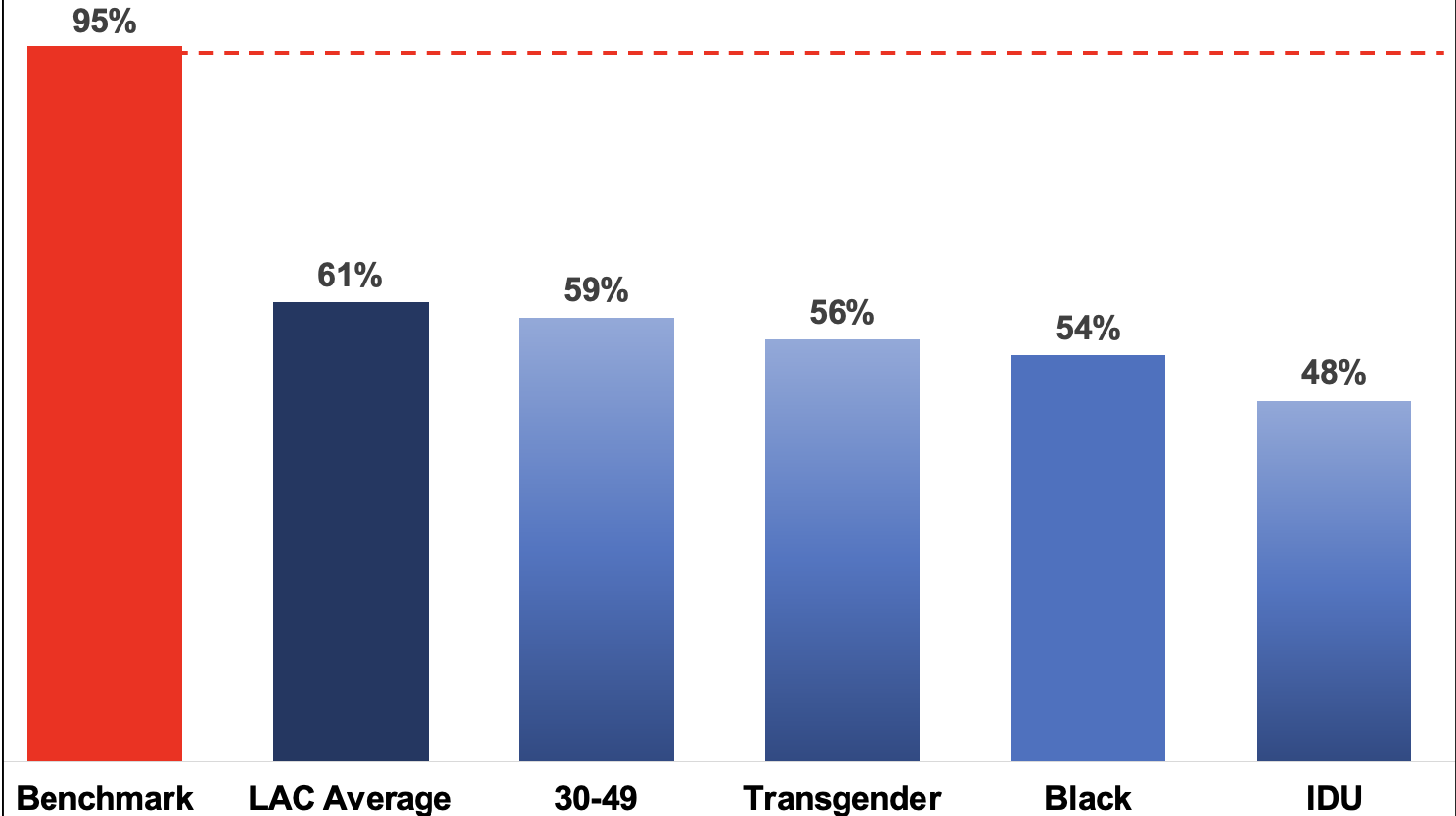
Health District – Most Aware	% Aware of HIV Status
Hollywood-Wilshire	93.2%
West	91%
Pasadena	90.9%
Central	90.7%
Northeast	90.5%

Health District - Least Aware	% Aware of HIV Status
Compton	84%
Southeast	83.5%
Whittier	83.3%
El Monte	82.7%
Pomona	81.7%

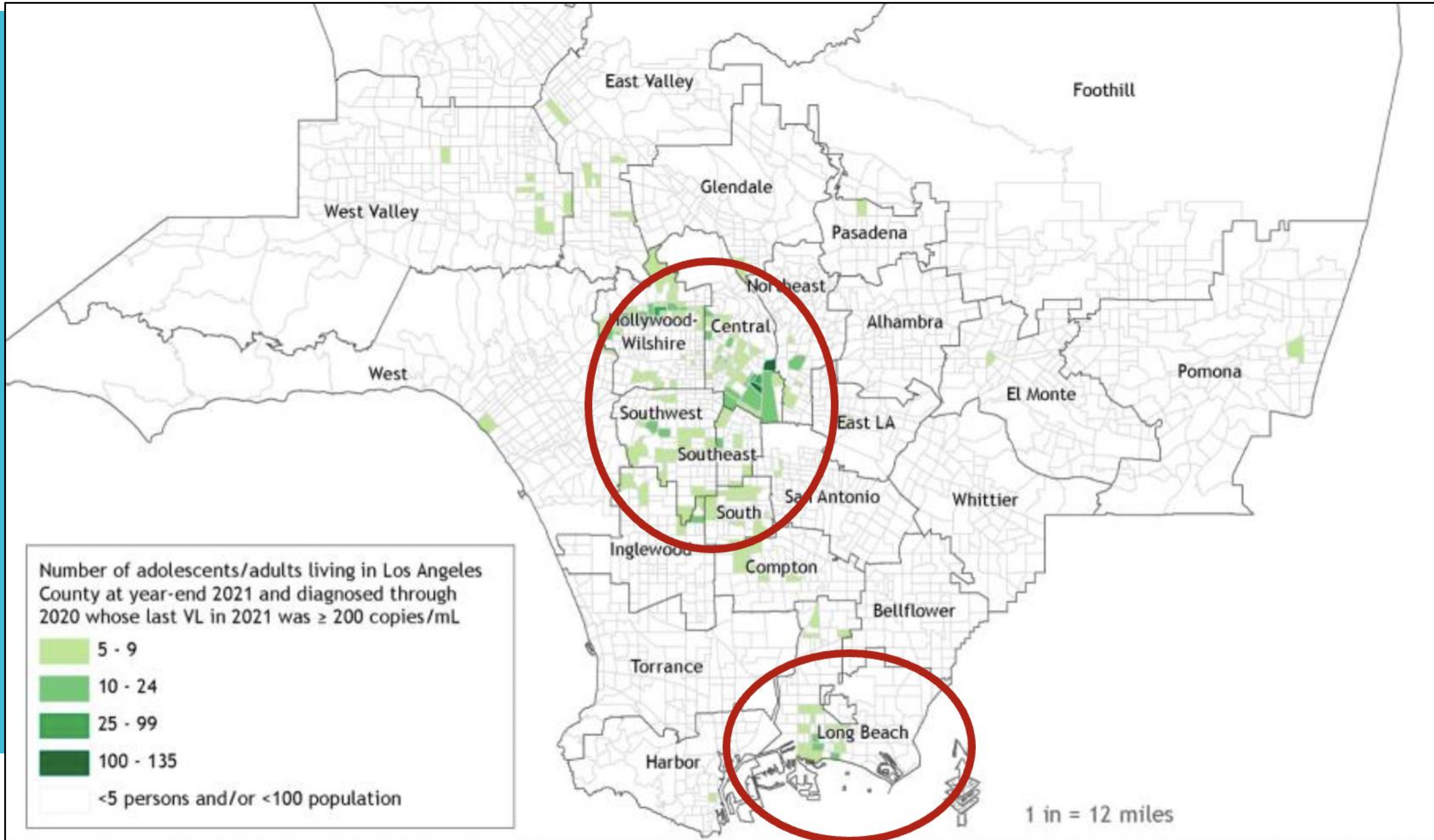
Figure 47: Persons aged ≥ 13 years newly diagnosed with HIV in 2020 and **linked to care** within 1 month of diagnosis[113] by select demographics[114] and risk[115] characteristics, LAC




Linkage to Care among Persons aged ≥ 13, LAC 2020
95%
76%
71%
71%
67%
67%
66%
63%
Benchmark
LAC Average
Black
"Other" Race
Women
MSM-IDU
Heterosexual
13-19


Viral Suppression among Persons aged ≥ 13, LAC 2021
95%
61%
59%
56%
54%
48%
Benchmark
LAC Average
30-49
Transgender
Black
IDU

Viral Load among PLWDH, 2020



Molecular HIV cluster cases by zip code and priority, Los Angeles County, 2020

Count of cluster cases by priority level per zip code

Zip codes with small number of low priority cluster cases	Zip codes with large number of high priority cluster cases

Categorized HIV cluster priority as:

- Low <5 cases (**blue**)
- Medium ≥5 cases (**green**)
- High ≥5 cases (**orange/red**)

Findings:

- Highest number of high priority cluster cases in **West Hollywood, Downtown, and South LA**
- Risk profiles of persons in high priority cluster:
  - ~One in five have a history of meth use
  - ~10% have a history of homelessness
  - ~70% had anonymous sex partners
  - Nearly half have co-infection with syphilis

Source: Update on HIV and STD Surveillance in Los Angeles County, Intersections and Opportunities. Andrea Kim, PhD, MPH Chief, HIV and STD Surveillance, Division of HIV and STD Programs, 5/21