San Diego HIV Planning Group
PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

COMBINED 2023 KEY DATA FINDINGS

HIV Planning Group
Priority Setting and Resource Allocation Committee

Overall 2023 Key Data Findings

Approved July 20, 2023

Co-occurring health conditions, poverty & insurance status

- Persons living with HIV (PLWH) are more likely than general San Diego County populations to experience the following conditions: TB, STDs, hepatitis B & C, mental illness, injection and non-injection drug use, homelessness, poverty & lack of insurance.
- These conditions can complicate adherence and make care more complex and more expensive.
- Co-occurring health conditions make providing medical care more complex, require greater provider expertise, and **increase the cost of care** for PLWH.
- Research also reveals a higher incidence of gastrointestinal diseases, circulatory diseases, endocrine/nutritional/metabolic disease, nervous system diseases and neoplastic diseases such as cancer or lymphoma.
- PLWH greater than 50 years of age, experience an increase in age-related diseases; causes of morbidity and mortality for older PLWH include non-infectious comorbidities, such as cardiovascular disease, hypertension, bone fractures, chronic kidney disease, liver disease, diabetes mellitus and non-AIDS-defining cancers.

Regional availability of Ryan White (RW) Part A/B services

- The fewest RW Part A services are available in East County, followed by South Bay.
- All of the RW services are available in the Central region with the exception of Peer Navigators (Referral to Health and Support Services), which is not available in the Southeast San Diego region.

Service Eligibility Guidelines

- To be eligible to receive Ryan White Parts A/B services in San Diego County, one must:
  - Be a resident of San Diego County
  - Have an income at or below 500% Federal Poverty Level (FPL) ($72,990 annually or $6,082/month for a household of one)
  - Have a confirmed HIV diagnosis (except in service categories that permit services to HIV-negative and unaware)
  - Have no other payer for service
- All clients must be reassessed for eligibility every twelve months

HIV epidemiology

- Total number of Persons Living with HIV disease (PLWH) in San Diego County (Prevalent cases) = **14,634.**
- Recent cases (2018 – 2022) = **2,139** (this is a subset of the total or prevalent cases)
- Th majority of people living with HIV disease (PLWH) through year-end 2021 were men who have sex with men (MSM). For women, heterosexual transmission was the largest mode of transmission. Central Region and South Region have the largest proportion of recent HIV disease diagnoses among women (>50% of total women in the two regions).
- The majority of recent HIV disease diagnoses for over ten years were people of color. The proportion of Non-Hispanic White cases decreased over time, while the proportion of Hispanic/Latino cases increased over time. The HIV rate (number/100,000 or 105) was higher for Non-Hispanic Black/African American **(40.4/105)** than Hispanic/Latino **(19.6/105)** or Non-Hispanic White **(6.8/105)** during in 2021.

- Since 2018, the 20 – 29 years and 30 – 39 years age groups were the most frequent age groups at diagnosis among recent HIV disease diagnoses (31.0% and 31.1% respectively), while the 50 - 59 was the most frequent current age for total PLWH (29%) , and 60+ years was the second most frequent (28.8%).
- The groups with the highest percentage of simultaneous diagnosis for recent HIV disease diagnoses (2018-2022) were Hispanic/Latino 26.9%, vs. 23.2%)), Persons who inject drugs (PWID) (27.3%) and age groups 40 – 49 (29.4%), 50 – 59 (35.7%), and 60+ (45.2%)**.**

Survey of HIV Impact 2020 - 21

- The top 5 ranked services are (in order) **HIV medications**, **HIV primary care**, **Dental care**, **Case management** and **Medical specialist**.
- The top "need but can't get" services are **Dental care**, **Help to pay rent**, **Legal services, Counseling/Therapy, Peer Advocacy/Navigation**.
- The percentage of respondents who said they "need but can't get" a service ***increased*** **in all top 5 services** noted above, since the 2017 survey.

Needs Assessment Focus Groups 2020 – 21

- The **top 3 concerns** Consumers discussed in the focus groups were:
    - Access to care
    - Mental Health Issues
    - Housing
- The **top reasons for not taking HIV medication** as prescribed were:
    - Drug use and drug addiction;
    - Forgetting to take the medication;
    - Lack of access to healthcare or resources to get the medication refilled;
    - Experiences of homelessness;
    - Side effects of HIV medication; and
    - Experiences of mental health issues, such as depression.

Getting to Zero Community Action Plan Focus Groups 2020 – 21

- **160 community participants** living with or vulnerable to HIV provided input to the following 11 recommendations:
    1. Acknowledge and address medical system mistrust. Representation noted as an issue; ensure ongoing recruitment, support, and retention of a workforce representative of those living with HIV.
    2. Improve communications and outreach strategies for those living with and are vulnerable to HIV who live, work, or participate in historically underserved, Low Information communities.
    3. Ensure that all HIV community members have opportunities for equitable access to tele-health appointments and to participation in public meetings, address the digital disparities present for those with lower income who are also living with or vulnerable to HIV.
    4. Provide increased mental health and alcohol/substance use treatment opportunities for those living with or vulnerable to HIV.
    5. More consistently provide rapid access to basic support services: housing, food, transportation, emergency financial assistance including shut-off & eviction prevention.
    6. Continue to expand the opportunities to hire, support and utilize peer navigators, peer health educators, peer outreach specialists, benefits navigators, and housing specialists.
    7. Design, integrate, and deploy strategies to address the stigmas faced by HIV community members including: the multiple layers of stigma faced by those living with HIV who are also Black and Latino MSM; Transgender persons; Immigrants who may be under-documented or undocumented; those struggling with mental health symptoms or alcohol/ substance use challenges or those without stable housing.

8. Increase the number of HIV service sites that have the capacity for whole person-whole health services including PrEP, mental health services, substance use treatment services, hormone treatment, case management, and housing resources.
9. Design, create and execute improved community engagement and outreach strategies that utilize community organizing principles and personal relationship building.
10. Revise and refine the documentation processes that create a barrier to access services for persons living with or at increased vulnerability to HIV.
11. Design and deploy a variety of brief, on-line trainings for those living with or vulnerable to HIV.

Care Continuum/Viral Suppression

- In San Diego County, of the total number of people who are infected with HIV, **70%** are **in receipt of care**; **46%** are **retained in care** and **57%** are **virally suppressed**.
- African Americans/Blacks had a significant lower level of viral suppression **(50%),** compared to all PLWH (56.7%), but not for all RW clients w/VL test (88.7% vs. 91.7%)
- **Persons who inject drugs (46%)** and **persons with no identified risk (50%)** had lower percentages of viral suppression compared to all PLWH (56.7%).

Unaware Estimate

- Definition: Persons living with HIV, not aware of their status/has not been tested.
- **The estimate of PLWH and unaware of their status** in San Diego County in 2021 is **1,272 or 9%** (of 14,133 estimated # of PLWH in San Diego County).

Unmet Need Estimate

- Definition: Persons living with HIV disease, but not in medical care.
- **The unmet need estimate of PLWH** in San Diego County in 2017 is **4,240 or 30% (**of 14,133 estimated # of PLWH in San Diego County)**.**

Non-Ryan White Mental Health and Substance Use Disorder Treatment services in San Diego County.

- There are several **non-Ryan White** mental health and substance use treatment services providers in San Diego County (SDC) that have HIV/PLWA/LGBTQ competencies. Some of the providers noted also receive Ryan White funds for services and may provide services using non-Ryan White funds as well.

- Additionally, all programs operated by, or contracted through the COUNTY OF SAN DIEGO'S BEHAVIOR HEALTH SERVICES (BHS) are required to provide services and supports that respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served. Programs are responsible for evaluating the need for culturally/linguistically specialized services and linking individuals with those services or making appropriate referrals.

HIV Planning Group
Priority Setting and Resource Allocation Committee
Key Data Findings by Service Category 2023
Approved June 22, 2023

SERVICE CATEGORY		KEY DATA FINDINGS
© **Outpatient Ambulatory Health Services: Primary Care**	1	Core service; ranked #2 in 2020 - 21 Survey of HIV Impact. (HIV/AIDS Medications a core service linked to Primary Care and is #1 ranked in 2020 - 21 Survey of HIV Impact).
© **Outpatient Ambulatory Health Services: Medical Specialty**	2	Core service; linked to Primary Care; ranked #4 in 2020 - 21 Survey of HIV Impact; 7% of respondents noted as a service gap ("need but can't get"). Co-occurring health conditions make providing medical care more complex, require greater provider expertise, and increase the cost of care for people living with HIV (PLWH).
© **Mental Health: Psychiatric Medication Management**	3	Core service; linked to Primary Care. #12 ranked in 2020 - 21 Survey of HIV Impact. Links PLWH to care and helps sustain PLWH in care; also 5th largest service gap (12%; of those with history of mental illness, top ranked for 16%; 37.1% of PLWH diagnosed or treated for mental health condition (cf. 19.1% in general population); increased need noted in focus groups
© **Oral Health**	4	Core service #3 ranked in 2020 - 21 Survey of HIV Impact and largest service gap (22% need but can't get). Many PLWH lack dental insurance.
© **Medical Case Management (MCM)**	5	Core service; #5 ranked in 2020 - 21 Survey of HIV Impact; 9th largest service gap (9%), Links clients to other services, including Primary Care. Many PLWH have co-occurring health conditions that require additional services/assistance. Reaches diverse groups/regions. Links PLWH to care and helps sustain PLWH in care.
Case Management: Non-Medical	6	#5 ranked in 2020 - 21 Survey of HIV Impact, 9th largest service gap (9%)
Non-Medical Case Management for Housing	7	Rental Assistance #6 ranked in 2020 - 21 Survey of HIV Impact & the 2nd largest service gap (20%) in NA survey; Emergency Housing #10 ranked in 2020 - 21 Survey of HIV Impact & the 7th largest service gap (10%), 25% of PLWH unstably housed or homeless in 2020 & poverty prevalent among PLWH (72% at or below 500% FPL in 2020; Links PLWH to care and helps sustain PLWH in care
Housing: Emergency Housing	8	#10 ranked in 2020 - 21 Survey of HIV Impact; The 7th largest service gap (10%), Homelessness: 25% unstably housed or homeless in 2020 & poverty prevalent among PLWH (72% at or below 400% FPL; Links PLWH to care and helps sustain PLWH in care.
Housing Location, Placement and Advocacy Services	9	As noted above in Non-Medical Case Management for Housing.
Housing: Partial Assistance Rental Subsidy (PARS)	10	#6 ranked in 2020 - 21 Survey of HIV Impact; the 2nd largest service gap (20%; in NA survey (20%). (25% of PLWH unstably housed or homeless in 2020 & poverty prevalent among PLWH (72% at or below 500% FPL in 2020; Links PLWH to care and helps sustain PLWH in care

© **Coordinated HIV Services for Women, Infants, Children, Youth, and Families (CHS: WICYF)** *(Formerly Early Intervention Services (EISC): Countywide Services for Women, Children & Families)*	11	Core service; includes direct provision of Medical Case Management, Mental Health, Family/Peer Advocacy, Outreach, Childcare/Babysitting & Mentor/Buddy Support. Females represent 10% of PLWH. Reaches diverse groups/regions. Links PLWH to care and helps sustain PLWH in care. #16 ranked in 2020 - 21 Survey of HIV Impact; 4th largest service gap (13%) of 2021 survey respondents reported "need but can't get"; Central and South regions have largest proportion of recent HIV disease among women (>50% of total in the two regions); Countywide the proportion of female HIV disease diagnoses has increased slightly over the last 5 years to about 13.6%
Childcare services	11a	#20 ranked in 2020 - 21 Survey of HIV Impact, in 2017 ranked top ranked by 62% of those with children, 1% of total sample "need but can't get".
© **Early Intervention Centers: Regional Services**	12	Core service; addresses HRSA focus on identifying PLWH not in care and linking them to care. CM is a central component. #16 ranked in 2020 - 21 Survey of HIV Impact, 4th largest service gap (13% of 2021 survey respondents reported "need but can't get"; Co-located with HIV Primary Care in Southeast SD, South Bay and North County. Links PLWH to care and helps sustain PLWH in care; RW service not available in the East region of county.
Outreach Services	12b	#13 ranked in 2020 - 21 Survey of HIV Impact, 5th highest service gap (12%)
Referral Services	12c	#13 ranked in 2020 - 21 Survey of HIV Impact, 5th highest service gap (12%); RW service not available in South or Southeast regions.
Health Education & Risk Reduction (stand-along HERR)	13	30% of HIV+ respondents in the 2020 - 21 Survey of HIV Impact did not use condoms during sex in preceding 12 months; 9% of HIV negative/unaware reported that "they have never heard of PrEP"
Peer Navigation (Referral for Health Care and Support Services)	14	#17 ranked in 2020 - 21 Survey of HIV Impact, 5th highest service gap (12%), not available in Southeast or South regions; recommendation for increased use in focus groups.
© **Mental Health: Counseling/ Therapy & Support Groups**	15	Core service; #8 ranked in 2020 - 21 Survey of HIV Impact; 3rd largest service gap (15%) "need but can't get"; 40% of PLHW diagnosed or treated for mental health condition (cf. 20.6% in general population); 20% of survey respondents reported a history of chronic mental illness; Links PLWH to care and helps sustain PLWH in care; increased need noted in focus groups
Psychosocial Support Services	16	40% of PLWH diagnosed or treated for mental health condition (cf. 20.6% in general population)
© **Substance Abuse Services: Outpatient**	17	Core Service. #14 ranked, 50% of survey respondents reported a history of substance use; frequent co-occurring condition among PLWH. Links PLWH to care and helps sustain PLWH in care. RW service not available in East or North regions PWID have stat. signif. lower % of viral suppression; increased need noted in focus groups
Substance Abuse Services: Residential	18	#14 ranked, 50% of survey respondents reported a history of substance use Links PLWH to care and helps sustain PLWH in care. RW service not available in East, South or North regions; PWID (prev. IDU and MSM+IDU) have stat. signif. lower % of viral suppression; increased need noted in focus groups

© **Home-based Care Coordination**	19	Core service; #18 ranked in 2020 – 21 Survey of HIV Impact, 5% "need but can't get
Transportation: Assisted and Unassisted	20	#8 ranked in 2020 - 21 Survey of HIV Impact; 8th largest service gap (9%).
Food Services: Home-Delivered Meals	21	#7 ranked in 2020 - 21 Survey of HIV Impact; 6th largest service gap (11 %), 5% of respondents stated "too sick to make own meals"
© **Medical Nutrition Therapy**	22	Core service;
Legal Services	23	#10 ranked in 2020 - 21 Survey of HIV Impact; 3rd largest service gap (15%).
Emergency Financial Assistance	24	Emergency Utility Payment #15 ranked in 2020 - 21 Survey of HIV Impact; and 5th largest service gap (12%) in the survey. Links PLWH to care and helps sustain PLWH in care.
Home Health Care	25	Core service; #18 ranked in 2020 – 21 Survey of HIV Impact, 5% need but can't get
© **Early Intervention Services: HIV Counseling and Testing**	26	Core service; important to getting persons unaware of status aware and linked to and retained in care if needed. Improves availability of HIV testing and links PLWH to care.
Cost-Sharing Assistance	27	Core service; Focus group participants stated "lack of access to healthcare or resources to get the medication refilled" was a primary reason for not taking HIV medication
© **Hospice**	28	Core service;

© **= Core Service**

Light Blue lettering = service categories with $0 at present

San Diego HIV Planning Group
Priority Setting and Resource Allocation Committee

Key Data Findings
2023 Co-Occurring Conditions/Poverty/Insurance

Draft June 8, 2023

Data regarding co-morbidities or co-occurring disorders is important to the delivery of services for people living with HIV (PLWH) for all the following reasons:

- Co-occurring health conditions make providing medical care more complex, require greater provider expertise, and **increase the cost of care** for PLWH.
- PLWH/A who live with other health conditions often have many service needs, so case managers and other service providers may need to spend more time with fewer clients.
- Substance use, homelessness and mental illness can **interfere with HIV care**, treatment, and medication adherence.
- When a PLWH has tuberculosis (TB), a sexually transmitted disease (STD) or hepatitis, both the person's HIV and the other disease(s) can **progress faster** and have more serious effects.
- STDs make it easier for a PLWH to **transmit HIV** to someone else.
- Support services keep PLWHin care and improve medical outcomes, especially those of women, African Americans, and persons with lower incomes.

2021 findings are self-report by HIV positive respondents to the *2021 Survey of HIV Impact*: (2)

- Total sample: 182
- People living with HIV: 158

2017 findings are self-report by HIV positive respondents to the *2017 Survey of HIV Impact*: (3)

- Total sample: 1,038
- People living with HIV: 781

Condition	***Estimated prevalence* within the general population* (Population = 3,343,349; Males = 1,685,822 Female = (1,661,702** (1)		***Estimated prevalence* based on self-report by people living with HIV from the 2021 *Survey of HIV Impact*** (2)	
	Number	***Percentage***	***Number***	***Percentage***
Tuberculosis	201	Less than 0.01% (4)	17	11.0% (2)
Syphilis*	2,177 female: 411 male: 1,765 (5,6)	0.066% female: 0.025% male: 0.11%	309, est. female:1, male: 308 (3)	2.2% female: 0.07 male: 2.4
Gonorrhea	7,884 female: 2,652 male: 5,229 (5,6)	0.24% female: 0.16 male: 0.31	93 est. female: 0 male:93 (3)	10.7% female: 0% male: 10.7%
Chlamydia	18,075 female: 10,632 male: 7,430 (5,6)	0.55% female: 0.65% male: 0.45%	98 est. female: 2 male: 96 (3)	1.4% female: 3.5% male: 12.3%
Hepatitis B (HBV)	638	0.03% (5)	30	20% (3)
Hepatitis C (HCV)	3,845	1.1% (6)	18	12% (2)
Mental Illness	688,730 (7) (method of estimating combines serious and chronic)	20.6%	312	40% (2) (ever diagnosed or treated)
Substance Use: Injection Drug Use	50,150 est. ages 12+ (8)	1.5% est. ages 12+ (11)	36	Ever Injected: 23.9 (3) Injected last 12 months: 7.8% (11)

Condition	*Estimated prevalence* within the general population* (Population = 3,343,349; Males = 1,685,822 Female = (1,661,702 [1]		*Estimated prevalence* based on self-report by people living with HIV from the 2021 *Survey of HIV Impact* [2]	
	Number	***Percentage***	***Number***	***Percentage***
Substance Use: Illegal Drug Use (non-inj. use)	110,331 est. illicit drug use, ages 12) [9]	3.3% estimated	11	7.8% est. [11]
Fentanyl Use	424 deaths in SDC in 2022 [21]		-	-
Homelessness	10,264 [12]	0.31%	619 est. [3]	Unstably housed: 22.4%) Homeless: 4.4% [3]
Poverty Level (Threshold = $1,215 /month)	518,219 [10]	15.5% below poverty level	273 below pov. level 562 below 500% pov. level	35% below poverty level 72% below 500% poverty level [3]
Lack of Insurance (Non-elderly population <65 years old)	314,715	9.5% [13]	104	13% [3]
Formerly incarcerated	10,030 est. prison pop	0.3% [14]	35	23%
Hypertension (High Blood Pressure)	10,030	30% [15]	54	35% (Among ART-experienced individuals >50 years, >50%) [15]
Diabetes	227,347	6.8% [16]	18	10.3% [16]
Coronavirus (COVID 19)	983,031 [17]	29.4% [17]	187 est.	Increased risk of (hospitalization, increased risk of death [18] RR = 1.24 [24]
Monkeypox (MPOX)	471 [19]	0.00014%	Of pts with MPOX, 40% are PLWH	Increased risk for advanced MPOX [20]

*Detailed data for sexually transmitted infections, including data by race/ethnicity and gender /can be found at https://www.sandiegocounty.gov/hhsa/programs/phs/hiv_std_hepatitis_branch/reports_and_statistics.html

Notes:

- Research reveals higher incidences of additional co-occurring conditions for PLWH/A that include gastrointestinal diseases, circulatory diseases, endocrine/nutritional/metabolic diseases (includes diabetes), nervous system diseases, and neoplastic diseases (cancer, lymphoma).
- Women experience an increased incidence of some HIV-related including gynecological conditions such as genital herpes, pelvic inflammatory disease, human papillomavirus, and candida; additionally, there is an increased incidence of diabetes, heart disease; hepatitis C; cancer, mental Illness, and substance abuse.
- PLWH greater than 50 years of age, experience an increase in age-related diseases; causes of morbidity and mortality for older PLWH include non-infectious comorbidities, such as cardiovascular disease, hypertension, bone fractures, chronic kidney disease, liver disease, diabetes mellitus and non-AIDS-defining cancers. Many of the age-related diseases are seen in the population of greater than 50 years of age PLWH approximately 10 years earlier than seen in the general population. [22, 23, 24]

Data Sources:

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San Diego HIV Planning Group
Priority Setting and Resource Allocation Committee

2023 Key Data Findings: Ryan White Programs (RWP) Parts A/B Regional Service Availability

Approved June 8, 2023

The table below identifies **service gaps** in availability for ***only*** those services funded by the Ryan White Programs (RWP) Parts A/B. ***If RWP services are not available* in specific areas, they may be accessed in other regions of the county.*** Additionally, non-Ryan White funded services may or may not also be available through other community resources.

A RWP service is considered to be ***not*** available in a region if it is 1) not available at a provider site in the region; 2) Not out stationed in the region; and 3) The service is not available in a client's home; The following RWP services are currently ***not*** available in the given regions:

Region(s)**	RWP Parts A/B funded services ***not*** available
Central/North Central/Southeast	• All services available except Referral to Health and Supportive Services (Peer Navigation) (not available in Southeast San Diego)
East	• Early Intervention Services: Regional Services • Substance Abuse (Drug & Alcohol) Treatment Services (Residential)*** • Substance Abuse (Drug & Alcohol) Treatment Services (Outpatient)
North Coastal/North Inland	• Substance Abuse (Drug & Alcohol) Treatment Services (Residential)*** • Substance Abuse (Drug & Alcohol) Treatment Services (Outpatient)'
South	• Substance Abuse (Drug & Alcohol) Treatment Services (Residential) *** • Referral to Health and Supportive Services (Peer Navigation)

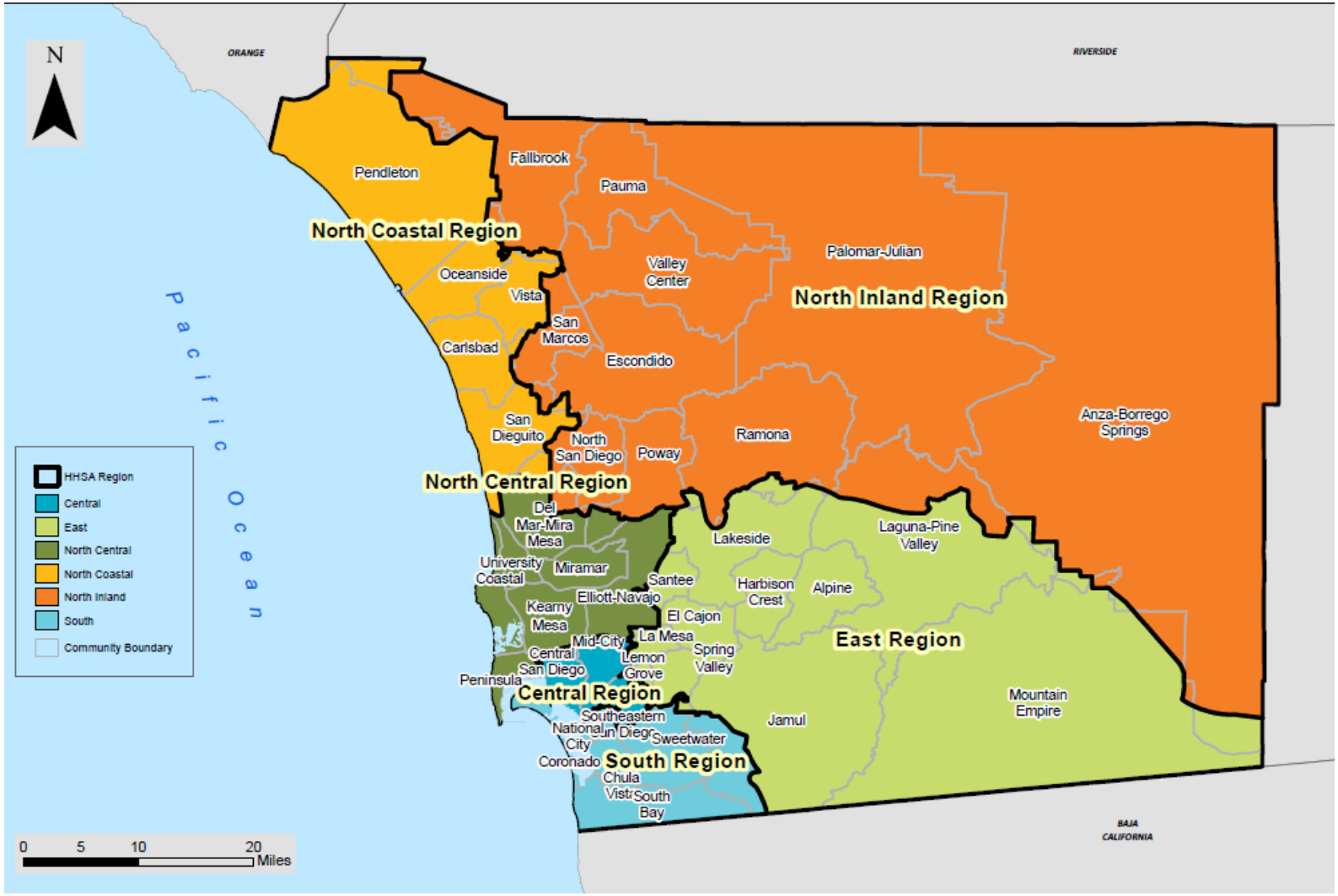
* Not available at a provider site, as an out-stationed service nor as a service in the home

**County of San Diego Health and Human Services Agency (HHSA) defined regions. See reverse side for map

*** Substance Abuse (Drug & Alcohol) Treatment Services (Residential) are available countywide, regardless of the regions in which clients reside, because clients will reside at the service site while they are in treatment.

- Non-Medical Case Management for Housing and Housing Location, Placement and Advocacy Services are awaiting full procurement.
- The stand-alone service category Health Education and Risk Reduction is not currently funded and is not available in any region until further notice.

County of San Diego Health and Human Services Agency (HHSA) Regions



San Diego HIV Planning Group
Priority Setting and Resource Allocation Committee

2023 Key Data Findings

SERVICE ELIGIBILITY CRITERIA AND SERVICE GUIDELINES BY SERVICE CATEGORY FOR RYAN WHITE PART A/B SERVICES

Approved June 22, 2023

The Health Resources and Services Administration (HRSA) require that the income eligibility criteria be the same for all Ryan White service categories. Having different income eligibility criteria for different services creates barriers to receiving care and treatment.

Thus, to be eligible to receive Ryan White Parts A/B services in San Diego County, one must:

- Live in San Diego County
- Have an income at or below 500% Federal Poverty Level (FPL)* ($72,900 annually for a household of one)
- Have a confirmed HIV diagnosis (except in service categories that permit services to HIV-negative and unaware)
- Have no other payer for service

All clients must be reassessed for eligibility every twelve months

Service specific guidelines for each Ryan White service provided in the County are noted in the chart beginning on page 2.

*The FPL for changes every year and is usually published within the first few months of each calendar year. The 2023 500% FPL is $72,900 annually for a household of one (adjusted for additional family members).

Definitions:
Medical Provider = Medical Doctor (MD or DO), Nurse Practitioner (NP), Physician Assistant (PA)

Clinical Provider = Medical Doctor (MD or DO), Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Case Manager (CM), Licensed Clinical Social Worker (LCSW), Licensed Marriage Family Therapist (LMFT)

Mental Health Provider = Psychiatrist (a Medical Doctor, MD or DO), Psychologist (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Licensed Marriage Family Therapist (LMFT)

Dental Provider = Dentist (DDS or DDM), Dental Specialist (DDS or DDM)

© = Core Medical Service

San Diego County EMA Ryan White Treatment Extension Act (RWTEA) Parts A/B
SERVICE SPECIFIC CRITERIA
Draft June 22, 2022

Priority Rank/Category	Criteria	Limitations	Requires referral
1. © Outpatient Ambulatory Health Services (Primary Care)	No additional guidelines	Emergency room or urgent care services are not considered outpatient settings. There are no annual limits on the number of services provided.	
2. © Medical Specialty	Must have a referral from Ryan White HIV Primary Care provider	Requests triaged based on medical necessity, HIV relatedness and urgency.	• Medical provider
3. © Psychiatric Services	Must have a confirmed mental health diagnosis, and/or referral for specialized psychiatric care from a medical provider or mental health provider	There are no annual limits on the number of services provided.	• Medical provider • Mental health provider
4. © Oral Health Care (Dental Care)	Must have a referral from Ryan White Primary Care provider	Primary dental services are available as medically necessary or as required to treat pain. Dental specialty is limited to procedures to support palliative and medically necessary dental care outside of primary dental care setting. Service specifically excludes dental implants (with four specific exceptions)	• Medical provider • Dental provider for dental specialty service
5. © Medical Case Management Services	Limited to individuals who are unable to access or remain in HIV medical care as determined by medical care managers based on whether: • Client is currently enrolled in outpatient/ambulatory health services • Client is following his/her medical plan • Client is keeping medical appointments Client is taking medication as prescribed	Services are not intended for individuals who are able to access and remain in HIV medical care. Case is closed when all action items on the care plan are competed, and medical care is stabilized There are no annual limits on the number of services provided.	
6. Non-Medical Case Management Services	Must demonstrate ability to access or remain in HIV medical care	Services are not intended for individuals who are unable to access or remain in HIV medical care. Case is closed when all action items on the care plan are competed, and medical care is stabilized. There are no annual limits on the number of services provided.	
7. Non-Medical Case Management for Housing	Eligible to receive Ryan White services Upon intake, all eligible clients will be required to enroll in all available housing assistance waiting	Housing case management does not provide support or guidance for accessing other services, and it is required that housing case managers closely coordinate client needs outside of housing	

Priority Rank/Category	Criteria	Limitations	Requires referral
	lists, including Section 8, Housing Opportunities for Persons with AIDS (HOPWA), and Tenant-Based Rental Assistance (TBRA). A housing plan must be developed within 60 days of enrolling in housing case management and no later than 90 days after enrolling in PARS. The client & case manager should review the plan regularly, and at least every quarter.	with medical or non-medical case managers as part of a treatment team approach.	
8. Housing: Emergency Housing	Eligible to receive RW services. Because all housing support provided under Ryan White is temporary, a housing transition plan is required to ensure clients maintain housing self-sufficiency at the conclusion of assistance.	Services prioritize hotel/single room occupancy (SRO) vouchers over rental assistance. Service can be used once in a 12-month period. Service is not available to individuals who: • Receive Housing Opportunities for People with AIDS (HOPWA) funds. • Receive a tenant-based or project-based rent subsidy including, but not limited to, subsidized low-income housing, or subsidized independent housing associated with any program such as Public Housing, Affordable Housing, Section 8, HOPWA, or PARS rental assistance. • Have previously been terminated from receiving emergency housing assistance or tenant-based rental assistance, have violated program guidelines in their use of emergency housing funds, or have been identified as ineligible for services. • Can include sober living and assisted living. Housing services may not: • Be used for mortgage payments • Be in the form of direct cash payments to clients • Be used for rental or security deposits. Such deposits are typically returned to clients as cash which would violate the prohibition on providing cash payments to clients.	• Case manager
9. Housing Location, Placement and Advocacy Services	(The Strategies and Standards Committee will draft service standards for this service category)		

Priority Rank/Category	Criteria	Limitations	Requires referral
10. Housing: Partial Assistance Rental Subsidy (PARS)	Must not receive other subsidized housing, either tenant-based or project-based Because all housing support provided under Ryan White is temporary, a housing transition plan is required to ensure clients maintain housing self-sufficiency at the conclusion of assistance. All clients enrolled in the Partial Assistance Rental Subsidy (PARS) program must also enroll in housing case management.	Provides 40% of a client's monthly rental costs not to exceed 40% of the fair-market rent for San Diego County as determined by the U.S. Department of Housing and Urban Development (HUD). Clients shall not receive PARS if they receive tenant-based or project-based rent subsidy including, but not limited to, subsidized low-income housing, or subsidized independent housing associated with any program such as Public Housing, Affordable Housing, HOPWA, or Section 8. Housing services may not: • Be used for mortgage payments • Be in the form of direct cash payments to clients • Be used for rental or security deposits. Such deposits are typically returned to clients as cash which would violate the prohibition on providing cash payments to clients.	• Case manager
11. © Coordinated HIV Services for Women, Infants, Children, Youth and Families(CHS:WICYF)	Limited to: • Individuals who do not know their HIV status and need to be referred to counseling and testing • Individuals who know their status and are not in care and need assistance to enter or re-enter HIV-related medical care	Services focus on linkage or re-engagement in care and are not intended to be ongoing.	
a. Childcare Services (A subcategory of CHS:WICYF)	Available for children living in the household of individuals with a confirmed HIV diagnosis and their affected family members while attending medical visits, related appointments, and/or Ryan White-funded meetings, groups, or training sessions.	For children from infancy through 12 years of age. Services are also available, if permitted at the appointing clinic, for parents and caregivers attending medical, dental, and mental health care appointments, including support groups, on-site childcare is prioritized for appointments, so family members can access support service needs. It may be available for other purposes as determined appropriate. For parents and caregivers utilizing on-site services, at least one parent or caregiver must remain on-site.	• Case manager
12. © Early Intervention Services: Regional Services (EIS:RS)	Services focus on linkage or re-engagement in care and are not intended to be ongoing.	Limited to: • Individuals who do not know their HIV status and need to be referred to counseling and testing	•

Priority Rank/Category	Criteria	Limitations	Requires referral
		Individuals who know their status and are not in care and need assistance to enter or re-enter HIV-related medical care	
a. Outreach Services (a subcategory of EIS:RS)	Services focus on linkage or re-engagement in care and are not intended to be ongoing.	Limited to: • Individuals who do not know their HIV status and need to be referred to counseling and testing Individuals who know their status and are not in care and need assistance to enter or re-enter HIV-related medical care	
13. Health Education and Risk Reduction (stand-alone service, not part of CHS:WICFY or EIS:RS)	Eligible to receive Ryan White funded care The provision of education and information to clients living with HIV and how to reduce the risk of HIV transmission. It includes education, referral and related service navigation to clients living with HIV to improve their health and their partners to prevent HIV transmission.	Services are intended to complement and not replace other funded HIV prevention activities Exclusions: • Affected individuals (partners and family members not living with HIV) are only eligible if receiving services concurrently with the client. • Health Education/Risk Reduction may not be delivered anonymously. However, all information is confidential.	
14. Referral to Health and Care and Support Services (Peer Navigation)	Must currently be receiving case management, non-case management, mental health, substance abuse or outreach services	Services focus on linkage or re-engagement in care and are not intended to be ongoing.	• Self-Referral • Case manager • Early Intervention Services
15. © Mental Health: Counseling, Therapy/Support Groups	May request or be referred by providers or case manager	Case is closed when all action items on the care plan are competed, and medical care is stabilized. There are no annual limits on the number of services provided.	
16. Psychosocial Support Services	Available to clients living with HIV; may include support groups and may be provided by a trained staff or volunteer, including peers.	Funds under this service category may not be used to pay for food, transportation or for professional mental health services.	
17. © Substance Use Outpatient Care	Cannot currently be in a residential substance abuse treatment program	Case is closed upon successfully completion of treatment and client chooses not to participate in any other aftercare program activities. There are no annual limits on the number of services provided.	
18. Substance Use Residential Care	Must have a written referral from the clinical provider as part of a substance use disorder	Case is closed upon completion of treatment program. There are no annual limits on the number of services provided.	• Clinical provider

Priority Rank/Category	Criteria	Limitations	Requires referral
	treatment program funded under the Ryan White program		
19. G Home and Community Based Health Services	Must be at risk for hospitalization or entry into a skilled nursing facility. Must also: • Have a health condition consistent with in-home services • Have a home environment that is safe for both the client and the service provider Have a score of 70 or less on the Cognitive and Functional Ability (Karnofsky) Scale	Service specifically excludes: • Emergency room services • In-patient hospital services • Nursing homes • Other long-term care facilities Case is closed when all action items on the comprehensive service plan are complete and medical care is stabilized. There are no annual limits on the number of services provided.	• Medical provider • Case manager
20. Transportation Pool – Assisted & Unassisted	Individuals shall be eligible for transportation only if they would not otherwise have access to core medical and support services and only if they do not qualify for other transportation assistance programs.	Specific eligibility criteria for **assisted transportation***: • Specific Eligibility Criteria: Used for transport to and from various core medical and support service providers. • Assisted transportation, consisting of ADA Para-Transit Passes and certified medical transport may be used if a client is unable to access unassisted transportation. • Contractor shall refer all clients requesting assisted transportation for screening and potential eligibility for AIDS Waiver program. • Clients are not eligible for assisted transportation services if they receive or are eligible for other public transportation benefits such as, but not limited to, ADA Para-Transit, AIDS Waiver Transportation Assistance, Home and Community-based Health Services, or Medi-Cal reimbursed medical transport. Specific eligibility criteria for **unassisted transportation**: • Specific Eligibility Criteria: Reserved for individuals unable to access or stay in core medical and support services. • Disabled monthly passes may be issued for individuals who qualify for the disabled	• Case manager • Any service provider

Priority Rank/Category	Criteria	Limitations	Requires referral
		monthly pass and have more than three medical visits per month. • Day passes may be issued for individuals who do not qualify for the disabled monthly passes and for those eligible for disabled monthly passes who have fewer than three medical visits per month. ○ Individuals who receive day passes can be issued two extra day passes to cover unexpected or emergency medical visits. Clients are limited to two unused emergency day passes at a time. • Monthly passes may be issued to clients in lieu of day passes if a client's predetermined number of day-passes for a month equals or exceeds the cost of a standard monthly pass. • Other forms of transportation may include but are not limited to: taxis, ride sharing program and/or mileage reimbursement. Transportation services are limited to travel to and from core medical and support service appointments only; however, clients traveling with legal dependents are permitted to make stops at childcare facilities to drop children off before appointments and to pick children up after appointment. Unallowable services include: 1. Direct cash payment or reimbursements to clients 2. Direct maintenance expenses of personally owned vehicles (tires, repairs, etc.) 3. Payment of other cost associate with a personally owned vehicle (insurance, license, etc.)	
21. Food Services/Home Delivered meals	Must be physically and/or mentally incapable of preparing own meals to qualify for home delivered meal services. Individuals who can prepare meals may still be eligible for food vouchers and food bank services	Services do not provide: • Permanent water filtration systems for water entering a home; • Household appliances; • Pet foods and • Other non-essential products. Case is closed when the service is deemed no longer medically necessary. There are no annual limits on the number of services provided.	• Case manager • Medical provider

Priority Rank/Category	Criteria	Limitations	Requires referral
22. Medical Nutrition Therapy	Must be referred by a medical provider	Case is closed when all action items on the nutrition plan are competed, and medical care is stabilized. There are no annual limits on the number of services provided.	• Medical provider
23. Legal Services (Other Professional Services)	Services can also be provided to family members and others affected by a client's HIV disease when the services are specifically necessitated by the person's HIV status	Excludes criminal defense and class-action suits unless related to access to services eligible for funding under the Ryan White program. Case is closed when the legal matter has been resolved. There are no annual limits on the number of services provided.	
24. Emergency Financial Assistance	Eligible to receive RW services.	The maximum amount for each item per year per client are as follows: • Clients are eligible to receive up to $1,000/year to use for utility payments. • Food bags: Each client is allowable a maximum of 12 weeks of emergency food bags per 12 months. • Medication: Covers prescription medication (1) not available through the AIDS Drug Assistance Program and (2) only intended for short term need. • Eyeglasses: One set of lenses per year, one set of frames every other year; one opportunity to replace if lost/stolen/damaged. • Eviction prevention: Limited to $1,490/year. Electronic devices (tablets, small laptops, etc.) can be provided to assist clients access virtual environments/telehealth appointments/RW planning meetings.	• Case manager
25. Home Health Care	Must be deemed medically homebound by a medical provider	Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities. Case is closed when all services are completed, and medical care is stabilized. There are no annual limits on the number of services provided.	• Medical provider • Case manager
26. Early Intervention Services: HIV Counseling and Testing	Limited to: • Individuals who do not know their HIV status and need to be referred to counseling and testing	Services focus on linkage or re-engagement in care and are not intended to be ongoing.	

Priority Rank/Category	Criteria	Limitations	Requires referral
	• Individuals who know their status and are not in care and need assistance to enter or re-enter HIV-related medical care		
27. Cost-Sharing Assistance	(The Strategies and Standards Committee will draft service standards for this service category)		
28. © Home Hospice	Must be certified as terminally ill by a physician and have a defined life expectancy of six months or less	Case is closed upon death. This service category does not extend to skilled nursing facilities or nursing homes. There are no annual limits on the number of services provided.	• Medical provider • Case manager

San Diego HIV Planning Group
Priority Setting and Resource Allocation Committee

2023 Key Data Findings

HIV EPIDEMIOLOGY

Approved June 22, 2023

OVERALL

- Total Persons Living with HIV disease (PLWH) in San Diego County (Prevalent cases) = **14,634.**
- Recent cases (2018 – 2022) = **2,139** (this is a subset of the total or prevalent cases)

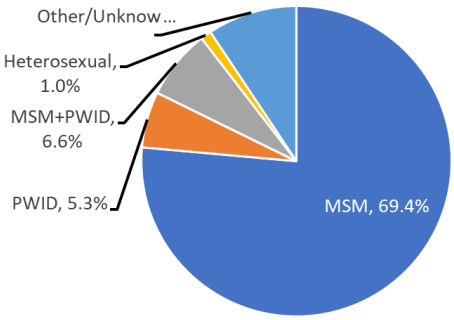
BIRTH SEX

- The proportion of female HIV disease diagnoses has increased slightly over the last 5 years to about 13.6% (n = 291, recent cases) (cf. 10.7% of prevalent cases; (n = 1,560, total cases for females).
- Central Region and South Region have the largest proportion of recent HIV disease diagnoses among women (>50% of total women in the two regions; (n =138).

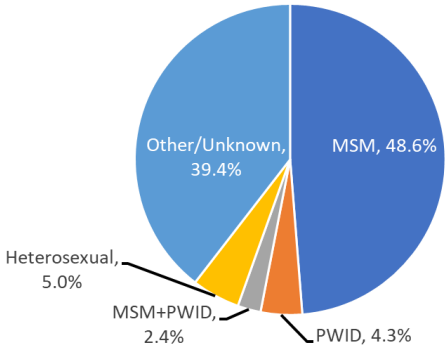
MODE OF TRANSMISSION

- The majority of people living with HIV disease (PLWH) through year-end 2022 were men who have sex with men (MSM, 69.4%; n = 10,161). For women, heterosexual transmission was the largest mode of transmission. Most recent diagnoses and PLWH were male and MSM.

People Living with HIV (PLWH)[2]



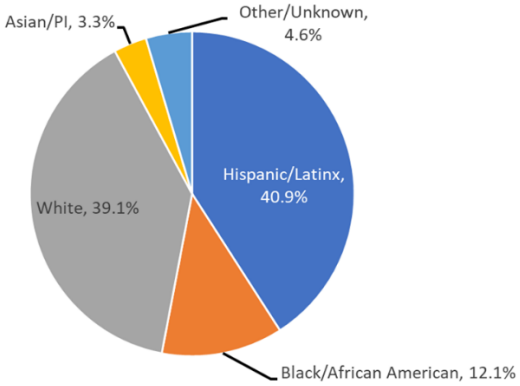
Recent HIV Cases[1]



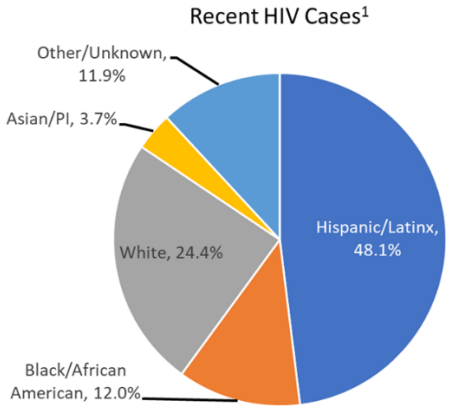
RACE/ETHNICITY

- The majority of recent HIV disease diagnoses for over ten years were people of color. The proportion of Non-Hispanic White cases decreased over time, while the proportion of Hispanic/Latino cases increased over time. The HIV rate (number/100,000 or 10^5) was higher for Non-Hispanic Black/African American **(40.4/10^5)** than Hispanic/Latino **(19.6/10^5)** or Non-Hispanic White **(6.8/10^5)** during in 2021.

People Living with HIV (PLWH)[2]



Recent HIV Cases[1]



[1]**Persons Living with HIV disease (PLWH) =** Residing in San Diego County and alive as of December 31, 2022

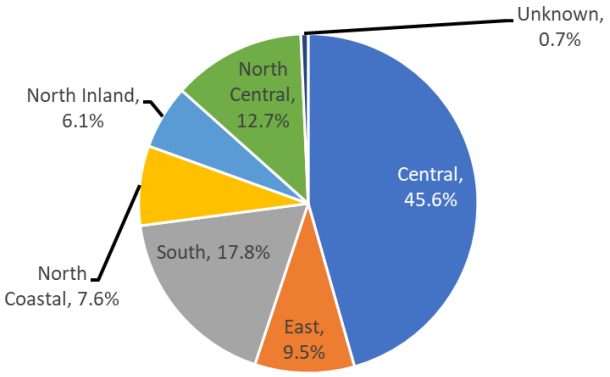
[2]**Recent Cases** = HIV disease diagnosis, regardless of stage of disease, between 2018 – 2022 while residing in San Diego County

All data provided by San Diego County Health & Human Services Agency; Epidemiology and Immunizations Services Branch (EISB), 2023

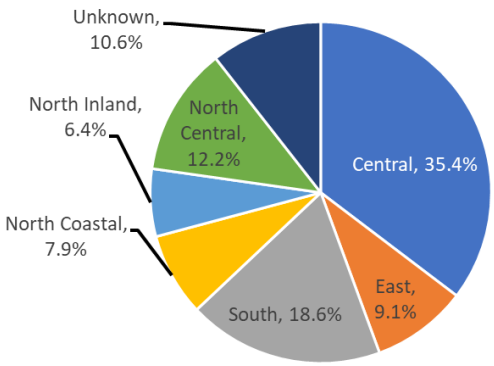
REGION AT DIAGNOSIS

- Central Region has the highest number (n = 6,666) and percentage (45.6%) of PLWH cases, followed by the South Region (n = 2,612; 17.8%).
- The proportion of HIV disease in the Central Region residents decreased over time, while the proportion of HIV disease diagnoses among South Region residents increased slightly over time.

People Living with HIV (PLWH)[2]



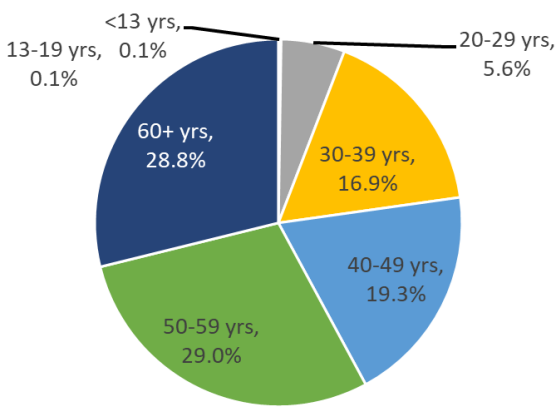
Recent HIV Cases[1]



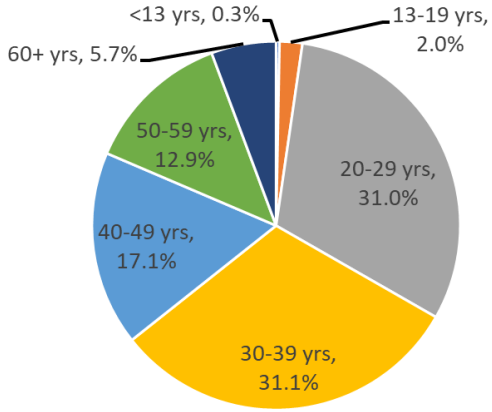
AGE

- The 20 – 29 years and 30 – 39 years age groups were the most frequent age groups at diagnosis among recent HIV disease diagnoses (n = 663, 31.0% and 661, 31.1% respectively), while the 50 - 59 was the most frequent current age for total PLWH (n = 4,251; 29% , and 60+ years was the second most frequent (n = 4,225; 28.8%).

People Living with HIV (PLWH)[2]



Recent HIV Cases[1]



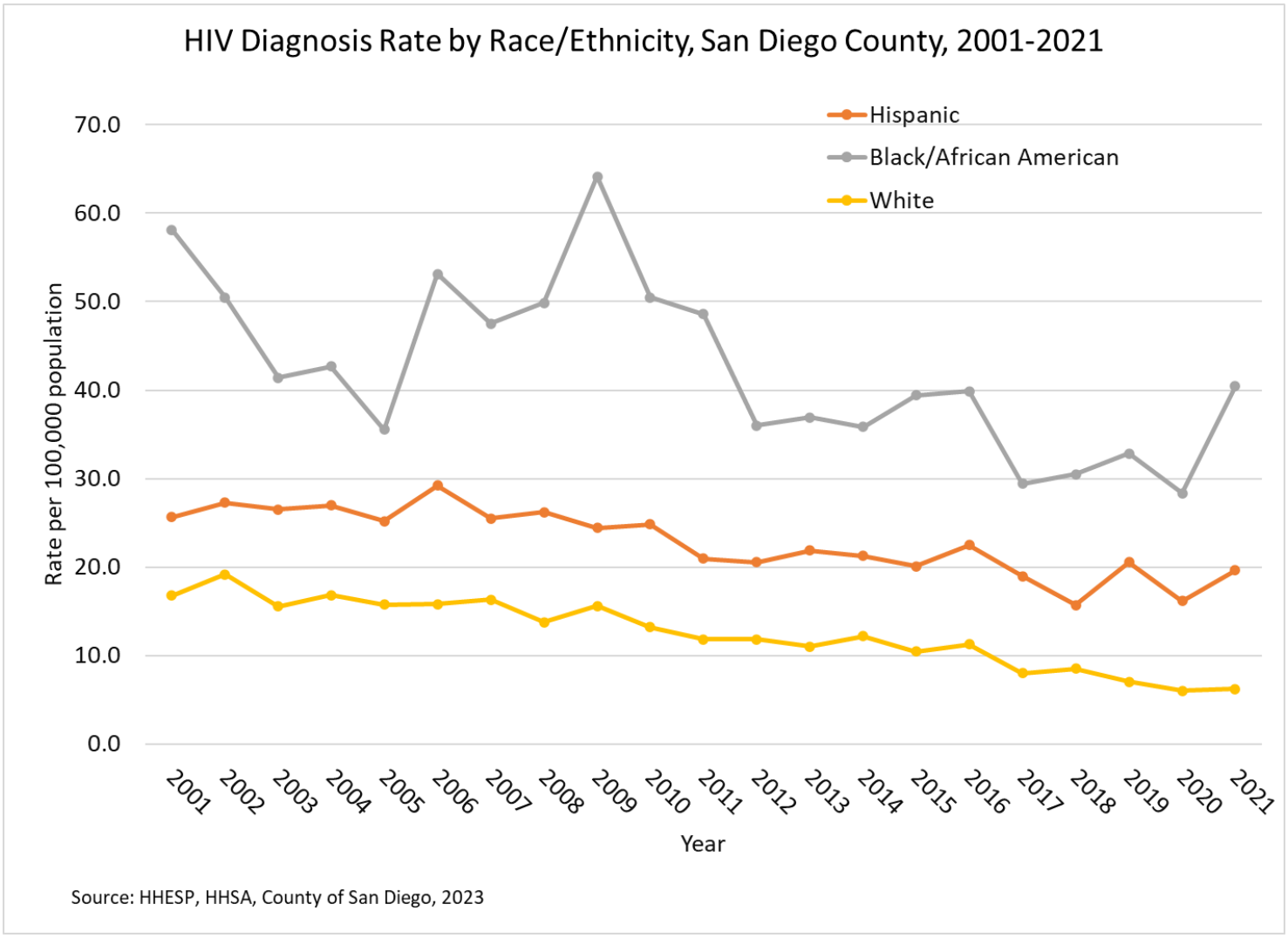
Age in 2022

Age at Diagnosis

[1] **Recent Cases** = HIV disease diagnosis, regardless of stage of disease, between 2018 – 2022 while residing in San Diego County

[2] **Persons Living with HIV disease (PLWH) =** Residing in San Diego County and alive as of December 31, 2022. Age is calculated at 12/31/2022.

All data provided by San Diego County Health & Human Services Agency; Epidemiology and Immunizations Services Branch (EISB), 2023



SIMULTANEOUS DIAGNOSIS:

Defined as a diagnosis of AIDS occurring within 12 months of initial diagnosis of HIV.

The groups with the highest percentage of simultaneous diagnosis for recent HIV disease diagnoses (2018-2022) were Hispanic/Latino 26.9% (vs. 23.2% overall), North Inland (32.1%), North Coastal (31.6%) and North Central (30.6%) regions, PWID (27.3%) and age groups 40 – 49 (29.4%), 50 – 59 (35.7%), and 60+ (45.2%). Late testing represents missed opportunities to test clients and the subsequent entry of clients into care.

¤ AIDS case definition (as of March 4, 2014): CD4 <200 (percent not used unless count is missing). CD4 <200 is not diagnostic for AIDS if patient had a negative test within 180 days of HIV diagnosis.

[1] **Recent Cases** = HIV disease diagnosis, regardless of stage of disease, between 2018 – 2022 while residing in San Diego County

[2] **Persons Living with HIV disease (PLWH) =** Residing in San Diego County and alive as of December 31, 2022. Age is calculated at 12/31/2022.

All data provided by San Diego County Health & Human Services Agency; Epidemiology and Immunizations Services Branch (EISB), 2023

San Diego HIV Planning Group
Priority Setting and Resource Allocation Committee

2023 Key Data Findings

SAN DIEGO COUNTY MENTAL HEALTH AND SUBSTANCE USE TREATMENT SERVICES WITH A PARTICULAR FOCUS ON HIV/PLWH/LGBTQ COMPENTENCIES

Approved July 20, 2023

The following is a list of some of the **non-Ryan White** mental health and substance use treatment service providers in San Diego County (SDC). Some of the providers on this list also receive Ryan White funds for services and may provide services using non-Ryan White funds as well.

In addition to the programs listed below, all programs operated by, or contracted through the COUNTY OF SAN DIEGO'S BEHAVIOR HEALTH SERVICES (BHS) are required to provide services and supports that respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served. Programs are responsible for evaluating the need for culturally/linguistically specialized services and linking individuals with those services or making appropriate referrals.
(*See attachment on County Behavior Health Services*)

1. FAMILY HEALTH CENTERS OF SAN DIEGO INC. SOLUTIONS FOR RECOVERY
   Address: 4094 4th Ave. San Diego, CA 92103 (Hillcrest location providing LGBTQ-focused services), phone: 619-515-2300, website www.fhcsd.org/lgbt-services
   - Outpatient alcohol and other drug treatment, recovery, ancillary, and supportive services for individuals who identify as lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ). Additional special early intervention case work is also provided for clients who voluntarily disclose that they are HIV positive.

2. SAN YSIDRO HEALTH (SYH):
   Address: CASA 3045 Beyer Blvd., Suite D-101, San Diego, CA 92154, phone: (619) 662-4161
   Address: Our Place 286 Euclid Ave., Suite 309, San Diego, CA 92114, phone:(619) 527-7390, Website: https://www.syhealth.org/lgbtq
   - San Ysidro Health offers an array of support and clinical services for people who identify as LGBTQ+, people living with HIV, and people who use substances. Services include patient navigation, case management, counseling, primary care, gender-affirming care, and medication-assisted treatment for substance use disorders.

3. THE SAN DIEGO LESBIAN GAY BISEXUAL TRANSGENDER (LGBT) COMMUNITY CENTER:
   Address: 3909 Centre St, San Diego, CA 92103, phone: (619) 692-2077,
   Website: The San Diego LGBT Community Center (thecentersd.org)
   - Non-Ryan White (RW) mental health and substance use relapse prevention services (support group) at the main site (Central) and two youth centers (Central and South). They also have two new grants (SAMHSA and Sierra Health Foundation) to address stigma related to opioid and stimulant use in the LGBTQ community and substance misuse prevention in the LGBTQ community.

4. SAN DIEGO YOUTH SERVICES OUR SAFE PLACE:
   Address: 3255 Wing Street San Diego, CA 92110, phone: 619-221-8600,
   website: www.sdyouthservices. org
   - Individual/group/family services provided at schools, home, drop-in center, or office/clinic location. Utilizing a team approach that when indicated offers case management, family, or youth partner support, and/or co-occurring substance treatment. Supportive services at 4 drop-in centers. Our Safe Place provides necessary mental health services and drop-in centers for LGBTQ+ youth up to age 21 and their families.

5. YMCA YOUTH AND FAMILY SERVICES: OUR SAFE PLACE NORTH:
   Address: 1050 N Broadway, Escondido CA, 92026, phone: (760) 271 – 4855
   Hours: Monday - Friday, 2:00 - 6:00pm and Saturday - Sunday, 4:00 - 8:00pm.
   A certified outpatient behavioral health program that provides a welcoming and supportive environment for LGBTQ+ youth, ages 12-21, and their families. Services include support groups for youth and family members, case management, mentorship, community outreach, training, skill development, and educational workshops. We also have opportunities for experienced individuals to work as Connection Coaches and Support Specialists. Services include:
   - Individual and group psychotherapy
   - Psychiatric services
   - Case management for children, adolescents, young adults, and their families and guardians

   Our Safe Place has five drop-in centers located throughout San Diego County, two of which are operated by the YMCA TAY Academy. Centers are open midday during the week and some hours during the weekend, with extended evening and holiday hours.

6. SOUTH BAY COMMUNITY SERVICES (SBCS) Trolley Trestle Youth Hub
   Address: 746 Ada Street, Chula Vista, CA 91911, phone**:** 619-628-2444
   Website: https://sbcssandiego.org/our-safe-place/
   Email**:** OurSafePlace@csbcs.org Instagram: @sbcs.ospsouth

7. VISTA COMMUNITY CLINIC (VCC):
   Address: 1000 Vale Terrace Dr Vista Ca 92084, phone: (760)631-5000 HIV Clinical Manager - Teresa Gomez ext.7194
   Website: https://www.vistacommunityclinic.org/
   - VCC – Valuable Connected Care: Meeting the health and wellness needs of our community.

8. UNIVERSITY OF CALIFORNIA, SAN DIEGO (UCSD): OWEN CLINIC
   Address: 4168 Front St 3rd Floor, San Diego, CA 92103, phone: 619-543-3995,
   Website: HIV Care | Owen Clinic | UC San Diego Health (ucsd.edu)
   - At the Owen Clinic, care is led by doctors and nurses with expertise in HIV care; the Owen Clinic also offers on-site substance use disorder counseling and has a part time psychologist, co-occurring conditions support groups twice a week and psychiatry support.

9. STEPPING STONE OF SAN DIEGO INC. STEPPING STONE OF SAN DIEGO
   Address: 3767 Central Avenue San Diego, CA 92105, phone: 619-278-0777, website: https://steppingstonesd.org/
   - State DHCS-licensed residential alcohol and other drug (AOD) treatment, recovery, case management, MH counseling for adults (18+) with alcohol and other drug-induced problems. Stepping Stone has been serving the LGBTQ community since 1976.

10. CHOICES IN RECOVERY:
    Address: 733 S Santa Fe Ave, Vista, CA 92083, phone: (760) 945-5290, website: Choices in Recovery (choicesinrecoveryvista.org)
    - Has a residential placement for men living with HIV in North County. Residential treatment, long term and outpatient treatment, Case manager assigned through the county of San Diego for PLWHIV.

11. SUBSTANCE USE DISORDER INTENSIVE OUTPATIENT MCALISTER INSTITUTE FOR TREATMENT AND EDUCATION (MITE) - NORTH CENTRAL TEEN RECOVERY CENTER (TRC)
    Address: 7625 Mesa College Drive, Ste. 115b, San Diego, CA 92111, phone: 858-277-4633, website: www.mcalisterinc.org/ programs/
    - Provides outpatient substance abuse treatment and education to adolescents between the ages of 12-17. Offers individual counseling, family counseling, family groups, random drug testing, and education classes consisting of life skills, relapse prevention, goal setting, crisis intervention, conflict resolution for teens, introduction to recovery, health, recovery issues, employment preparation, HIV/AIDS, and nutrition.

SERVICES

PREVENTION & COMMUNITY ENGAGEMENT

- Community Engagement and Outreach
- DUI Programs
- Mental Health Prevention and Early Intervention
- Mental Health Services Act Coordination
- Prevention Initiatives Coordination
- Stigma and Discrimination Reduction
- Substance Use Disorder Prevention Services
- Suicide Prevention

CHILDREN, YOUTH & FAMILIES SYSTEM OF CARE

- Case Management
- Day & Residential Treatment
- Emergency Screening & Stabilization
- Family/ Youth Advocacy
- Juvenile Forensics
- Outpatient & Residential Women's Perinatal Substance Use Disorder Programs
- Outpatient & School Based Treatment
- Pathways to Well Being
- Rehabilitation Support
- Teen Recovery Centers
- Therapeutic Behavioral Services
- Wraparound Services

ADULT & OLDER ADULT SYSTEM OF CARE

- Case Management
- Clubhouses
- Conservatorship Collaboration
- Crisis Residential Treatment
- Detoxification Services
- Full Service Partnerships
- Justice Services
- Outpatient Substance Use Disorder Programs
- Outpatient Mental Health
- Residential Substance Use Disorder Programs
- Rehabilitation Recovery Centers
- Supported Employment
- Supportive Housing Services

CLINICAL DIRECTOR'S OFFICE

- Integrated Care
- Long Term Care
- Whole Person Wellness
- Workforce Development

INPATIENT HEALTH SERVICES

- Edgemoor Skilled Nursing
- San Diego County Psychiatric Hospital
- State Hospital Services
- Youth Inpatient Services

LIVE WELL SAN DIEGO
LIVEWELLSD.ORG

County of San Diego

Behavioral Health Services




The Behavioral Health Services (BHS) Department of the County's Health and Human Services Agency provides a broad continuum of services for mental health and substance use issues.

Services are provided to groups across the lifespan-from perinatal, children, youth and families, to adults and older adults.

BHS promotes recovery, discovery, resiliency and well-being through prevention, treatment and intervention, as well as integrated services for clients experiencing co-occurring mental illness and substance use issues.

BHS embraces *Live Well San Diego*, the County's vision to promote healthy, safe and thriving communities countywide.

Links to Access Resources:

Access & Crisis Line
A 24/7 information and referral line will help you find a provider for your needs.
1-888-724-7240

Behavioral Health Services
For more information, see:
www.sdcounty.ca.gov/hhsa/programs/bhs/

It's Up 2 Us Website
For Suicide Prevention and Stigma Reduction, go to:
Up2sd.org

San Diego HIV Planning Group
Priority Setting and Resource Allocation Committee

Key Data Findings
Survey of HIV Impact 2021 of the Needs Assessment
Approved June 24, 2021

182 **total respondents*** (164 completed online)

160 **living with HIV/AIDS** (87% of respondents)

22 **HIV negative/unaware/no answer** (13% of respondents)

Access to Care (n=154-158)

98% of PLWHA report **having current medical care**

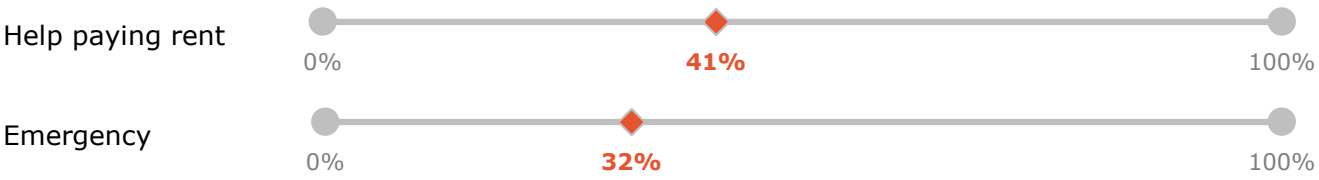
3% of PLWHA report **not having care**

13% of PLWHA reported **being out-of-care for at least 1 year** in the past

Top Ranked Needs

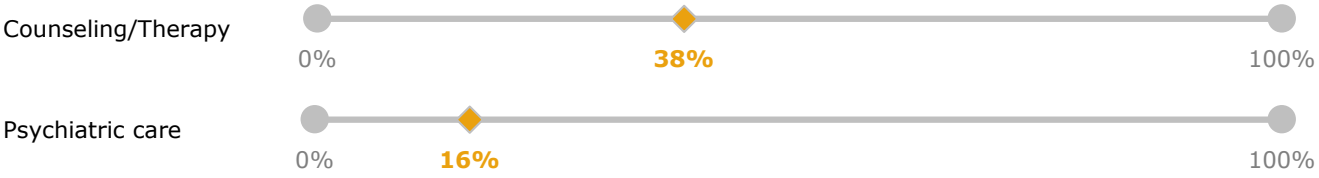
Housing

Out of 140 PLWHA who responded to the question, 26% (n=37) reported unstable housing. Of those 41% (n=15) selected help paying rent as a top priority and 32% (n=12) selected emergency housing/shelter as a priority.



Mental Health

Out of 152 PLWHA who responded to the question, 37% (n=56) have seen a therapist or received counseling in the past 6 months. Of those, 38% (n=21) selected counseling/therapy as a top priority and 16% (n=9) selected psychiatric services as a top priority.



Alcohol/drug use

Out of 142 PLWHA who responded to the question, 40% (n=57) indicated they had current or past issues with alcohol or drugs. Of those, 26% (n=15) selected alcohol/drug recovery as a top priority.

Top 5 services ranked as most important

Service Category	Rank of Category		
	2021	2017	2014
HIV/AIDS medication	**#1**	#1	#1
HIV primary care	**#2**	#2	#2
Dental care	**#3**	#3	#3
Medical specialist other than HIV	**#4**	#5	#7
Case management	**#5**	#4	#4

Top 6 service PLWHA ranked as "need, but can't get"

Compared to the 2017 survey the "need but can't get" percentages were higher for the top six categories including dental care, help to pay rent, legal services, counseling/therapy, peer advocacy or peer navigation and coordinated services center (n=150 to155).

Service Category	Percent of Respondents		
	2021 (n=150-154)	2017	2014
Dental care	**22%**	18%	24%
Help to pay rent	**20%**	18%	20%
Legal services	**15%**	12%	13%
Counseling/therapy	**15%**	11%	11%
Peer advocacy or peer navigation	**13%**	9%	8%
Coordinated services center	**13%**	7%	7%

*Note: The number of survey respondents is relatively small compared to previous surveys, however the results are consistent with previous needs assessment surveys.

San Diego HIV Planning Group Priority Setting and Resource Allocation Committee

A total of eight focus group and two interviews were conducted as part of the HIV Needs Assessment between January and March 2021. The focus groups and interviews were targeted to specific priority populations identified by the HIV Planning Group. The following are high level findings from these engagements with members of the PLWHA community.

Focus Group Participants

Population	Number of Focus Groups	Number of Participants
Black/African American HIV positive	2	5
HIV positive Women	1	11
Latina HIV positive Women	1	12
Latinx HIV positive (English and Spanish)	2	4
MSM	1	7
Older (65+) HIV positive	1	3
Total	**8**	**42**

Access to Treatment and Care

Focus group respondents talked in length about access to care; most of them shared having been connected to case management services at some point but did share that it was **very difficult to find a case manager they felt comfortable with**, and they often must "shop around" for the right one.

Related, focus group participants shared **the need for more cultural sensitivity training** for case managers, especially for case managers who serve Latinx and Trans women.

Being consistent with HIV medication is often a challenge. Many group participants shared they stopped taking medication at some point, citing that they feel like they **"live to take medication"**. The top reasons cited for **stopping HIV medication** are:

- Drug use and drug addiction;
- Forgetting to take the medication;
- Lack of access to healthcare or resources to get the medication refilled;
- Experiences of homelessness;
- Side effects of HIV medication; and
- Experiences of mental health issues, such as depression.

"Sometimes I'm out and about and I get home late or something and I lay down and I'm knocked out. And I forget to take it. I'm like, oh, I forgot to take my medication last night."

Stigma continues to affect the PLWHA community, despite all the information available about HIV. All groups mentioned that **stigma often affects their willingness to seek treatment, testing or services,** because they are afraid of being judged by others.

According to focus group participants, stigma affects all groups of people living with HIV, however, there are added layers of challenges for trans women, Latinx, and Black/African American HIV positive men. Family dynamics and cultural beliefs often result in additional challenges around being open about an HIV diagnosis. Specifically, a participant shared:

"Just the stigma, fear of just coming out is, in a Black community...just growing up with my Black father and all that stuff just in a family dynamic, it's a very taboo thing to bring up. And no one wants to hear that."

Mental Health

Mental health plays a big role in PLWHA's ability to lead a healthy life; this topic came up across all focus groups, regardless of the population. Additionally, participants shared many of the challenges faced around mental health in the HIV positive community. Focus group participants also highlighted the need for more open conversation and transparency around the use of medication to support mental health conditions. As one focus groups participant shared:

"For me, it was the mental health part. Fighting the depression and not knowing what to do or who to turn to or who to talk to. And, although now I know that there are plenty of resources to help with that, that was something that I didn't know in the beginning."

Some focus group participants shared that **even when they have reached out for mental health support, they are met with barriers and inferior care**. Specifically, one participants talked about **not having been told about any mental health services** available to them when they were diagnosed. This was particularly difficult as they were very young and trying to navigate their diagnosis.

An additional consideration was shared for the Latinx Community, given mental health is not often openly spoken about in this community. One focus group participant shared:

"I feel like mental health is not really popular in the Latino community itself. And with HIV, there comes a lot of stigmas. Even if you don't live in the United States, but in Mexico, it's HIV equals gay, is you're gay, you get HIV. You're gay, you're this, you're gay, you're that. So, it comes with a lot of stigmas. So mental health overall will be another issue that can compare to HIV, that is as big as HIV."

Housing

Housing came up as one important issue affecting the HIV positive community; while this problem is not unique to this community, many factors exacerbate access to affordable housing for PLWHA. Focus group participants voiced concern that, despite the ongoing affordable housing crisis, the city continues to shift zoning requirements to fit **"Condos in backyard alleyways...and charging three times [their] rent for those units. [They] can tell you [they feel they are] eventually going to have to move because [they] can't, [they're] not going to be able to afford it."**

Focus group participants also shared barriers they encounter related to housing that are experienced by PLWHA. One barrier focus group participants highlighted is gatekeeping from system and patient navigators.

"When you go to some of these places, you have some people that will work with you and won't work with you. […] And they're controlling those that get the first pick at housing vouchers and those that don't kind of thing."

Along with these barriers, focus group participants also shared many problems with existing programs designed to support the HIV positive community specifically. When asked what kind of housing services or assistance are currently available for PLWHA in the San Diego community, focus group participants mentioned Mercy Housing, Partial Assistance Rental Subsidy (PARS), and Housing Opportunities for Persons with AIDS (HOPWA). Participants also expressed how difficult it is to access housing resources, in general. A number of participants highlighted various issues with PARS, and many have not heard anything about HOPWA in several years and would like to see more current information publicly available.

San Diego County HIV Needs Assessment

Key Findings | June 2021

Prepared by **Harder+Company Community Research**

Background

A total of eight focus groups, two interviews, and 182 surveys were completed as part of the HIV Needs Assessment between November 2020 and March 2021. The focus groups and interviews were targeted to specific priority populations identified by the HIV Planning Group. The populations engaged were: Black/African American HIV positive individuals, HIV positive women, Latina HIV positive women, Latinx HIV positive individuals (in English and Spanish), MSM, trans/non-binary HIV positive individuals, and Older HIV positive individuals. The number of participants was relatively small compared to previous years; however, the results are consistent with previous needs assessment focus groups. The following are high level findings from these engagements with members of the persons living with HIV/AIDS (PLWHA) community in San Diego County.

226 total community member participants

182 survey respondents
42 focus group participants
2 interviewees

160 survey respondents living with HIV/AIDS

87% of survey respondents

22 survey respondents HIV negative/unsure of status

13% of survey respondents

Access to Treatment and Care

98% of PLWHA who completed the survey report **having current medical care**

3% of PLWHA who completed the survey report **not having medical care**

13% of PLWHA who completed the survey reported **being out-of-care for at least 1 year** in the past

(n=154-158)

Access to Treatment and Care

Top **six** services survey respondents who identified as PLWHA **need** but **cannot access.**

Dental Care	**22%**
Help to pay rent	**20%**
Legal Services	**15%**
Counseling / Therapy	**15%**
Peer advocacy or navigation	**13%**
Coordinated services center	**13%**

(n=150-154)

Across all eight focus groups, respondents talked in length about access to care; most of them shared having been connected to case management services at some point but did share that at times it can be **difficult to find a case manager they feel comfortable with and that built trust is critical but takes time**. Focus group participants find they often must jump around to find one they feel accepted by and who holds compassion and patience. When they do find a case manager that feels like a right fit and they are able to connect them to resources relevant to their needs, they find the support very helpful.

Focus group participants from five of the eight focus groups shared **the need for more cultural sensitivity training** for case managers or **more community-based peer navigator/support programs with navigators who have similar lived experiences.**

Access to Treatment and Care

While consistency with HIV medication is key to a healthy life for HIV positive individuals, several participants across all eight groups shared they stopped taking medication at some point and one common thread shared was pill fatigue. Other top reasons cited for **not taking HIV medication** are:

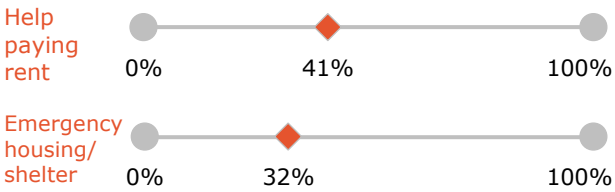
- Lack of access to healthcare or resources to get the medication refilled;
- Experiences with homelessness;
- Side effects of HIV medication;
- Drug use, addiction, experiences with relapse;
- Forgetting to take the medication; and
- Experiences of mental health issues, such as depression.

Stigma continues to affect the PLWHA community, despite all the information available about HIV. Participants in all eight focus groups mentioned that **stigma often affects their willingness to seek treatment, testing or services,** because they are afraid of being judged by others.

According to focus group participants, stigma affects all groups of PLWHA, however, there are added layers of challenges **for trans women, Latinx, and Black/African American HIV positive men**. Family dynamics and cultural beliefs often result in additional challenges around being open about an HIV diagnosis.

Housing

Out of 140 PLWHA who shared their housing status, 26% (n=37) reported unstable housing. Of those **41%** (n=15) selected help paying rent as a top priority and **32%** (n=12) selected emergency housing/shelter as a priority.



In four of the focus groups, housing came up as one important issue affecting the HIV positive community; while this problem is not unique to this community, many factors exacerbate access to affordable housing for PLWHA. Two focus group participants voiced concern that, despite the ongoing affordable housing crisis, the city continues to shift zoning requirements to fit in more housing and price new units at exorbitant rental prices.

Housing

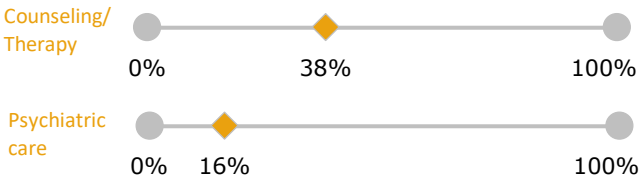
"Condos in backyard alleyways...and charging three times [their] rent for those units. [They] can tell you [they feel they are] eventually going to have to move because [they] can't, [they're] not going to be able to afford it."
– Focus Group Participant

Focus group participants also described that some individuals in charge of helping them navigate housing services, instead act as gatekeepers that create additional barriers for them. is gatekeeping from system navigators.

Along with these barriers, focus group participants also shared **many problems with existing programs designed to support the HIV positive community** specifically. When asked what kind of housing services or assistance are currently available for PLWHA in the San Diego community, focus group participants mentioned Mercy Housing, Partial Assistance Rental Subsidy (PARS), and Housing Opportunities for Persons with AIDS (HOPWA). Participants from all four of those groups also **expressed how difficult it is to access housing resources**, in general. Several participants highlighted various issues with PARS, and many have not heard anything about HOPWA in several years and would like to see more current information publicly available.

"When you go to some of these places, you have some people that will work with you and won't work with you. [...] And they're controlling those that get the first pick at housing vouchers and those that don't kind of thing."
– Focus Group Participant

Out of 152 PLWHA who responded to the question, 37% (n=56) have seen a therapist or received counseling in the past 6 months. Of those, **38%** (n=21) selected counseling/therapy as a top priority and **16%** (n=9) selected psychiatric services as a top priority.



Mental health plays a big role in PLWHA's ability to lead a healthy life; this topic came up across all eight focus groups, regardless of the population. Additionally, participants shared many of the challenges faced around mental health in the HIV positive community. Focus group participants also highlighted the need for more open conversation and transparency around the use of medication to support mental health conditions.

Some focus group participants shared that **even when they have reached out for mental health support, they are met with barriers and inferior care**. Specifically, one participant talked about **not having been told about any mental health services** available to them when they were diagnosed. This was particularly difficult as they were very young and trying to navigate their diagnosis.

"For me, it was the mental health part. Fighting the depression and not knowing what to do or who to turn to or who to talk to. And, although now I know that there are plenty of resources to help with that, that was something that I didn't know in the beginning."
– Focus Group Participant

Important Services

Top **five** services survey respondents listed as **most important** to them when **getting care.**

- **HIV/AIDS Medication**
- **HIV Primary Care**
- **Dental Care**
- **Medical Specialist (other than HIV)**
- **Case Management**

Consultant Memo: D. Jacobs, PhD
GTZ Community Engagement 2023
June 2023

DRAFT Final 2023 Report

Summary & Recommendations GTZ Community Engagement Project: *Consumer Recommendations & Implementation 2023*

Background

The San Diego County HIV Planning Group's (HPG) *Community Engagement Project for Getting to Zero and Ending the HIV Epidemic* began in January 2020 and the recommendations continue to help to guide HPG planning and HPG committee work. The Consumer Recommendations and the 2022-23 committee progress are contained in this report. HPG has envisioned a 3-year Action Plan to incorporate this consumer feedback and 2022-23 is year 1 of this 3-year Action Plan. A total of 30 Action Items were presented for HPG Committees to address: 40% of items (12 items) were fully completed, an additional 30% (9 items) are currently in various stages of completion in the committee process, and 30% (9 items) remain not yet addressed by the committees. Items and their completion status are listed in this report. Finally, consultant observations and recommendations are provided at the end of this report.

Community Engagement Methodology

This project included **160 community participants** living with or vulnerable to HIV. Participation included: 1 large group, in-person community member event (98 participants), 2 rounds of extended key informant telephone interviews (64 participants), 12 Advisory Committee meetings, 32 small regional team meetings , and a final framework for a 3-year action plan for HPG implementation. The final action plan contains 11 recommendations for addressing consumer needs and redressing disparities in late HIV diagnoses, retention in care, and viral suppression rates.

Participant Demographics & Descriptors

- ¾ participants living with HIV, ¼ participants vulnerable to HIV
- 78% identified as MSM, 8% of participants identified as women, and 14% as Transgender/Nonbinary.
- 77% of interview participants identified as community members of color: 36% as Black/African American; 36% as Latinx; 20% as White; and 6% as Bi-racial
- Ages of participants ranged from 20-71 years of age
- Among interview participants, 70% endorsed a history of **one of the following experiences** -
    - Substance use (primarily alcohol and/or methamphetamine)
    - or homelessness & food insecurity,
    - or significant traumatic experiences
    - or mental health symptoms.
- For 11% of the 70% indicating at least one of the above difficulties, the use of drugs included injection drug use.
- Further, among the 70% endorsing at least one of above, 83% of those participants discussed a history **that included all of the above experiences -** not only drug and alcohol use, but also struggles with homelessness, food insecurity, significant traumatic experiences, and mental health symptoms.
- 90% of **those indicating all of the experiences** above also indicated periodic struggles to remain in HIV care and adherent to medication protocols.

Consumer Recommendations Overview

Participants appeared very engaged and thoughtful. Responses were focused both on broad themes including: experiences which have created and reinforced care system mistrust; the need for greater transparency and improved communication about available resources; and the need for greater access to mental health and substance use treatment resources. Participants also offered descriptions of their every-day challenges in

prioritizing their healthcare and the barriers to accessing the systems of HIV care, as well as their suggestions for improvements that might reduce those barriers. These suggestions included improved workforce representation, enhanced communications and improved access to service and health information, greater and more rapid access to mental health and substance use treatments, greater and more rapid access to basic support resources (housing, food, transportation, emergency financial assistance), improved access to peer navigators, access to social support groups, and reduced duplicative, confusing bureaucratic barriers to service.

Brief Listing Consumer Recommendations & Committee Progress thru June 2023

Recommendation 1: Acknowledge and address medical system mistrust
REPRESENTATION **1a.** Ensure progress toward a contracted **HIV service-delivery workforce representative of those living with and at higher risk for HIV in San Diego County and ensure ongoing recruitment, support and retention of this representative workforce**
PROGRESS: Completed. Cultural Humility and Competence Standards including instruction to service providers to "Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success."
1b. Acknowledge systemic racism, missteps, mistakes and harms of the past and ensure plans are created and implemented to ensure ongoing training to help to ensure this past is not repeated.
PROGRESS: Partially completed. Anti-racist Retreat conducted, now awaiting consultant recommendations for further training or dialogues.
1c. WORKFORCE TRAINING CULTURAL HUMILITY, TRAUMA INFORMED CARE Provide access via links to **enhanced, skill-based trainings** to HIV service-delivery staff which improve the ability to consistently communicate **cultural respect, knowledge, and humility**, as well as the skills required for **trauma-informed care**.
Recommendation 2: Improve communications and outreach strategies for those living with and at higher risk for HIV who live, work or participate in historically-underserved, Low Information communities.
2a. Use multiple communications platforms and outreach strategies to better provide HIV services information to HIV community members and historically-underserved communities impacted in San Diego County, including the following HIV services information: What services are available? Where are services located? Who is eligible for services? What is the cost of services to the eligible community member? What is the contact information for scheduling or for more information? **This recommendation is intended to proactively provide the information to the community rather than placing the burden of information seeking solely on consumers.**
PROGRESS: Partially completed and ongoing. Enhanced Communication Plan begun and continuing weekly via email and social media. Awaiting app completion and deployment. Awaiting completion of services App.
2b. Provide increased and readily available **basic health information** to low information, historically-underserved community members and communities, including: **What is early disease detection and why is it important? Where is HIV, HCV, STD testing available? What is PrEP and who is eligible? Importance of early connection to HIV treatment and medication, What does an undetectable viral load mean for transmission of HIV? Information regarding mental health or substance use treatment (both out-patient and residential treatment).**
PROGRESS: Completed and ongoing. Health messaging via social media begun and continuing X2 monthly.
Recommendation 3: Ensure that all HIV community members have opportunities for equitable access to tele-health appointments and to participation in public meetings, address the digital disparities present for those with lower-income who are also living with or at higher risk for HIV
3a. For low-income HIV consumers, and HPG members who have not been able to access County or City digital resource programs, provide opportunities to gain access to affordable or no-cost, broadband internet connectivity and the hardware necessary to participate in healthcare appointments and public meeting opportunities.
PROGRESS: Completed and ongoing. Addressed via standards to allow telehealth to continue (as appropriate) and to provide for access to internet and hardware to those who need it.

3b. For those HIV community members who have experienced digital disparities, provide information regarding virtual training opportunities to learn digital/virtual skills that can allow them to more easily participate in virtual meetings and resources.
Recommendation 4: Provide increased mental health and alcohol/substance use treatment opportunities for those living with or at higher risk for HIV. Additionally, more widely communicate information about these opportunities to HIV community members.
4a. **Coordinating** with the existing harm reduction task force, provide **guidance** to contracted HIV service providers designed to **increase the availability of harm reduction services** for substance misuse treatment.
PROGRESS: Completed and ongoing. Guidance provided
4b. Expand and augment the current syringe exchange program(s) in San Diego County to allow services to be provided for an increased number of community members (including HIV community members) and to include more opportunities for connection to additional needed services (i.e., wound care, MAT, Case management, vaccinations, etc.)
PROGRESS: Completed approval syringe exchange (BOS), 2 programs up in County and ongoing.
4c. **Coordinating** with County drug and alcohol services personnel, ensure the design and implementation of a **coordinated system for rapid response** for HIV community members who desire to enter substance use residential or out-patient treatment.
4d. In light of reported treatment disruptions which often occur for those without secure housing, design and deploy more rapid interventions for consumers, **particularly when insecure housing and either substance misuse or mental health symptoms are co-occurring**.
4e. Investigate the current opportunities for substance use treatment for methamphetamine and, if inadequate opportunities exist, expand those available.
4f. Continue to increase the opportunities for s**ame-site location of medical providers, mental health providers and alcohol/substance use counselors** for those living with or at higher risk for HIV.
4g. **In collaboration with UCSD and AETC,** provide links and resources for **skill-based training for HIV service personnel** regarding the stigmatizing behaviors faced by substance using HIV community members and ways to reduce those stigmatizing behaviors within the health care system itself.
Recommendation 5: More consistently provide rapid access to **basic support services: housing, food, transportation, emergency financial assistance including shut-off** & **eviction prevention. Additionally, more widely communicate information about these opportunities and the processes to access them.**
5a. Chief among those mentioned above and directly related to community members' ability to meaningfully participate consistently in health care is **Housing**.
PROGRESS: Partially completed and continuing. Emergency Housing resources increased and continuing to monitor. Continuing to monitor PARS. Awaiting guidance/outcome of transportation recommendations.
Recommendation 6: Continue to expand the opportunities to hire, support and utilize peer navigators, peer health educators, peer outreach specialists, benefits navigators, and housing specialists.
PROGRESS: Partially completed. Peer Navigation deployed, awaiting housing case management and benefits specialists.
Recommendation 7: Design, integrate, and deploy strategies to address the stigmas faced by HIV community members including: the multiple layers of stigma faced by those living with HIV who are also Black and Latino MSM; Transgender persons; Immigrants who may be under-documented or undocumented; those struggling with mental health symptoms or alcohol/substance use challenges or those without stable housing.
7a. Increase opportunities/programs for participation in Psychosocial Support Groups for those living with or at higher risk for HIV who may, as a function of family or community stigma, have fewer social supports.
PROGRESS: Partially completed. Provided funding for Psychosocial support groups category, but not yet deployed.
Recommendation 8: Increase the number of HIV service sites that have the capacity for whole person-whole health services including PrEP, mental health services, substance use treatment services, hormone treatment, case management, and housing resources. This should include the capacity for coordinated, integrated, same-day, appointments when requested.

PROGRESS: Partially completed. Standard approved to ensure inclusion of Transgender/Nonbinary clients and hormone treatments. Coordinated service centers include mental health and substance use treatment services. Same-day appts not yet widely available to those who prefer them.
Recommendation 9: Design, create and execute improved community engagement and outreach strategies that utilize community organizing principles and personal relationship building. Strategies should include: transportation and meal reimbursements, as well as appropriate and respectful incentives, engaging, interesting meeting opportunities for planning participation and routine report-outs regarding what has been done with HIV community feedback.
Recommendation 10: Revise and refine the documentation processes that create a barrier to access services for persons living with or at increased risk for HIV.
10a. Reduce the duplication of forms and paperwork required to access HIV services.
PROGRESS: Awaiting completion of reduced paperwork process for initial/renewal RW eligibility.
10b. Explore use of an electronic signature system that does not require in-person, wet signatures for eligibility or authorization forms.
PROGRESS: Not available at this time in RW or County systems.
Recommendation 11: Design and deploy a variety of brief, on-line trainings for those living with or at higher risk for HIV. Trainings include but are not be limited to: what is the HIV Planning Group and options for involvement; What is the HPG Consumer group and how to get involved; What are HPG committees and how to get involved; How to effectively advocate for the HIV community.

Additional Data

Several of the community/consumer recommendations listed above are likely familiar to HPG members as they mirror findings from other relevant sources. These findings and their sources are listed below.

- San Diego County and City remain in a "Housing Crisis" with very limited availability of "affordable" housing options, an ever-growing unhoused and insecurely housed population, as well as ten-year wait-lists for government subsidized housing options (Section 8, HOPWA). Further, in Needs Assessment data, consumers continue to endorse being insecurely housed or unhoused in concerning numbers.
- Previous findings contained in Needs Assessment data have found that in order to remain in care, priority populations need basic support services (disproportionately Black MSM, Latinx MSM, Transgender populations and additionally women, specifically black and Latinx women).These support categories include: housing, food, transportation and emergency financial assistance.
- Additionally, the need for improved access to mental health and substance use service opportunities continues to be reflected in Needs Assessment focus groups discussion and themes. Needs Assessment data contained in the Co-Occurring Conditions report also reflects rates of mental health symptoms and substance use challenges that far exceed those endorsed by the non-HIV community sample.
- Two additional data points are provided by several 2021 consumer comments to the HIV Planning Group. These include 1) the need and desire for increased availability of Peer Navigators and/or Educators and 2) the need for Psychosocial Support Groups, particularly for those without familial support in their HIV health pursuits.

Overview HPG & Committee Progress 2022-23

Below listed are the 2022-23 HPG and HPG Committee accomplishments and progress toward addressing the Consumer Recommendations.

HPG

- Continuing to build a more welcoming, inclusive and supportive HPG culture

- HPG Retreat (initial anti-racist training/dialogue completed) and awaiting consultant recommendations for further dialogue training r/e anti-racist activities)
- Approved below-listed Standards
- Approved allocations for increased Housing Funds, Psychosocial Support Groups and Peer Navigation

Communications Task Force

- Enhanced Communications Work Plan drafted which now includes weekly emails and social media posts, including: monthly ICYMI, HIV & Health, Engagement and Participation opportunities. Also includes website enhancement and continuing work to target and expand lists.

Strategies & Standards

- Acknowledge and Address Hesitation& Mistrust
    - Crafted JEDI Principles
    - Potential JEDI Task Force (awaiting future consultant recommendations regarding JEDI Trainings/Dialogue)
- Crafted and approved Standards to ensure:
    - Access to Telehealth
    - Access to Primary Care, including Transgender clients
    - Cultural humility & culturally competent care
        - * Note that this Standard includes below language:
            - "Clients receive education and support to advocate for what they need, speak out when their needs are not being adequately addressed, and receive timely and adequate responses and supports to address their needs."
            - "Client support needs are assessed and reasonable accommodations are available to allow clients to participate in and receive benefit from services."
            - "Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success."

PSRAC

- Recommended allocations to increase access to Housing supports
- Continues to evaluate and focus upon capacity building for mental health services
- Recommended allocations for Peer Navigation and Psychosocial Support Groups

Membership

- Drafted HPG Recruitment Plan and continues to discuss additional items
- Attempting to build an HPG culture of consistent, ongoing Recruitment opportunities for consumers to learn about HPG and receive personal invitations to join HPG & HPG Committees

Consultant Observations & Recommendations – HPG and HPG Committee Ongoing work

This year HPG and its committees, with the help of HPG support staff, has completed 40% of the 3-year Action Plan items, with an additional 30% introduced into the committee process. This is indeed an encouraging and promising beginning! However, with HPG membership at a reduced number of members (27) and a reduced number of committee participants (especially Membership and Community Engagement Committees), it appeared challenging for many members to consistently participate as fully as they would like. Further complicating this has been the recent transitions in HPG support staff personnel and the return to in-person meetings, which created the additional time demands of travel for members and staff. Additionally, next year (2024) brings the end of the HPG terms of ¼ of the current HPG members. Those members terming out are primarily long-term members, many of whom are existing committee members and chairs. These circumstances underline the **need for HPG recruitment, particularly consumer recruitment.**

Recruitment and Training. Consumer recruitment for both HPG and HPG committees is a priority concern for HPG and likely will require active participation and focus by all HPG members and service providers. In addition, to

better ensure success, recruitment will also be accompanied by a need for enhanced training and support. As longer-term members step back to provide training and support, newer members can more confidently step forward to begin their participation and leadership.

Consultant Recommendations for 2023-2024 work

1. Focus upon building the HPG recruitment culture, including fully utilizing the successful Project PEARL program. This focus can include encouraging all HPG members and service providers to reach out to consumers who may be interested in opportunities to participate in HPG and/or it's committees and personally invite them to apply to HPG.
    a. Consult with the Recipient's office regarding the potential tools (standards, contract language, etc.) to provide guidance to contracted HIV service providers as they educate and support consumers in their awareness of and participation in planning opportunities with HPG.
    b. It may be the case that small recruitment events (perhaps held in a variety of provider identified support groups in all regions) may also be an effective vehicle for consumer awareness, education and opportunity to seek participation.
    c. Additionally, pursuing non-RW, private funds to subsidize small stipends for those with lived experience may increase consumer interest in participation.
2. Continue to focus upon building and sustaining a welcoming, inclusive, and supportive HPG culture
3. Continue to complete work on items (listed below) that are still in the committee processes
    a. As a part of that work - receive consultant recommendations regarding trainings, dialogues r/e anti-racist work and begin to implement
4. Begin the designated committee work on items not yet addressed (listed below)
5. **Note:**
    a. Unfinished work remains on Recommendation 10 - bureaucratic duplication for enrollment/recertification – Continue to routinely check on estimated completion
    b. Unfinished work remains on Recommendation 2a - Services Availability application – Continue to routinely check on estimated app completion
    c. Unfinished work remains on transportation service recommendation(s) – continue to check on progress
    d. **Note also** the periodic consumer comments this year about difficulties in accessing mental health services including: uncertainties about whom to call to access, delays of weeks to obtain initial appointments and difficulties in scheduling timely routine appointments once treatment begins. It may be the case that Strategies and Standards needs to review and address Standards of Care for mental health services.
6. In both Steering Committee and Strategies Committees - Begin to discuss potential strategies to comprehensively address the ongoing, multiple **stigmas** encountered by HIV consumers/community members.
7. As MediCal recipients renew and MediCal itself expands eligibility and enhanced services, the potential for decreased demands for RW Part A services exists. HPG can monitor service utilization and explore any potential for increasing funds in other service categories. If funds are available for the basic support services categories, it may help those with the greatest need to more consistently remain in care.

Listing 2022-23 Completed Items and Tasks

Below listed are the specific tasks enumerated in this first Action Plan year and progress to date. **(Initial Tasks Assigned are described in Bold)**

1. ***Completed initial retreat and awaiting consultant recommendations for ongoing trainings/dialogue, Completed Steering, Strategies, HPG.*** **JEDI Principles & Taskforce.**
2. ***Completed, Strategies, HPG.*** **Equitable Access Telehealth: Updating Primary Care standards** to ensure that clients, if interested, can participate in virtual medical visits, including provision of necessary equipment and Internet access
3. ***Completed, Strategies, HPG.*** **Updating Primary Care standards** to include requirements for **serving transgender clients,** including whole-person care, hormone therapy and STD testing and treatment.
4. ***Completed, Strategies, HPG.*** Updating **Client Rights and Responsibilities** to support inclusion of **family members/chosen others in supporting care.**
5. ***Completed, Strategies, HPG.*** **Cultural Humility & Competency: Updated Universal Standards including recruitment and retention of those with lived experience.**
6. ***Completed, Strategies, PSRAC.*** **Requested expanded and completed epi data (including demographic data) and continuum of care (viral loads) as well as multivariate analysis. Strategies and Standards Committee to identify any additional data needs to support planning and implementation of services to reduce disparities in health outcomes.**
7. ***Completed, Steering and HPG.*** Establish clear processes and timelines for **addressing requests from the public** to the HIV Planning Group
8. ***Completed Membership. (for on-line recruitment, now discussing in-person recruitment)*** *With Community Engagement Committee, **further develop and implement a Recruitment Plan for recruitment**
9. ***Completed and ongoing, Communications.*** **Develop and communicate a list of community engagement opportunities** beyond the HIV Planning Group.
10. ***Completed and ongoing, Communications. Continue to refine frequency based on need as further described below.*** The frequency and modes of communications for Communications Plan.
11. **Completed and ongoing, Communications. Continue to review: Post HPG meeting ICYMI emails, Community Events and participation emails at least twice monthly; HIV monthly themes(CDC); membership recruitment for HPG and committees once monthly Describe the types of messages that will be communicated**
12. **Completed and ongoing, Communications. Continue to review use of Instagram, Facebook, Twitter: Strategies for membership recruitment for HPG and committees and community awareness of HPG Describe strategies for use of social media platforms**

Items in active committee process

1. ***In process; Trauma-Informed Care components draft to be submitted in August Strategies Committee.**
2. ***Strategies - Strategies and Standards Committee to review models and resource requirements that would support drop-in services for primary care, mental health, and substance use treatment. In process currently with contract awarded. Services began March 01 2023. Awaiting data to evaluate resource requirements, particularly with regard to drop-in mental health, substance use treatments.**
3. ***Strategies - Strategies and Standards Committee to explore the feasibility and effectiveness of further expanding HIV testing into nontraditional testing sites. In process currently with RFP/Award. Awaiting data to evaluate resources and effectiveness.**
4. ***Steering - Completed and awaiting ongoing consultant recommendations.** Participate in **HPG retreat focused on GTZ Recomendation1: Acknowledge and Address Mistrust (JEDI Principles & Task Force)**
5. ***** **Membership - Discuss the feasibility and desirability of focusing recruitment efforts for service provider seats on frontline staff rather than supervisorial or managerial staff. Membership Committee discussing feasibility now.**
6. ***Community Engagement Committee - Membership committee with Community Engagement Committee to develop Community Engagement Outreach Plan. in process for in-person out-reach plans.**

7. ***Communications – Outline strategies for in-person and on-line outreach. Communications Task Force Currently working on continuing to identify on-line influencers and providers willing to help increase list for communications**
8. ***Communications- Strategies to expand and create consistent culturally respectful communications into high mistrust, low information communities, including communications in Spanish. Communications Task Force *has identified review process for accuracy and appropriateness for Spanish translation but requires further standardization*.**

Remaining Tasks Not yet addressed.

1. *Not yet addressed. **Strategies and Standards Committee** to Update standards for **emergency financial assistance** to identify circumstances where same-day response is warranted
2. *Not yet addressed. **Strategies and Standards Committee** to incorporate strategies for **dismantling HIV-related stigma** among Black, Hispanic and transgender persons living with or vulnerable to HIV
3. *Not yet addressed **Strategies and Standards Committee** to review and **re- evaluate eligibility criteria for basic needs support**
4. *Not yet addressed. **Strategies and Standards Committee** to explore the potential effectiveness and feasibility of funding **mobile health clinic**s
5. *Not yet addressed. **Steering Committee -** Discuss the feasibility and desirability of developing **an online orientation and training** for members of the HIV Planning Group
6. *Not yet addressed.***Membership, Steering** - Strategies to **develop and maintain relationships in neighborhoods** and communities and to involve existing groups and community leaders
7. *Not yet addressed. **Steering** - develop an **evaluation plan** for the communications plan
8. *Not yet fully addressed. **Communications Task Force** - Strategies for development and dissemination of **printed materials**
9. *Not yet fully addressed. **Communications Task Force** - Needs standardization.*Strategies for ensuring that all messaging is accessible to people regardless of **literacy levels or health literacy levels**

San Diego HIV Planning Group
Priority Setting & Resource Allocation Committee

2023 Key Data Findings

Care Continuum/Viral Suppression

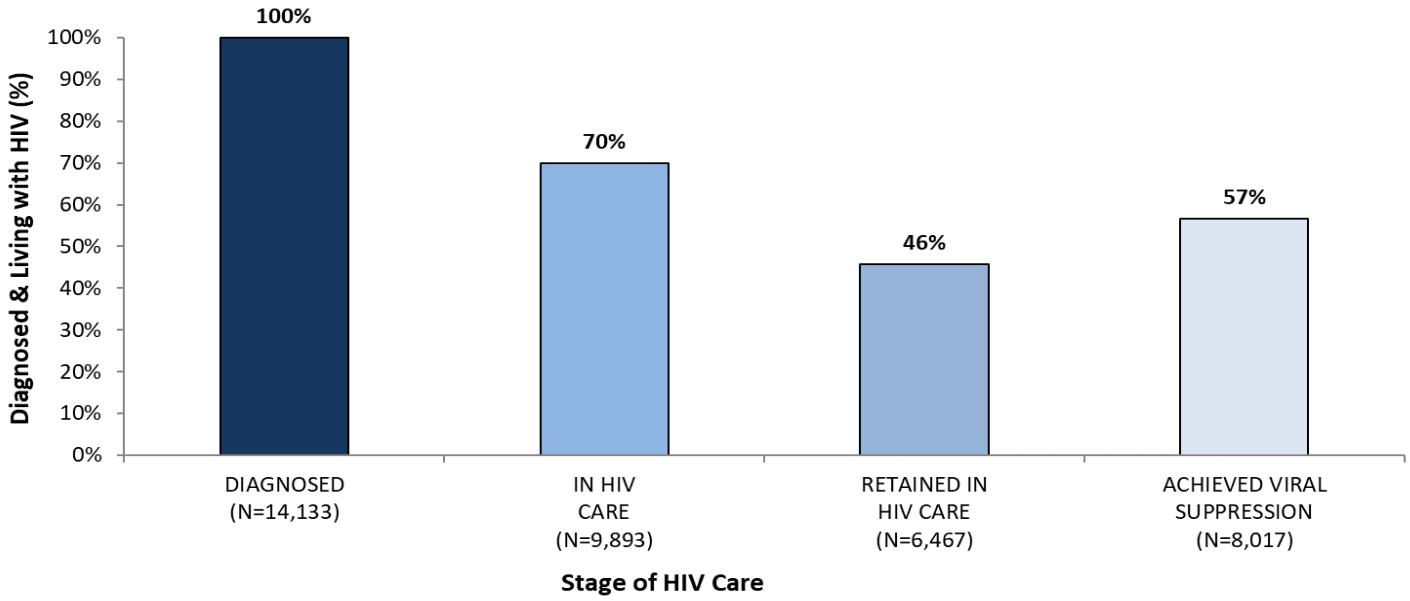
Approved July 20, 2023

San Diego Data: Diagnosed with HIV infection through 12/31/2021 and living through 12/31/2021 (excluding military and VA diagnoses).

DEFINITIONS:

Care Continuum (aka Continuum of Care), includes:

1. **Receipt of care** (sometimes called "Linkage to Care"): Of those diagnosed with HIV disease, persons who had ≥1 CD4 or viral load tests during 2021
2. **Retention in care:** Of those diagnosed with HIV disease, persons who had ≥2 CD4 or viral load tests at least 3 months apart during 2021.
3. **Viral suppression:** Of those diagnosed with HIV disease, persons virally suppressed (<200 copies/mL) at most recent test during 2021.



CARE CONTINUUM/VIRAL SUPPRESSION OVERALL

Viral Suppression of all persons living with HIV (PLWH) in San Diego County was **56.7%**, which includes those without a viral load (VL) test on record) and **92.1%** for PLWH who had a VL test on record. For **Ryan White (RW) clients**, viral suppression was **91.7%** (for those who had a VL test on record.

Population	All PLWH (incl. w/o VL test)	All PLWH w/ VL test	All RW clients w/ VL test
In HIV Care	69.9%	-	92.0%
Retained in HIV Care	45.7%	-	85.2%
Viral Suppression	56.7%	92.1%	91.7%

*Note: 38.9% of all PLWH, and 17% of RW clients, did not have a viral load test.

AGE

There was no significant difference in viral suppression among age groups 25 -44 (55%), 45 – 64 (57%) , or 65+ (59%) age groups compared to all PLWH (56.7%).

Population	All PLWH (incl. w/o VL test)	All PLWH w/ VL test
Age 20 – 29	58%	87%
Age 30 – 39	57%	91%
Age 40 – 49	52%	91%
Age 50 - 59	57%	94%
Age 60+	59%	96%
All clients	56.7%	93%

GENDER

There was no significant difference in viral suppression between cis males (58%) and cis female (57%) compared to all PLWH (56.7%); and no significant different for sex assigned at birth, males (93.1%) vs. females (91%), for those w/ VL test.

RACE/ETHNICITY

African Americans/Blacks had a significant lower level of viral suppression **(50%)**, compared to all PLWH (56.7%), but not for all RW clients w/VL test (88.7% vs. 91.7%). There was no significant difference in viral suppression among Latinx/Hispanics (53%), Native Americans/Alaskan Native (50%, but n = 36), Whites (61%), Asian/API (64%), or Native Hawaiians/Pacific Islanders (58%) compared to all PLWH (56.7%)

Population	All PLWH (incl. w/o VL test)	All PLWH w/ VL test	All RW clients w/ VL test
African Am./Black	**50.0%**	89%	88.7%
Latinx/Hispanic	53%	92%	92%
White	61%	95%	94%
Asian/API	63%	96%	91%
Native Hawaiian/Pacific Islanders	58%	-	88%
Native American/Alaskan Natives	50%	-	92%
Other	67%	93%	-
All Clients	56.7%	93%	91.7%

TRANSMISSION RISK CATEGORY

Persons who inject drugs (46%) and **persons with no identified risk (50%)** had lower percentages of viral suppression compared to all PLWH (56.7%).

Population	All PLWH (incl. w/o VL test)	All PLWH w/ VL test
Persons who inject drugs (PWID)	**46%**	86%
No identified risk (NIR)**	**50%**	82%
All clients	56.7%	93%

**Risk category for persons in NIR may change as additional information becomes available.

San Diego HIV Planning Group
Priority Setting & Resource Allocation Committee

2023 Key Data Findings

Unaware Estimate/Unmet Need Estimate

Approved July 20, 2023

Unaware Estimate:

- The estimate of persons living with HIV disease (PLWH) and **unaware of their status** in San Diego County in 2022 is **1,272 (9%)***(of 14,133 estimated # of PLWH in San Diego County).

Methodology/Limitations: This Unaware estimate was previously based on the proportion CDC estimates unaware nationwide- this is no longer supported. Current recommendations are to develop a method based on local data. The new method is based on the proportion unaware from National HIV Behavioral Surveillance survey conducted in San Diego. One of the limitations is the NHBS survey does not use a random sample or weighted sample; self-reported status subject to social desirability bias.

*The number of PLWH and Unaware of their status in San Diego County was calculated by multiplying the percent unaware of HIV status in most recent NHBS survey by the prevalence from the most recent HIV Care Continuum dataset by each subgroup to get the estimate of those unaware of their status;1,272.

Unmet Need Estimate:

- The estimate of **Unmet Need** among PLWH (person who live with HIV disease, are aware of their status, but are not in care) in San Diego County for 2021 is **4,240 (30%)** (of 14,133 estimated # of PLWH in San Diego County).

All data provided by San Diego County Health & Human Services Agency, Epidemiology, and Immunizations Services Branch (EISB)

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

Policy Clarification Notice (PCN) #16-02
Replaces Policy #10-02

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

Purpose of PCN

This policy clarification notice replaces the Health Resources and Services Administration (HRSA) PCN 10-02: Eligible Individuals & Allowable Uses of Funds for Discretely Defined Categories of Services regarding eligible individuals and the description of allowable service categories for Ryan White HIV/AIDS Program and program guidance for implementation.

Background

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

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

The HIV/AIDS Bureau (HAB) has developed program policies that incorporate both HHS regulations and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S.

Government Accountability Office may assess and publicly report the extent to which a RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

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

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

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

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

RWHAP funds are intended to support only the HIV-related needs of eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with RWHAP funds and the intended client's HIV status, or care-giving relationship to a person with HIV.

Eligible Individuals:

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

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

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

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

b. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income HIV-infected family member, or child care for children, while an infected parent secures medical care or support services.

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

d. Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member.

Unallowable Costs:
RWHAP funds may not be used to make cash payments to intended clients of RWHAP-funded services. This prohibition includes cash incentives and cash intended as payment for RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers,

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the RWHAP are allowable as incentives for eligible program participants.

coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

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

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services
- Funeral and Burial Expenses
- Property Taxes

Allowable Costs:
The following service categories are allowable uses of RWHAP funds. The RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for RWHAP Part recipient implementation. These service category descriptions apply to the entire RWHAP. However, for some services, the RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a RWHAP Part would cover all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to care for seropositive individuals, retention in care, and the provision of HIV treatment. To be an allowable cost under the RWHAP, all services must relate to HIV diagnosis, care and support and must adhere to established HIV clinical practice standards consistent with HHS treatment guidelines. In addition, all providers must be appropriately licensed and in compliance with state and local regulations. Recipients are required to work toward the development and adoption of service standards for all RWHAP-funded services.

[3] General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

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

RWHAP Services

AIDS Drug Assistance Program Treatments
AIDS Pharmaceutical Assistance
Child Care Services
Early Intervention Services (EIS)
Emergency Financial Assistance
Food Bank/Home Delivered Meals
Health Education/Risk Reduction
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
Home and Community-Based Health Services
Home Health Care
Hospice Services
Housing
Legal Services
Linguistic Services
Medical Case Management, including Treatment Adherence Services
Medical Nutrition Therapy
Medical Transportation
Mental Health Services
Non-medical Case Management Services
Oral Health Care
Other Professional Services
Outpatient/Ambulatory Health Services
Outreach Services
Permanency Planning
Psychosocial Support Services
Referral for Health Care and Support Services
Rehabilitation Services
Respite Care
Substance Abuse Outpatient Care
Substance Abuse Services (residential)

Effective Date

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

Appendix

RWHAP Legislation: Core Medical Services

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Program Guidance:
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program
See Early Intervention Services

AIDS Drug Assistance Program Treatments
Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must conduct a cost effectiveness analysis to ensure that purchasing health insurance is cost effective compared to the cost of medications in the aggregate.

Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Program Guidance:
See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance; and

PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance
Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.

1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

   RWHAP Part A or B recipients using the LPAP service category must establish the following:
   - Uniform benefits for all enrolled clients throughout the service area
   - A recordkeeping system for distributed medications
   - An LPAP advisory board
   - A drug formulary approved by the local advisory committee/board
   - A drug distribution system
   - A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
   - Coordination with the state's RWHAP Part B ADAP
     - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
   - Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:

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

Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See Ryan White HIV/AIDS Program Part A and B National Monitoring Standards
See also LPAP Policy Clarification Memo
See also AIDS Drug Assistance Program Treatments and Emergency Financial Assistance

Oral Health Care
Description:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

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

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

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

- RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
    - Other clinical and diagnostic services related to HIV diagnosis

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

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core

antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services

- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying cost-sharing on behalf of the client

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

See PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance;
PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid; and
PCN 14-01: Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

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

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:

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

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:

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

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

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

See Food-Bank/Home Delivered Meals

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

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

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

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

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

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

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

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

Program Guidance:
Mental Health Services are allowable only for HIV-infected clients.

See Psychosocial Support Services

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

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

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

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

See Substance Abuse Services (residential)

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

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

Program Guidance:
Medical Case Management services have as their objective <u>improving health care outcomes</u> whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in <u>improving access</u> to needed services.

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

RWHAP Legislation: Support Services

Non-Medical Case Management Services
Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Child Care Services
Description:
The RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care

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

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

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

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories

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

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

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

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

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

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

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

See Early Intervention Services

Housing
Description:
Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation.

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Program Guidance:
RWHAP Part recipients must have mechanisms in place to allow newly identified clients access to housing services. Upon request, RWHAP recipients must provide HAB with an individualized written housing plan, consistent with RWHAP Housing

Policy 11-01, covering each client receiving short term, transitional and emergency housing services. RWHAP recipients and local decision making planning bodies, (i.e., Part A and Part B) are strongly encouraged to institute duration limits to provide transitional and emergency housing services. The US Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients consider using HUD's definition as their standard.

Housing services funds cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

See PCN 11-01 The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs

Legal Services
See Other Professional Services

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

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

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

Program Guidance:
Medical transportation may be provided through:

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

- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Unallowable costs include:

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

Other Professional Services

Description:

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

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

Program Guidance:

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

See 45 CFR § 75.459

Outreach Services
Description:
Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services

Program Guidance:
Outreach programs must be:

- Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior
- Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

Funds may not be used to pay for HIV counseling or testing under this service category.

See Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

See Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support (RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups

- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

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

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

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

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

See Respite Care Services

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

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

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

Rehabilitation Services
Description:
Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.

Program Guidance:

Examples of allowable services under this category are physical and occupational therapy.

Respite Care
Description:
Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

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

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

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

See Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

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

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

Substance Abuse Services (residential) are not allowable services under RWHAP Parts C and D.

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

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