LOS ANGELES COUNTY
COMMISSION ON HIV

AGING CAUCUS
VIRTUAL MEETING AGENDA
TUESDAY, JUNE 13, 2023
1:00 PM – 2:30 PM
TO JOIN BY WEBEX, CLICK:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mace189f08b7fafcf0f6260b38ef08a08
Join by phone : +1-213-306-3065
Meeting Number and Access Code: 2591 658 3780
Password: AGING

1	Welcome & Introductions	1:00pm-1:10pm
2	Co-Chairs' Report Comprehensive HIV Plan 2022-2026 | Proposed a. Ideas for Aging Caucus Activities b. STDs and HIV in Older Adults | Status Neutral Opportunities	1:10pm-1:15pm
3	Division of HIV and STD Programs (DHSP) Report **a.** Internal Workgroups Status Report	1:15pm-1:25pm
4	DISCUSSION: Planning for National HIV/AIDS and Aging Awareness Day *a. Finalize theme/topic – Sexual Health in Older Adults?* *b. Determine date in September, presentation/panel objectives, speakers, and format.- September 8 in person? Time to be determined* **c.** *Aging Caucus Co-Chairs to meet with Department of Aging leadership on June 19 for Collaboration*	1:25pm-1:45pm
5	Conference and Training Reports | American Geriatric Society Annual Meeting (May 4-6, 2023)	1:45pm-1:50pm
6	Commission Bylaws Review | Feedback	1:50pm-2:05pm
7	Executive Director/Staff Report a. Equity Lens for Decision Making Tool	2:05pm-2:10pm
8	Next Steps and Agenda Development for Next Meeting Future Meetings | Proposed Topics a. Aging in BIPOC Women Communities b. November Annual Meeting i. Disability and aging **ii.** Older adults and housing	2:10pm-2:15pm
9	Public Comments & Announcements	2:15pm-2:20pm
10	Adjournment	2:30pm

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING CAUCUS
April 4, 2023
Virtual Meeting Summary

In attendance:

Kevin Donnelly (Co-Chair)	**Paul Nash (Co-Chair)**	Jayda Arrington
Al Ballesteros	Alasdair Burton	Viviana Criado
David	Arlene Frames	Joe Green
Lee Kochems	Elicica Morris	Pamela Ogata (DHSP)
Russel Ybarra	Cheryl Barrit (COH Staff)	Catherine Lapointe (COH Staff)
Lizette Martinez (COH Staff)		

COH: Commission on HIV
DHSP: Division of HIV and STD Programs
DPH: Department of Public Health

1. Welcome & Introductions

Kevin Donnelly, Aging Caucus Co-Chair, called the meeting to order at 1:03 PM, welcomed attendees, and led introductions.

2. Co-Chairs' Report

a. Planning for National HIV/AIDS and Aging Awareness Day | Update

Determine date in September, presentation/panel objectives, speakers, and format.

The Aging Caucus began planning for a National HIV/AIDS and Aging Awareness Day (September 18) event. Elicica Morris and Russell Ybarra suggested having an in-person event. The group concurred. Cheryl Barrit, Executive Director, COH, requested if the event could be co-sponsored by the Los Angeles Alliance for Community Health and Aging (LAACHA). Viviana Criado, Project Manager, LAACHA, agreed and suggested forming a small planning group to discuss the event. Those interested in volunteering can contact C. Barrit at cbarrit@lachiv.org. K. Donnelly suggested including a panel presentation with people living with HIV (PLWH) with lived experience. Dr. Paul Nash, Aging Caucus Co-Chair, suggested a stand-alone event and inviting service providers to the event to highlight where services are or are not being met.

b. Conference Updates

i. Conference on Retroviruses and Opportunistic Infections (CROI) National AIDS Treatment Advocacy Project – Aging, Comorbidities and HIV CROI Updates

K. Donnelly informed the Caucus that the CROI recording can be accessed here. He reported that more research is needed on women living with HIV and on how to age well.

ii. American Society on Aging

Dr. Nash reported that he attended the American Society on Aging Conference, which was targeted for service providers and agencies who serve the aging population. The conference had two presentations centered on HIV, aging, and stigma; however, the data were 5-10 years old, highlighting the need for more up to date research. Dr. Nash shared that he was a keynote speaker at the conference and presented on the intersectionality of HIV and aging.

Pamela Ogata, DHSP staff, shared that the American Geriatrics Society 2023 Annual Scientific Meeting will take place in Long Beach from May 4-6, 2023.

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

P. Ogata reported that the workgroup on assessment and training on gerontology for providers met on April 3, 2023. DHSP will begin reimagining Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services to include the needs of older adults. DHSP staff will develop a timeline and share with the Caucus.

P. Ogata noted that first step is for DHSP to review gerontology trainings currently available and identifying gaps specific to HIV and aging. Dr. P. Nash noted that he is leading efforts to develop micro-trainings (10 mins in duration) at USC- an alternative approach to retaining attention for learning.

P. Ogata will work with Commissioners Joe Green and Arlene Frames to schedule a meeting for the housing workgroup. J. Green requested to also be added to the peer support workgroup (#3: Acknowledge and support nontraditional family relationships that nurture well-being and social connection).

4. DISCUSSION: Comprehensive HIV Plan and Aging-related Strategies

a. Strategy 2H – Expand capacity to provide whole-person care to PLWH who are age 50 and older and long-term survivors

K. Donnelly presented Strategy 2H of the Comprehensive HIV Plan (CHP) 2022-2026 to the Caucus and provided an opportunity for open feedback on how to achieve the strategy (expand capacity to provide whole-person care to PLWH who are age 50 and older and long-term survivors). Al Ballesteros inquired about the reasoning and purpose behind achieving this goal. K. Donnelly responded that the CHP serves as a guide for

addressing the HIV epidemic in Los Angeles County (LAC) and he would like to help move the strategies forward. V. Criado noted that it is important to ensure that the system of care supports the strategies identified in the CHP. Dr. Nash added that addressing Strategy 2H can help facilitate positive change. A. Ballesteros stated that the COH does not have the authority to expand the capacity to provide whole-person care; the responsibility falls on DHSP. A. Ballesteros provided the following suggestions on how to address Strategy 2H, considering the charge and capacity of the Aging Caucus:

- The Aging Caucus could get information from within the currently funded DHSP system about organizations or agencies and their approaches to dealing with their aging populations receiving care (medical, mental health, case management, etc.).
- The Caucus could ask the following questions: What are these agencies doing? Is it working? What holes/gaps exist?
- The answers to the aforementioned questions could be collected and presented to the Caucus by DHSP, the contracting agency. Based on the information presented, the Caucus could identify mechanisms DHSP uses to ensure quality of care across those funded agencies and categories with respect to aging people.
- The Caucus could identify gaps in best practices and request further research and work with SBP to strengthen standards.

b. Identify 1 priority activity to accomplish for 2023

Jayda Arrington commented that it is difficult to accomplish the tasks identified in the CHP as a consumer and inquired about the purpose behind the strategies. A. Ballesteros reiterated that the strategies are outside the scope of the Aging Caucus.

5. Executive Director/Staff Report

a. Pandemic Response and Recovery Task Force Board Motion

C. Barrit shared the Board of Supervisors (BOS) Motion on the Pandemic Response and Recovery Task Force for immunocompromised individuals and people living with disabilities. As part of the motion, the Department of Aging was directed to form a task force of community stakeholders to develop a set of recommendations as part of the County's ongoing commitment to be better prepared for future pandemics and public health emergencies. The COH was invited to serve as a stakeholder for the task force. The group will meet next on Tuesday, April 11th at the Vermont Corridor from 9:30 to 11:30 AM. All Caucus members were invited to attend the meeting. V. Criado noted that this is a great opportunity to provide representation for affected populations.

6. Next Steps and Agenda Development for Next Meeting

a. NEXT MEETING: June 13, 2023

- P. Ogata will provide an update on the progress of the various DHSP workgroups.
- The Caucus did not yet decide if the June 6th meeting will be held virtually or in-person.
- Dr. Nash requested if the June meeting could be moved to the 13th rather than the 6th due to a scheduling conflict. The Caucus agreed to hold their next meeting on June 13th.

7. Public Comments & Announcements

J. Green invited Caucus members to join the Bylaws Review Task Force.

8. Adjournment

The meeting was adjourned by K. Donnelly at 2:32 PM.

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March 13, 2022

To: Michael Green, PhD, MHSA, Chief Planning, Development and Research, Division of HIV and STD Programs, Department of Public Health, County of Los Angeles

Jesus "Chuy" Orozco, HOPWA Program Manager, City of Los Angeles Housing Department

From: Kevin Donnelly and Dr. Paul Nash, Aging Caucus Co-Chairs

Re: Housing for Older Living with HIV

As reported at the March 9, 2023 Commission on HIV meeting, the Aging Caucus heard from two long-term survivors/older adults living with HIV who shared challenges they experienced with aging and accessing housing services. We are providing a summary of their testimonies to bring to your attention the barriers clients face when accessing housing services. While these testimonies focused on the experiences of two individuals, we believe they reflect larger system issues that prevent PLWH, especially older adults, from accessing critical support services such as housing, in a timely and efficient manner.

- Both speakers spoke about having to talk to multiple case managers with different information about housing eligibility and related services—they talked about not having a clear road map of what the housing application process entails and were not provided a specific timeline for securing the services they need or information about waiting lists associated with housing programs. One speaker spoke to five case managers, the other with two.
- At the time of their attendance at the February 7 Aging Caucus meeting, there was no plan in place for long-term housing while they were in interim housing. Consequently, they were likely to be in the streets again after a few weeks of being in temporary or emergency housing.
- These two individuals have been able to maintain stable housing for over 25 years but lost their housing due to rising rents and being evicted by developers/investors. They never thought they would be in this predicament (homeless, living on the streets) as older adults living with HIV.
- Driving long distances to see their medical provider could be a challenge depending on where they find housing (temporary and/or permanent).
- Cost of living and housing affordability are major issues affecting their survival.

- They spoke about not knowing whom to talk to or where to go for mental health and other services.
- Conducting research on available services on their own was overwhelming.
- Their stories underscore that the safety net does not have a way to catch older adults with HIV when they lose stable housing. They are often given the option to live in Skid Row which does not serve their needs or may exacerbate their health conditions.
- They would like to see educational workshops on services in all places where HIV and seniors programs are offered.
- The clients expressed that it is also difficult to get proper nutrition when they do not have access to a kitchen or refrigeration, which is often the case with temporary motel housing.
- One speaker was told there is a 3 month wait for an appointment to see a psychiatrist.

We remain committed to working with you on addressing the housing crisis for people living with HIV (PLWH) and its profound impact on older adults living with HIV.

cc: Bridget Gordon
Luckie Fuller

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Comprehensive HIV Plan (CHP) 2022-2026 | HIV and Aging
Proposed Activities for the Aging Caucus

Role: Evaluate CHP objectives and recommendations made with respect to the HIV care system that exists now primarily funded by the Division of HIV and STD Programs (DHSP).

Focus: Focus on objectives 2H.1 through 2H5; spread out work through 2026

Activities:

- Review the current system of care and identify where DHSP-funded patients over the age of 50 receive care; review actual number of patients and DHSP-funded agencies approach care for this population; identify best practices that may be adopted across DHSP-funded agencies

- Assess client education and promotion of services.

- Review how DHSP ensures quality of care for this population across all the DHSP-funded categories, i.e., medical, dental, mental health, etc. Compare, and contrast how different systems/entities (such as Kaiser, VA system, etc.) address this population.

- Acquire data from DHSP on number of clients eligible and number of clients served under services that address psychosocial and behavioral health needs, substance use treatment, mental health treatment, nutritional support and social isolation. Identify barriers to utilization of services.

- Identify whether there is a mechanism for DHSP to evaluate the effectiveness of these services to decrease or address social isolation.

- Work with Commission staff to conduct analysis of other systems that are doing similar efforts for aging populations.

- Acquire report from DHSP on whether or not the screening tools proposed by the Aging Caucus are used and at what percentage of providers are using the screening tools. Include information on average time for referral. Request copies of screening tools used.

- Determine if DHSP-contracted providers screen patients for comprehensive benefits analysis and financial screening; determine if DHSP-funded agencies assess access to

caregiving support. What credentials are required for the staff? What training do they receive and what ongoing training is neededto do this specialized benefits counseling?

- Review Home-Based Case Management service standards for alignment with OT and PT assessments *(add to Standards and Best Practices' Workplan for 2023-2024)*

Activity 2C.4: Leverage and monitor CalAIM to ensure their programs are appropriate and effective for PLWH
Activity 2C.5: Develop transitional case management programs that help PLWH transition from Ryan White Program into Medi-Cal, Medicare and CalAIM, and develop case management services that can monitor if care and support services are meeting the needs of PLWH post-transition.
Activity 2C.6: Expand the use of street medicine for unhoused PLWH and at-risk for HIV
Strategy 2D: Expand the promotion of Ryan White Program services to increase awareness, access to, and utilization of available medical care and support services for PLWH
Activity 2D.1: Assess how clients are currently learning about available RWP services. Identify existing and new resources to assist with promotion and educational outreach including, but not limited to, print materials and online resources
Strategy 2E: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH
Activity 2E.1: Determine processes and program operations for housing assistance that are aligned with federal funding guidance and restrictions
Activity 2E.2: Identify potential housing partners positioned to serve PLWH and implement an expanded housing program.
Strategy 2F: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH
Activity 2F.1: Develop processes and program operations for a pilot program that is acceptable to clients and is aligned with federal funding guidance and restrictions
Activity 2F.2: Identify potential clinical sites, train staff on pilot processes, and implement program
Activity 2F.3: Develop a robust evaluation plan to determine continued use of financial incentives and potential for expansion to other populations
Strategy 2G: RFP: EHE Priority Populations Interventions
Activity 2G.1: Develop and release RFP to fund 7-10 contracts for identified interventions
Strategy 2H: Expand capacity to provide whole-person care to PLWH who are age 50 and older and long-term survivors[59]
Activity 2H.1: Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services[64]
Activity 2H.2: Identify and implement best practices related to addressing psychosocial and behavioral health needs of older PLWH and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation[59]
Activity 2H.3: Review/update diagnostic screenings to include age-related conditions (i.e. screen for loneliness, ACEs, depression, anxiety, experiences of discrimination), using LA County Commission on HIV's Aging Task Force recommendations as a guide
Activity 2H.4: Screen patients for comprehensive benefits analysis and financial screening; and assess access to caregiving support

[64] Adapted from the NHAS, 2022-2025

Activity 2H.5: Review Home-Based Case Management service standards for alignment with OT and PT assessments
Key Partners: RWP-supported HIV service providers, HIV medical providers outside of RWP network, FQHCs and Community Health Centers, HIV and STD Testing Providers, HOPWA, CA Dept. of Healthcare Services; LAC DHS Housing for Health program, LAC Homeless Services Authority (LAHSA), additional housing and homeless service providers, immigrant rights groups, public and private health plans, LAC DMH, LAC DHS, and City of Long Beach and City of Pasadena Health Departments.
Potential Funding Resources: HRSA EHE; HRSA CARES; HRSA RWP Part A; HRSA RWP Part B; HRSA RWP Minority AIDS Initiative; CDC Medical Monitoring Project; EHE funding to FQHCs, Academic Institutions/Research, and AIDS Education and Training Centers.
Outcomes: • Increased rapid linkage to HIV medical care • Increased early initiation of ART • Increased support to providers for linking, retaining, and re-engaging PLWH to care and treatment • Increased capacity to serve PLWH 50 and older and long-term survivors • Increased utilization of RWP core services among PLWH • Increase viral suppression among PLWH
Monitoring Data Source: HIV Casewatch, DHSP HIV Surveillance (eHARS), Medical Monitoring Project (MMP)
Expected Impact on HIV Care Continuum: Increase the percentage of PLWDH who are linked to HIV care within 90 days by 19% & and who are linked to HIV care within 7 days by 11%. Increase viral suppression rate by 34% (from 61% to 95%).
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☐ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

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AGING CAUCUS VOLUNTEERS

Division of HIV and STD Programs (DHSP) Workgroups - Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging (Updated 2.8.23)

#	Activity Description	Commission/Aging Caucus Volunteers
1	Examine housing inventory to ensure that it provides safe and welcoming environments for seniors	Arlene Frames frames.arlene1@yahoo.com Joseph Green joseph.green.ca@gmail.com
2	Add gerontology training to Ambulatory Outpatient Medical, Oral Health, Medical Care Coordination and Mental Health services providers to improve awareness and understanding of age-related inequities in care and treatment	Paul Nash pnash@usc.edu Viviana Criado VCriado@ph.lacounty.gov
3	Acknowledge and support nontraditional family relationships that nurture well-being and social connection	Alasdair Burton alasdairburton@gmail.com
4	Seek out mental health specialists who can treat both HIV and age-related conditions	Kevin Donnelly kevinjdonnelly.lacchoh@gmail.com Joseph Green joseph.green.ca@gmail.com

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POLICY/PROCEDURE #06.1000	Bylaws of the Los Angeles County Commission on HIV	Page 1 of 20

ADOPTED, 7/11/2013

SUBJECT: **The Bylaws of the Los Angeles County Commission on HIV.**

PURPOSE: **To define the governance, structural, operational and functional responsibilities and requirements of the Los Angeles County Commission on HIV.**

BACKGROUND:

- **Health Resources and Services Administration (HRSA) Guidance**: "Planning Councils must set up planning council operations to help the planning council to operate smoothly and fairly. This includes such features as bylaws, open meetings, grievance procedures, and conflict of interest standards." [Ryan White HIV/AIDS Program Part A Manual, VI (Planning Council Operations), 1. Planning Council Duties, C. Fulfilling Planning Council Duties, Planning Council Operations].

- **Centers for Disease Control and Prevention (CDC) Guidance: "**The HIV Planning Group (HPG) is the official HIV planning body that follows the *HIV Planning Guidance* to inform the development or update of the health department's Jurisdictional HIV Prevention Plan, which depicts how HIV infection will be reduced in the jurisdiction."

- **Los Angeles County Code, Title 3—Chapter 3.29.070 (Procedures)**: "The Commission shall adopt bylaws which may include provisions relating to the time and place of holding meetings, election and terms of its co-chairs and other officers, and such other rules and procedures necessary for its operation."

POLICY:

1) **Consistency with the Los Angeles County Code:** The Commission's Bylaws are developed in accordance with the Los Angeles County Code, Title 3—Chapter 29 ("Ordinance"), the authority which establishes and governs the administration and operations of the Los Angeles County Commission on HIV. These Bylaws serve as the Commission's administrative, operational and functional rules and requirements.

2) **Ryan White Program Review:** The Commission's activities and actions in execution of its role as Los Angeles County's Ryan White Part A planning council and funded by Ryan White

Part A administrative funds are subject to the conditions of the Ryan White Program, as managed by the Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau ("DMHAP/HAB"), Health Resources and Services Administration ("HRSA"), US Department of Health and Human Services (DHHS). Prior to approval by its members, the Commission must submit the Bylaws for review to the Ryan White Part A project officer, and re-submit the final version following their approval by the Commission.

3) **Commission Bylaws Approval**: The Commission's Bylaws must be amended accordingly following amendments to the Ordinance. Amendments or revisions to these Bylaws must be approved by a two-thirds vote of the Commission members present at the meeting, but must be noticed for consideration and review at least ten days prior to such meeting (*see Article XVI*).

ARTICLES:

I. NAME AND LEGAL AUTHORITY:

Section 1. Name. The name of this Commission is the Los Angeles County Commission on HIV.

Section 2. Created. This Commission was created by an act of the Los Angeles County Board of Supervisors ("BOS"), codified in sections 3.29.010 – 3.29.120, Title 3— Chapter 29 of the Los Angeles County Code.

Section 3. Organizational Structure. The Commission on HIV is housed as an independent commission within the Executive Office of the BOS in the organizational structure of the County of Los Angeles.

Section 4. Duties and Responsibilities. As defined in Los Angeles County Code 3.29.090 (*Duties*), and consistent with Section 2602(b)(4) (42 U.S.C § 300ff-12) of Ryan White legislation, HRSA guidance, and requirements of the CDC HIV Planning Guidance, the Commission is charged with and authorized to:

A. Develop a comprehensive HIV plan that is based on assessment of service needs and gaps and that includes a defined continuum of HIV services; monitor the implementation of that plan; assess its effectiveness; and collaborate with the Division of HIV and STD Programs ("DHSP")/Department of Public Health ("DPH") to update the plan on a regular basis;

B. Develop standards of care for the organization and delivery of HIV care, treatment and prevention services;

C. Establish priorities and allocations of Ryan White Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee's allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations and comprehensive HIV plan, without the review of individual contracts; provide and monitor directives to the grantee

on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the BOS and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan;

D. Evaluate service effectiveness and assess the efficiency of the administrative mechanism, with particular attention to outcome evaluation, cost effectiveness, rapid disbursement of funds, compliance with Commission priorities and allocations, and other factors relevant to the effective and efficient operation of the local Eligible Metropolitan Area's ("EMA") delivery of HIV;

E. Plan and develop HIV and public health service responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STD clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STD and co-morbidity response;

F. Study, advise, and recommend to the BOS, the grantee and other departments policies and other actions/decisions on matters related to HIV;

G. Inform, educate, and disseminate information to consumers, specified target populations, providers, the general public, and HIV and health service policy makers to build knowledge and capacity for HIV prevention, care, and treatment, and actively engage individuals and entities concerned about HIV;

H. Provide a report to the BOS annually, no later than June 30th, describing Los Angeles County's progress in ending HIV as a threat to the health and welfare of Los Angeles County residents with indicators to be determined by the Commission in collaboration with DHSP; make other reports as necessary to the BOS, the grantee, and other departments on HIV-related matters referred for review by the BOS, the grantee or other departments;

I. Act as the planning body for all HIV programs in DPH or funded by the County; and

J. Make recommendations to the BOS, the grantee and other departments concerning the allocation and expenditure of funding other than Ryan White Part A and B and CDC prevention funds expended by the grantee and the County for the provision of HIV-related services.

Section 5. Federal and Local Compliance. These Bylaws ensure that the Commission meets all Ryan White, HRSA, and CDC requirements and adheres to the Commission's governing Los Angeles County Code, Title 3—Chapter 29.

Section 6. Service Area. In accordance with Los Angeles County Code and funding designations from HRSA and the CDC, the Commission executes its duties and respon-

sibilities for the entire County.

A. The geographic boundaries of Los Angeles County match the funding designnations from both the CDC and HRSA, which calls the Part A funding area an Eligible Metropolitan Area ("EMA").

II. MEMBERS:

Section 1. Definition. A member of this Commission is any person who has been duly appointed by the BOS as a Commissioner, Alternate or a Community Member.

A. Commissioners are appointed by the BOS as full voting members to execute the duties and responsibilities of the Commission;

B. Alternates are appointed by the BOS to substitute for HIV-positive Commissioners when those Commissioners cannot fulfill their respective Commission duties and responsibilities;

C. Community Members are appointed by the BOS to serve as voting members on the Commission's standing committees, according to the committees' processes for selecting Community Members.

Section 2. Composition. As defined by Los Angeles County Code 3.29.030 (*Membership*), all members of the Commission shall serve at the pleasure of the BOS. The membership shall consist of fifty-one (51) voting members. Voting members are nominated by the Commission and appointed by the BOS. Consistent with the Open Nominations Process, the following recommending entities shall forward candidates to the Commission for membership consideration:

A. Five (5) members who are recommended by the following governmental, health and social service institutions, among whom shall be individuals with epidemiology skills or experience and knowledge of Hepatitis B, C and STDs:
   1. Medi-Cal, State of California,
   2. City of Pasadena,
   3. City of Long Beach,
   4. City of Los Angeles,
   5. City of West Hollywood;

B. The Director of DHSP, representing the Part A grantee (DPH);

C. Four (4) members who are recommended by Ryan White grantees as specified below or by representative groups of Ryan White grant recipients in the County, one from each of the following:
   1. Part B (State Office of AIDS),
   2. Part C (Part C grantees),
   3. Part D (Part D grantees),
   4. Part F [Part F grantees serving the County, such as the AIDS Education and Training Centers (AETCs), or local providers receiving Part F dental reimbursements];

D. Eight (8) provider representatives who are recommended by the following types of organizations in the County and selected to ensure geographic diversity and who reflect the epicenters of the epidemic, including:
   1. An HIV specialty physician from an HIV medical provider,
   2. A Community Health Center/Federally Qualified Health Center ("CHC"/ "FQHC") representative,
   3. A mental health provider,
   4. A substance abuse treatment provider,
   5. A housing provider,
   6. A provider of homeless services,
   7. A representative of an AIDS Services Organization ("ASO") offering federally funded HIV prevention services,
   8. A representative of an ASO offering HIV care and treatment services;

E. Seventeen (17) unaffiliated consumers of Part A services, to include:
   1. Eight (8) consumers, each representing a different Service Planning Area ("SPA") and who are recommended by consumers and/or organizations in the SPA,
   2. Five (5) consumers, each representing a supervisorial district, who are recommended by consumers and/or organizations in the district,
   3. Four (4) consumers serving in an at-large capacity, who are recommended by consumers and/or organizations in the County;

F. Five (5) representatives, with one (1) recommended by each of the five (5) supervisorial offices;

G. One (1) provider or administrative representative from the Housing Opportunities for Persons with AIDS (HOPWA) program, recommended by the City of Los Angeles Department of Housing;

H. One (1) representative of a health or hospital planning agency who is recommended by health plans in Covered California;

I. One (1) behavioral or social scientist who is recommended from among the respective professional communities;

J. Eight (8) representatives of HIV stakeholder communities, each of whom may represent one or more of the following categories. The Commission may choose to nominate several people from the same category or to identify a different stakeholder category, depending on identified issues and needs:
   1. Faith-based entities engaged in HIV prevention and care,
   2. Local education agencies at the elementary or secondary level,
   3. The business community,
   4. Union and/or labor,
   5. Youth or youth-serving agencies,
   6. Other federally funded HIV programs,
   7. Organizations or individuals engaged in HIV-related research,
   8. Organizations providing harm reduction services,

9. Providers of employment and training services, and
10. HIV-negative individuals from identified high-risk or special populations.

Section 3. Term of Office. Consistent with the Los Angeles County Code 3.29.050 (*Term of Service*), all members serve two-year terms.

A. Commissioner and Alternate members serve two-year staggered terms.

B. A Community Member's term begins with the date of appointment.

C. Members are limited to two consecutive terms in the same seat, unless waived by vote of the BOS.

Section 4. Unaffiliated Consumer Membership. In accordance with Ryan White Part A legislative requirements outlined in Section 2602(b)(5)(C) and consistent with Policy/Procedure #08.3107 (*Consumer Definitions and Related Rules and Requirements*), the Commission shall ensure that 33% of its members are consumers of Ryan White Part A services who are not aligned or affiliated with Ryan White Part A-funded providers as employees, consultants, or Board members.

A. At least two (2) of the Commission's unaffiliated consumer members are expected to fill two (2) of the membership categories requiring representation, as defined in Ryan White legislation:
   1. At least one (1) unaffiliated consumer member must be co-infected with Hepatitis B or C; and
   2. At least one (1) unaffiliated consumer member must be a person who was incarcerated in a Federal, state or local facility within the past three (3) years and who has a HIV diagnosis as of the date of release, or is a representative of the recently incarcerated described as such.

Section 5. Reflectiveness. In accordance with Ryan White Part A legislative requirements [Section 2602(b)(1)], the Commission shall ensure that its full membership and the subset of unaffiliated consumer members proportionately reflect the ethnic, racial and gender characteristics of HIV disease prevalence in the EMA.

Section 6. Representation. In accordance with Ryan White Part A legislative requirements [Section 2602(b)(2)], the Commission shall ensure that all appropriate specific membership categories designated in the legislation are represented among the membership of Commission.

A. Commission membership shall include individuals from areas with high HIV and STD incidence and prevalence.

Section 7. Parity, Inclusion, and Representation (PIR). In accordance with CDC's *HIV Planning Guidance,* the planning process must ensure the parity and inclusion of the members.

A. "'Parity' is the ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation

and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities."

B. "'Inclusion' is the meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included."

C. "Representation" means that "members should be representative of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise."

Section 8. HIV and Target Population Inclusion. In all categories when not specifically required, recommending entities and the Commission are strongly encouraged to nominate candidates living with HIV and individuals who are members of populations at disproportionate risk for HIV.

Section 9. Accountability. Members are expected to report to and represent their recommending entities and constituencies. Members may, at times, represent multiple constituencies.

Section 10. Alternates. In accordance with Los Angeles County Code 3.29.040 (*Alternate members*), any Commission member who has disclosed that s/he is living with HIV is entitled to an Alternate who shall serve in the place of the Commissioner when necessary.

A. Alternates submit the same application and are evaluated and scored by the same nomination process as Commissioner candidates.

Section 11. Community Members. Consistent with the Los Angeles County Code 3.29.060 D (*Meetings and committees*), the Commission's standing committees may elect to nominate Community Members for appointment by the BOS to serve as voting members on the respective committees.

A. As outlined in Policy/Procedure #09.1007 (*Community Member Appointments*), Community Members are invited to submit an application by the appropriate committee and are nominated according to that committee's specific criteria for Community Membership.

III. MEMBER REQUIREMENTS:

Section 1. Attendance. Commissioners and/or their Alternates are expected to attend all regularly scheduled Commission meetings, priority- and allocation-setting meetings, orientation and training meetings, and the Annual Meeting.

A. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the BOS shall be notified of member attendance on a semi-annual basis.

Section 2. Committee Assignments. Commissioners are required to be a member of at least one standing committee, the member's "primary committee assignment," and adhere to attendance requirements of that committee.

A. Commissioners who live and work outside of Los Angeles County as necessary to meet expectations of their specific seats on the Commission are exempted from the requirement of a primary committee assignment.

B. Commissioners and Alternates are allowed to voluntarily request or accept "secondary committee assignments" upon agreement of the Co-Chairs.

Section 3. Conflict of Interest. Consistent with the Los Angeles County Code 3.29.046 (*Conflict of Interest*), Commission members are required to abide by the Conflict of Interest and Disclosure requirements of the Commission, the County of Los Angeles, the State of California (including Government Code Sections 87100, 87103, and 1090, et seq.), the Ryan White Program, as outlined in HRSA and relevant CDC guidance.

A. As specified in Section 2602(b)(5) (42 U.S.C § 300ff-12) of the Ryan White legislation, the Commission shall not be involved directly or in an advisory capacity in the administration of Ryan White funds, and shall not designate or otherwise be involved in the selection of particular entities as recipients of those grant funds. While not addressed in the Ryan White legislation, the Commission shall adhere to the same rules for CDC and other funding.

B. Section 2602(b)(5)(B) continues that a planning council member who has a financial interest in, is employed by, or is a member of a public or private entity seeking local Ryan White funds as a provider of specific services is precluded from participating in—directly or in an advisory capacity—the process of selecting contracted providers for those services.

C. Further, in accordance with HRSA guidance, Commission Policy/Procedure #08.3105 (*Ryan White Conflict of Interest Requirements*) dictates that all members must declare conflicts of interest involving Ryan White-funded agencies and their services, and the member is required to recuse him/herself from discussion concerning that area of conflict, or funding for those services and/or to those agencies.

Section 4. Code of Conduct. All Commission members are expected to adhere to the Commission's approved code of conduct at Commission and related meetings and in the private conduct of Commission business.

Section 5. Comprehensive Training. Commissioners and Alternates are required to fulfill all training requirements, as indicated in the Commission's approved comprehensive training plan, including, but not limited to, the New Member Orientation(s), and Los Angeles County Ethics and Sexual Harassment trainings.

Section 6. Removal/Replacement. A Commissioner or Alternate may be removed or replaced by the BOS for failing to meet attendance requirements, and/or other reasons determined by the BOS.

A. The Executive Director may vacate a seat after six months of consecutive absences if the member's term is expired, or during the term if a member has moved out of the jurisdiction and/or no longer meets the qualifications for the seat.

IV. NOMINATION PROCESS:

Section 1. Open Nominations Process. Application, evaluation, nomination and appointment of Commission members shall follow "...an open process (in which) candidates shall be selected based on locally delineated and publicized criteria," as described in Section 2602(b)(1) of the Ryan White legislation and "develop and apply criteria for selecting HPG members, placing special emphasis on identifying representatives of at-risk, affected, HIV-positive, and socio-economically marginalized populations," as required by the CDC *HIV Planning Guidance.*

A. The Commission's Open Nominations Process is defined in Policy/ Procedure #09.4205 (*Commission Membership Evaluation and Nominations Process*) and related policies and procedures.

B. Nomination of candidates that are forwarded to the BOS for appointment shall be made according to the policy and criteria adopted by the Commission.

Section 2. Application. Application for Commission membership shall be made on forms as approved by the Commission and detailed in Policy/Procedure #09.4203 (*Commission Membership Applications*).

A. All candidates for first-time Commission membership shall be interviewed by the Operations Committee in accordance with Policy/Procedure #09.4204 (*Commission Candidate Interviews*).

B. Any candidate may apply individually or through recommendation of other stakeholders or entities.

C. Candidates cannot be recommended to the Commission or nominated to the BOS without completing appropriate Commission-approved application materials and being evaluated and scored by the Operations Committee.

Section 3. Appointments. All Commission members (Commissioners, Alternates and Community Members) must be appointed by the BOS.

V. MEETINGS:

Section 1. Public Meetings. The Commission complies with federal open meeting requirements in Section 2602(b)(7)(B) of the Ryan White legislation and accompanying HRSA guidance, and with California's Ralph M. Brown Act ("Brown Act") governing open, public meetings and deliberations.

A. Ryan White legislation states that "meeting of the (planning) council shall be open to the public and shall be held only after adequate notice to the public." HRSA guidance stipulates that those rules apply to the Commission meetings and meetings of its committees.
B. The Brown Act instructs that any meeting involving a quorum of the Commission or a committee must be open to the public and noticed publicly.
C. Public meeting requirements of the Commission's working units are outlined in the Commission's Policy/Procedure #08.1102 (*Subordinate Commission Working Units*).

Section 2. Public Noticing. Advance public notice of meetings shall comply with HRSA's open meeting and Brown Act public noticing requirements, and all other applicable laws and regulations.

Section 3. Meeting Minutes/Summaries. Meeting summaries and minutes are produced in accordance with HRSA's open meeting requirements, the Brown Act, Commission Policy/Procedure #08.1102 (*Subordinate Commission Working Units*), and all other applicable laws and regulations.

A. Minutes and summaries are posted to the Commission's website at www.hivcommission-la.info following their approval by the respective body.

Section 4. Public Comment. In accordance with Brown Act requirements, public comment on agendized and non-agendized items is allowed at all Commission meetings open to the public. The Commission is allowed to limit the time of public comment consistent with Los Angeles County rules and regulations, and must adhere to all other County and Brown Act rules and requirements regarding public comment.

Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the Commission shall meet at least ten (10) times per year. Commission meetings are monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee.

A. The Commission's Annual Meeting replaces one of the regularly scheduled monthly meetings during the fall of the calendar year.

Section 6. Special Meetings. Special meetings may be called as necessary by the Co-Chairs, the Executive Committee, or a majority of the members of the Commission.

A. The members of the Commission requesting a special meeting shall do so in writing to the Executive Director, with original signatures, who is obliged to call the meeting, in consultation with the Co-Chairs, within ten (10) days upon receipt of the written request.

Section 7. Executive Sessions. In accordance with the Brown Act, the Commission or its committees may convene executive sessions closed to the public to address pending litigation or personnel issues. An executive session will be posted as such.

Section 8. Robert's Rules of Order. All meetings of the Commission shall be conducted ac-

cording to the current edition of "*Robert's Rules of Order, Newly Revised*," except where superseded by the Commission's Bylaws, policies/procedures, and/or applicable laws.

Section 9. Quorum. In accordance with Los Angeles County Code 3.29.070 (*Procedures*), the quorum for any regular or special Commission or committee meeting shall be a majority of the voting, seated Commission or committee members.

A. A quorum for any committee meeting shall be a majority of Board-appointed, voting members or their Alternates assigned to the committee.

VI. RESOURCES:

Section 1. Fiscal Year. The Commission's Fiscal Year (FY) and programmatic year coincide with the County's fiscal year, from July 1 through June 30 of any given year.

Section 2. Operational Budgeting and Support. Operational support for the Commission is principally derived from Ryan White Part A and CDC prevention funds, and Net County Costs ("NCC")—all from grant and County funding managed by DHSP. Additional support may be obtained from alternate sources, as needed and available, for specific Commission activities.

A. The total amount of each year's operational budget is negotiated annually with DHSP, in accordance with County budgeting guidelines, and approved by the DHSP Director and the Commission's Executive Committee.

B. Projected Commission operational expenditures are allocated from Ryan White Part A administrative, CDC prevention, and NCC funding in compliance with relevant guidance and allowable expenses for each funding stream. As the administrative agent of those funds, DHSP is charged with oversight of those funds to ensure that their use for Commission operational activities is compliant with relevant funder program regulations and the terms and conditions of the award/funding.

C. Costs and expenditures are enabled through a Departmental Service Order (DSO) between DHSP/DPH and the Executive Office of the BOS, the Commission's fiscal and administrative agent.

D. Expenditures for staffing or other costs covered by various funding sources will be prorated in the Commission's annual budget according to their respective budget cycles and the Commission's/County's fiscal year.

Section 3. Other Support. Activities beyond the scope of Ryan White Part A planning councils and CDC HPGs, as defined by HRSA and CDC guidance, are supported by other sources, including NCC, as appropriate.

Section 4. Additional Revenues. The Commission may receive other grants and/or revenues for projects/activities within the scope of its duties and responsibilities, as defined in these Bylaws Article I, Section 4. The Commission will follow County-approved procedures for allocating project-/activity-related costs and resources

in the execution of those grants and/or fulfillment of revenue requirements.

Section 5. Commission Member Compensation. In accordance with Los Angeles County Code 3.29.080 (*Compensation*), Ryan White Part A planning council requirements, CDC guidance, and/or other relevant grant restrictions, Commission members, or designated subsets of Commission members, may be compensated for their service on the Commission contingent upon the establishment of policies and procedures governing Commission member compensation practices.

Section 6. Staffing. The Executive Director serves as the Commission's lead staff person and manages all personnel, budgetary and operational activities of the Commission.

A. The Co-Chairs and the Executive Committee are responsible for overseeing the Executive Director's performance and management of Commission operations and activities consistent with Commission decisions, actions, and directives.

B. Within Los Angeles County's organizational structure, the County's Executive Officer and/or his/her delegated representative serve as the supervising authority of the Executive Director.

VII. POLICIES AND PROCEDURES:

Section 1. Policy/Procedure Manual. The Commission develops and adopts policies and procedures consistent with Ryan White, HRSA, and CDC requirements, Los Angeles County Code, Title 3—Chapter 29, these Bylaws, and other relevant governing rules and requirements to operationalize Commission functions, work and activities. The policy/procedure index and accompanying adopted policies/procedures are incorporated by reference into these Bylaws and are maintained electronically on the Commission's website (www.hivcommission-la.info) and manually in the Commission's offices.

Section 2. HRSA Approval(s). DMHAP/HAB at HRSA requires Ryan White Part A planning councils to submit their bylaws, grievance and conflict of interest policies for approval by the Ryan White Part A project officer.

A. Project officer approval is necessary before the Bylaws, the grievance procedures and the Ryan White conflict of interest procedures are amended, and/or the Bylaws and those procedures must be amended to abide by HRSA requirements, as instructed by the project officer.

Section 3. Grievance Procedures. The Commission's Policy/ Procedure #05.8001 (*Commission on HIV Grievance Process*) are incorporated by reference into these Bylaws. The Commission's grievance procedures must comply with Ryan White, HRSA, CDC, and Los Angeles County requirements, and will be amended from time to

time, as needed, accordingly.

Section 4. Complaints Procedures. Complaints related to internal Commission matters such as alleged violations of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302 *(Internal Complaints)*.

Section 5. Conflict of Interest Procedures. Specific member conflict of interest requirements are detailed in Policy/Procedure #08.3105 (*Ryan White Conflict of Interest Requirements*) and Policy/Procedure #08.3108 (*State Conflict of Interest Requirements*). The Commission's conflict of interest procedures must comply with Ryan White, HRSA, CDC, State of California and Los Angeles County requirements, and will be amended from time to time, as needed, accordingly. These policies/procedures are incorporated by reference into these Bylaws.

VIII. LEADERSHIP:

Section 1. Commission Co-Chairs. The officers of the Commission shall be two (2) Commission Co-Chairs ("Co-Chairs").

A. One of the Co-Chairs must be HIV-positive. Best efforts shall be made to have the Co-Chairs reflect the diversity of the HIV epidemic in Los Angeles County.

B. The Co-Chairs' terms of office are two years, which shall be staggered. In the event of a vacancy, a new Co-Chair shall be elected to complete the term.

C. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting at least four months prior to the start date of their term, after nominations periods opened at the prior regularly scheduled meeting. The term of office begins at the start of the calendar year. When a new Co-Chair is elected, this individual shall be identified as the Co-Chair-Elect and will have four months of mentoring and preparation for the Co-Chair role.

D. As reflected in Policy/Procedure #07.2001 (*Duty Statement, Commission Co-Chair*), one or both of the Co-Chairs shall preside at all regular or special meetings of the Commission and at the Executive Committee. In addition, the Co-Chairs shall:

1. Assign the members of the Commission to committees;
2. Approve committee co-chairs, in consultation with the Executive Committee;
3. Represent the Commission at functions, events and other public activities, as necessary;
4. Call special meetings, as necessary, to ensure that the Commission fulfills its duties;
5. Consult with and advise the Executive Director regularly, and the Ryan White Part A and CDC project officers, as needed;
6. Conduct the performance evaluation of the Executive Director, in consultation with the Executive Committee and the Executive Office of the BOS;

7. Chair or co-chair committee meetings in the absence of both committee co-chairs;
8. Serve as voting members on all committees when attending those meetings;
9. Are empowered to act on behalf of the Commission or Executive Committee on emergency matters; and
10. Attend to such other duties and responsibilities as assigned by the BOS or the Commission.

Section 2. Committee Co-Chairs: Each committee shall have two co-chairs of equal status.

A. Committee co-chairs' terms of office are one year, but they may be re-elected by the committee membership. In the event of a vacancy, a new co-chair shall be elected by the respective committee to complete the term.

B. Committee co-chairs are elected by a majority vote of the members of the respective committees present at regularly scheduled meetings at the beginning of the calendar year, after nominations periods opened at the prior regularly scheduled meetings of the committees. Once elected, the committee co-chairs' names shall be submitted to the Commission Co-Chairs and the Executive Committee for approval.

C. As detailed in Policy/Procedure #07.2003 (*Duty Statement, Commission Co-Chair*), one or both of the co-chairs shall preside at all regular or special meetings of their respective committee. Committee co-chairs shall have the following additional duties:
   1. Serve as members of the Executive Committee;
   2. Develop annual work plans for their respective committees in consultation with the Executive Director, subject to approval of the Executive Committee and/or Commission;
   3. Manage the work of their committees, including ensuring that work plan tasks are completed; and
   4. Present the work of their committee and any recommendations for action to the Executive Committee and the Commission.

IX. COMMISSION WORK STRUCTURES:

Section 1. Committees and Working Units. The Commission completes a majority of its work through a strong committee and working unit structure outlined in Policy/Procedure #08.1102 (*Subordinate Commission Working Units*).

Section 2. Commission Decision-Making. Committee work and decisions are forwarded to the full Commission for further consideration and approval through the Executive Committee, unless that work or decision has been specifically delegated to a committee. All final decisions and work presented to the Commission must be

approved by at least a majority of the quorum of the Commission.

Section 3. Standing Committees. The Commission has established five standing committees: Executive; Operations; Planning, Priorities and Allocations (PP&A); Public Policy (PP); and Standards and Best Practices (SBP).

Section 4. Committee Membership. Only Commissioners or Alternates assigned to the committees by the Co-Chairs, the Co-Chairs themselves, Community Members nominated by the committee and appointed by the BOS, and designated representatives of DHSP shall serve as voting members of the committees.

Section 5. **Meetings.** All committee meetings are open to the public, and the public is welcome to attend and participate, but without voting privileges.

Section 6. Other Working Units. The Commission and its committees may create other working units such as subcommittees, ad-hoc committees, caucuses, task forces, or work groups, as they deem necessary and appropriate.

A. The Commission is empowered to create caucuses of subsets of Commission members who are members of "key or priority populations" or "populations of interest" as identified in the comprehensive HIV plan, such as consumers. Caucuses are ongoing for as long as they are needed.
B. Task forces are established to address a specific issue or need and may be ongoing, such as the Community Engagement Task Force, or time-limited.

X. EXECUTIVE COMMITTEE:

Section 1. Voting Membership. The voting membership of the Executive Committee shall comprise the Commission Co-Chairs, the committee co-chairs, the Director of DHSP or his/her permanent designee, and three (3) At-Large members who may be elected by the Commission.

Section 2. Co-Chairs. The Commission Co-Chairs shall serve as the co-chairs of the Executive Committee, and one or both shall preside over its meetings.

Section 3. Responsibilities. The Executive Committee is charged with the following responsibilities:

A. Overseeing all Commission and planning council operational and administrative activities;
B. Serving as the clearinghouse to review and forward items for discussion, approval and action to the Commission and its various working groups and units;
C. Acting on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission;
D. Approving the agendas for the Commission's regular, Annual and special meetings;

E. Determining the annual Commission work plan and functional calendar of activities, in consultation with the committees and subordinate working units;
F. Conducting strategic planning activities for the Commission;
G. Adopting a Memorandum Of Understanding ("MOU") with DHSP, if needed, and monitoring ongoing compliance with the MOU;
H. Resolving potential grievances or internal complaints informally when possible, and standing as a hearing committee for grievances and internal complaints;
I. Approving the election of committee co-chairs;
J. Addressing matters related to Commission office staffing, personnel and operations, when needed;
K. Developing and adopting the Commission's annual operational budget;
L. Overseeing and monitoring Commission expenditures and fiscal activities; and
M. Carrying out other duties and responsibilities, as assigned by the BOS or the Commission.

Section 4. At-Large Member Duties. As reflected in Policy/Procedure #07.2002 (*Duty Statement, Executive Committee At-Large Members*), the At-Large members shall serve as members of both the Executive and Operations Committees.

XI. OPERATIONS COMMITTEE:

Section 1. Voting Membership. The voting membership of the Operations Committee shall comprise the Executive Committee At-Large members elected by the Commission membership, other members assigned by the Co-Chairs, and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The Operations Committee is charged with the following responsibilities:

A. Ensuring that the Commission membership adheres to Ryan White reflectiveness and representation and CDC PIR requirements (*detailed in Article II, Sections 5, 6 and 7*), and all other membership composition requirements;
B. Recruiting, screening, scoring and evaluating applications for Commission membership and recommending nominations to the Commission in accordance with the Commission's established Open Nominations Process;
C. Developing, conducting and overseeing ongoing, comprehensive training for the members of the Commission and public to educate them on matters and topics related to the Commission, HIV service delivery, skills building, leadership development, and providing opportunities for personal/professional growth;
D. Conducting regular orientation meetings for new Commission members and

interested members of the public to acquaint them with the Commission's role, processes and functions;

E. Developing and revising, as necessary, Commission member duty statements (job descriptions);

F. Recommending and nominating, as appropriate, candidates for committee, task force and other work group membership to the Commission;

G. Recommending amendments, as needed, to the Ordinance, which governs Commission operations;

H. Recommending amendments or revisions to the Bylaws consistent with Ordinance amendments and/or to reflect current and future goals, requirements and/or objectives;

I. Recommending, developing and implementing Commission policies and procedures and maintenance of the Commission's Policy/Procedure Manual;

J. Coordinating on-going public awareness and information referral activities in collaboration with the Community Engagement Task Force to educate and engage the public about the Commission and promote the availability of HIV services;

K. Working with local task forces to ensure their representation and involvement in the Commission and in its activities;

L. Identifying, accessing and expanding other financial resources to support the Commission's special initiatives and ongoing operational needs;

M. Conducting an annual assessment of the administrative mechanism, and overseeing implementation of the resulting, adopted recommendations; and

N. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XII. PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE:

Section 1. Voting Membership. The voting membership of the PP&A Committee shall comprise members of the Commission assigned by the Commission Co-Chairs, a DHSP representative, and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The PP&A Committee is charged with the following responsibilities:

A. Conducting continuous, ongoing needs assessment activities and related collection and review as the basis for decision-making, including gathering expressed need data from consumers on a regular basis, and reporting regularly to the Commission on consumer and service needs, gaps and priorities;

B. Overseeing development and updating of the comprehensive HIV plan, and monitoring implementation of the plan;

C. Recommending to the Commission annual priority rankings among service

categories and types of activities and determining resource allocations for Part A, Part B, prevention, and other HIV and STD funding;

D. Ensuring that the priorities and implementation efforts are consistent with needs, the continuum of HIV services, and the service delivery system;
E. Monitoring the use of funds to ensure they are consistent with the Commission's allocations;
F. Recommending revised allocations for Commission approval, as necessary;
G. Coordinating planning, funding, and service delivery to ensure funds are used to fill gaps and do not duplicate services provided by other funding sources and/or health care delivery systems;
H. Developing strategies to identify, document, and address "unmet need" and to identify people living with HIV who are unaware of their status, make HIV testing available, and bring them into care;
I. Collaborating with DHSP to ensure the effective integration and implementation of the continuum of HIV services;
J. Reviewing monthly fiscal reporting data for HIV and STD expenditures by funding source, service category, service utilization and/or type of activity;
K. Monitoring, reporting and making recommendations about unspent funds;
L. Identifying, accessing, and expanding other financial resources to meet Los Angeles County's HIV service needs; and
M. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XIII. PUBLIC POLICY (PP) COMMITTEE:

Section 1. Voting Membership. The voting membership of the PP Committee shall comprise members of the Commission assigned by the Commission Co-Chairs, a DHSP representative, additional community members nominated by the committee and appointed by the BOS, and the Commission Co-Chairs when attending.

Section 2. Resources. Since some PP Committee activities may be construed as outside the purview of the Ryan White Part A or CDC planning bodies, resources other than federal funds cover staff costs or other expenses used to carry out PP Committee activities.

Section 3. Responsibilities. The PP Committee is charged with the following responsibilities:

A. Advocating public policy issues at every level of government that impact Commission efforts to implement a continuum of HIV services or a service delivery system for Los Angeles County, consistent with the comprehensive HIV plan;
B. Initiating policy initiatives that advance HIV care, treatment and prevention services and related interests;
C. Providing education and access to public policy arenas for the Commission

members, consumers, providers, and the public;

D. Facilitating communication between government and legislative officials and the Commission;
E. Recommending policy positions on governmental, administrative, and legislative action to the Commission, the BOS, other County departments, and other stakeholder constituencies, as appropriate;
F. Advocating specific public policy matters to the BOS, County departments, interests and bodies, and other stakeholder constituencies, as appropriate;
G. Researching and implementing public policy activities in accordance with the County's adopted legislative agendas;
H. Advancing specific Commission initiatives related to its work into the public policy arena; and
I. Carrying out other duties and responsibilities as assigned by the Commission or the BOS.

XIV. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

Section 1. Voting Membership. The voting membership of the SBP Committee shall comprise members of the Commission assigned by the Commission Co-Chairs, a DHSP representative, additional Community Members nominated by the committee and appointed by the BOS, and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The SBP Committee is charged with the following responsibilities:

A. Working with the DHSP and other bodies to develop and implement a quality management plan and its subsequent operationalization;
B. Identifying, reviewing, developing, disseminating and evaluating standards of care for HIV and STD services;
C. Reducing the transmission of HIV and other STDs, improving health outcomes and optimizing quality of life and self-sufficiency for all people infected by HIV and their caregivers and families through the adoption and implementation of "best practices";
D. Recommending service system and delivery improvements to DHSP to ensure that the needs of people at risk for or living with HIV and/or other STDs are adequately met;
E. Developing and defining directives for implementation of services and service models;
F. Evaluating and designing systems to ensure that other service systems are sufficiently accessed;
G. Identifying and recommending solutions for service gaps;
H. Ensuring that the basic level of care and prevention services throughout Los Angeles County is consistent in both comprehensiveness and quality through the development, implementation and use of outcome measures;

I. Reviewing aggregate service utilization, delivery and/or quality management information from DHSP, as appropriate;

J. Evaluating and assessing service effectiveness of HIV and STD service delivery in Los Angeles County, with particular attention to, among other factors, outcome evaluation, cost effectiveness, capacity and best practices;

K. Verifying system compliance with standards by reviewing contract and RFP templates; and

L. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XV. OFFICIAL COMMUNICATIONS AND REPRESENTATIONS:

Section 1. Representation/Misrepresentation. No officer or member of the Commission shall commit any act or make any statement or communication under circumstances that might reasonably give rise to an inference that he/she is representing the Commission, including, but not limited to: communications upon Commission stationery; public acts; statements; or communications in which he/she is identified as a member of the Commission, except only in the following:

A. Actions or communications that are clearly within the policies of the Commission and have been authorized in advance by the Commission;

B. Actions or communications by the officers that are necessary for and/or incidental to the discharge of duties imposed upon them by these Bylaws, policies/procedures and/or resolutions/decisions of the Commission;

C. Communications addressed to other members of the Commission or to its staff, within Brown Act rules and requirements.

XVI. AMENDMENTS: The Commission shall have the power to amend or revise these Bylaws at any meeting at which a quorum is present, providing that written notice of the proposed change(s) is given at least ten days prior to such meeting. In no event shall these Bylaws be changed in such a manner as to conflict with Los Angeles County Code, Title 3—Chapter 29 establishing the Commission and governing its activities and operations, or with CDC, Ryan White, and HRSA requirements.

NOTED AND APPROVED: Craig A. Vincent-Jones **EFFECTIVE DATE:** July 11, 2013

Originally Adopted: 3/15/1995 *Revision(s): 1/27/1998, 10/14/1999, 8/28/2002, 9/8/2005, 9/14/2006, 7/1/2007, 4/9/2009, 2/9/2012, 5/2/2013, 7/11/2013*

HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH
Office of Diversity and Inclusion

Equity Lens for Decision Making

Below are the current equity lens questions for use in planning, decision-making and implementation for policies, practices, and programs. These are a guide only, and there may be other factors to consider. The Lens is an ever-evolving tool for decision making, that changes as our constructs and understandings change.

SECTION 1: Basic Racial Equity Lens

1. What is the policy, program or decision under review?
2. What racial, cultural and/or ethnic group(s) experience disparities related to this policy, program or decision? Are they at the table? (If not, why?)
3. How might the policy, program or decision affect the group(s)? How might it be perceived by the group(s)?
4. Does the policy, program or decision improve, worsen, or make no change to existing disparities? Please elaborate. Does it result in systemic change that addresses institutional racism?
5. Does the policy, program, or decision produce any intentional benefits or unintended consequences for the affected group(s)?
6. Based on the above responses, what are the possible revisions to the policy, program, or decision under review?
7. What next step is recommended and how will it be advanced?

Adapted from: Portland State University Equity Lens Assessment Tool

SECTION 2: Multi-Dimension Equity Lens

(Broad inclusion of multiple as well as intersecting historically marginalized groups and underserved populations) These questions provide more global considerations and speak to macro issues such as policy as well as individual project, program or micro issue decision making, action and implementation.

People

- How have we adequately ensured that our operational processes are inclusive and that elements of the process have not created barriers to meaningful participation?
- Which stakeholder groups would we like to have included but were unable to facilitate?
- Who is affected—positively, negatively, or not at all—by this decision, process, and actions? List positives and negatives.
- What are the specific ways this decision, process, or action, etc. is expected to reduce disparities and advance social justice?
- How have you intentionally involved stakeholders who are also members of the communities affected by the strategic investment or resource allocation? How do you validate your assessment?

Place

- On the basis of Harvard Chan School of Public Health's social, physical and cultural location, how does this process compensate for access limitations of various stakeholder groups?
- How have we modified our process to support access by marginalized community stakeholders?

Process

- How are our processes supporting the empowerment of communities historically most affected by inequities?
- How are processes ensuring that participants' emotional and physical safety needs are addressed?
- How are processes supporting participants' need to be productive and feel valued?
- How are our processes building ongoing community capacity for involvement with Harvard Chan School of Public Health by those communities historically most affected by inequities?
- How are we using this opportunity to contribute to the leadership development of those from marginalized communities?
- What types of biases have influenced the work of your group and how have these been identified and addressed?
- What improvements to team processes can you support for naming and identifying unaddressed bias?
- What have we learned about effective practices that we can recommend being continued by other offices and departments?
- What are the barriers to more equitable outcomes? (e.g. mandated, political, financial, programmatic, or managerial)